DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 410, 411, 414, 416, 419, 482, and 485

[CMS–1392–P]

RIN 0938–AO71

Medicare Program: Proposed Changes to the Hospital Outpatient Prospective Payment System and CY 2008 Payment Rates; Proposed Changes to the Ambulatory Surgical Center Payment System and CY 2008 Payment Rates; Medicare and Medicaid Programs: Proposed Changes to Hospital Conditions of Participation; Proposed Changes Affecting Necessary Provider Designations of Critical Access Hospitals

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

ACTION: Proposed rule.

SUMMARY: This proposed rule would revise the Medicare hospital outpatient prospective payment system to implement applicable statutory requirements and changes arising from our continuing experience with this system. In this proposed rule, we describe the proposed changes to the amounts and factors used to determine the payment rates for Medicare hospital outpatient services paid under the prospective payment system. These changes would be applicable to services furnished on or after January 1, 2008.

In addition, this proposed rule would update the revised Medicare ambulatory surgical center (ASC) payment system to implement certain related provisions of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). In this proposed rule, we propose the applicable relative payment weights and amounts for services furnished in ASCs, specific HCPCS codes to which the final policies of the ASC payment system would apply, and other pertinent ratesetting information for the CY 2008 ASC payment system. These changes would be applicable to services furnished on or after January 1, 2008.

In this proposed rule, we also are proposing changes to the policies relating to the necessary provider designations of critical access hospitals (CAHs) that are being recertified when a CAH enters into a new co-location arrangement with another hospital or CAH or when the CAH creates or acquires an off-campus location.

Further, we are proposing changes to several of the current conditions of participation that hospitals must meet to participate in the Medicare and Medicaid programs to require the completion and documentation in the medical record of medical histories and physical examinations of patients conducted after admission and prior to surgery or a procedure requiring anesthesia services and for postanesthesia evaluations of patients before discharge or transfer from the postanesthesia recovery area.

DATES: To be assured consideration, comments on all sections of the preamble of this proposed rule must be received at one of the addresses provided in the **ADDRESSES** section no later than 5 p.m. on September 14, 2007.

ADDRESSES: In commenting, please refer to file code CMS–1392–P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

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

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

2. *By regular mail.* You may mail written comments (one original and two copies) to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1392–P, P.O. Box 8011, Baltimore, MD 21244–1850.

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

3. *By express or overnight mail.* You may send written comments (one original and two copies) to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1392–P, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

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

If you intend to deliver your comments to the Baltimore address, please call telephone number (410) 786–9994 in advance to schedule your arrival with one of our staff members.

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

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

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

FOR FURTHER INFORMATION CONTACT:

Alberta Dwivedi, (410) 786–0378, Hospital outpatient prospective payment issues.

Dana Burley, (410) 786–0378, Ambulatory surgical center issues.

Suzanne Asplen, (410) 786–4558, Partial hospitalization and community mental health centers issues.

Sheila Blackstock, (410) 786–3502, Reporting of quality data issues.

Mary Collins, (410) 786–3189, and Jeannie Miller, (410) 786–3164, Necessary provider designations for CAHs Issues.

Scott Cooper, (410) 786–9465, and Jeannie Miller, (410) 786–3164, Hospital conditions of participation Issues.

SUPPLEMENTARY INFORMATION:

Submitting Comments: We welcome comments from the public on all issues set forth in this proposed rule to assist us in fully considering issues and developing policies. You can assist us by referencing file code CMS–1392–P and the specific ''issue identifier'' that precedes the section on which you choose to comment.

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

Comments received timely will also be available for public inspection as they are received, generally beginning approximately 3 weeks after publication

of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244, on Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone 1–800–743–3951.

Electronic Access

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

Alphabetical List of Acronyms Appearing in the Proposed Rule

ACEP American College of Emergency Physicians
AHA American Hospital Association
AHIMA American Health Information Management Association
AMA American Medical Association
APC Ambulatory payment classification
AMP Average manufacturer price
ASC Ambulatory Surgical Center
ASP Average sales price
AWP Average wholesale price
BBA Balanced Budget Act of 1997, Pub. L. 105–33
BBRA Medicare, Medicaid, and SCHIP [State Children's Health Insurance Program] Balanced Budget Refinement Act of 1999, Pub. L. 106–113
BCA Blue Cross Association
BCBSA Blue Cross and Blue Shield Association
BIPA Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, Pub. L. 106–554
CAH Critical access hospital
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 [Hospital] Condition of participation
CORF Comprehensive outpatient rehabilitation facility
CPT [Physicians'] Current Procedural Terminology, Fourth Edition, 2007, copyrighted by the American Medical Association
CRNA Certified registered nurse anesthetist
CY Calendar year
DMEPOS Durable medical equipment, prosthetics, orthotics, and supplies
DMERC Durable medical equipment regional carrier
DRA Deficit Reduction Act of 2005, Pub. L. 109–171
DSH Disproportionate share hospital
EACH Essential Access Community Hospital
E/M Evaluation and management
EPO Erythropoietin
ESRD End-stage renal disease
FACA Federal Advisory Committee Act, Pub. L. 92–463
FAR Federal Acquisition Regulations
FDA Food and Drug Administration
FFS Fee-for-service
FSS Federal Supply Schedule
FTE Full-time equivalent
FY Federal fiscal year
GAO Government Accountability Office
HCPCS Healthcare Common Procedure Coding System
HCRIS Hospital Cost Report Information System
HHA Home health agency
HIPAA Health Insurance Portability and Accountability Act of 1996, Pub. L. 104–191
HOPD Hospital outpatient department
HOP QDRP Hospital Outpatient Quality Data Reporting Program
ICD–9–CM International Classification of Diseases, Ninth Edition, Clinical Modification
IDE Investigational device exemption
IOL Intraocular lens
IPPS [Hospital] Inpatient prospective payment system
IVIG Intravenous immune globulin
MAC Medicare Administrative Contractors
MedPAC Medicare Payment Advisory Commission
MDH Medicare-dependent, small rural hospital
MIEA–TRHCA Medicare Improvements and Extension Act under Division B, Title I of the Tax Relief Health Care Act of 2006, Pub. L. 109–432
MMA Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. 108–173
MPFS Medicare Physician Fee Schedule
MSA Metropolitan Statistical Area
NCCI National Correct Coding Initiative
NCD National Coverage Determination
NTIOL New technology intraocular lens
OCE Outpatient Code Editor
OMB Office of Management and Budget
OPD [Hospital] Outpatient department
OPPS [Hospital] Outpatient prospective payment system
PHP Partial hospitalization program
PM Program memorandum
PPI Producer Price Index
PPS Prospective payment system
PPV Pneumococcal pneumonia (virus)
PRA Paperwork Reduction Act
QIO Quality Improvement Organization
RFA Regulatory Flexibility Act
RHQDAPU Reporting Hospital Quality Data for Annual Payment Update [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, Pub. L. 97–248
TOPS Transitional outpatient payments
USPDI United States Pharmacopoeia Drug Information
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) revised payment system. The provisions relating to the OPPS are included in sections I. through XV., XVII., and XIX. through XXII. of this proposed rule and in Addenda A, B, C (Addendum C is available on the Internet only; see section XIX. of this proposed rule), D1, D2, E, L, and M to this proposed rule. The provisions related to the revised ASC payment system are included in sections XVI., XVII., and XIX. through XXII. of this proposed rule and in Addenda AA, BB, DD1, and DD2 to this proposed rule.

Table of Contents

I. Background for the OPPS

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

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

The Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act (BBRA) of 1999 (Pub. L. 106–113) made major changes in the hospital OPPS. The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000 (Pub. L. 106–554) made further changes in the OPPS. Section 1833(t) of the Act was also amended by the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 (Pub. L. 108–173). The Deficit Reduction Act (DRA) of 2005 (Pub. L. 109–171), enacted on February 8, 2006, made additional changes in the OPPS. In addition, 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, made further changes in the OPPS. A discussion of these provisions is included in sections I.E., VII., and XVII. of this proposed rule.

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

Under the OPPS, we pay for hospital outpatient services on a rate-per-service basis that varies according to the ambulatory payment classification (APC) group to which the service is assigned. We use 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 proposed rule. Section 1833(t)(1)(B)(ii) of the Act provides for Medicare payment under the OPPS for hospital outpatient services designated by the Secretary (which includes partial hospitalization services furnished by community mental health centers (CMHCs)) and hospital outpatient services that are furnished to inpatients who have exhausted their Part A benefits, or who are otherwise not in a covered Part A stay. Section 611 of Pub. L. 108–173 added provisions for Medicare coverage of an initial preventive physical examination, subject to the applicable deductible and coinsurance, as an outpatient department service, payable under the OPPS.

The OPPS rate is an unadjusted national payment amount that includes the Medicare payment and the beneficiary copayment. This rate is divided into a labor-related amount and a nonlabor-related amount. The labor-related amount is adjusted for area wage differences using the 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, services and items within an APC group cannot be considered comparable with respect to the use of resources if the highest median (or mean cost, if elected by the Secretary) for an item or service in the APC group is more than 2 times greater than the lowest median cost for an item or service within the same APC group (referred to as the ''2 times rule''). In implementing this provision, we use the median cost of the item or service assigned to an APC group.

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

B. Excluded OPPS Services and Hospitals

Section 1833(t)(1)(B)(i) of the Act authorizes the Secretary to designate the hospital outpatient services that are paid under the OPPS. While most hospital outpatient services are payable under the OPPS, section

1833(t)(1)(B)(iv) of the Act excludes payment for ambulance, physical and occupational therapy, and speech-language pathology services, for which payment is made under a fee schedule. Section 614 of Pub. L. 108–173 amended section 1833(t)(1)(B)(iv) of the Act to exclude OPPS payment for screening and diagnostic mammography services. The Secretary exercised the authority granted under the statute to exclude from the OPPS those services that are paid under fee schedules or other payment systems. Such excluded services include, for example, the professional services of physicians and nonphysician practitioners paid under the Medicare Physician Fee Schedule (MPFS); laboratory services paid under the clinical diagnostic laboratory fee schedule (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 § 419.22 of the regulations.

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

C. Prior Rulemaking

On April 7, 2000, we published in the **Federal Register** a final rule with comment period (65 FR 18434) to implement a prospective payment system for hospital outpatient services. The hospital OPPS was first implemented for services furnished on or after August 1, 2000. Section 1833(t)(9) of the Act requires the Secretary to review certain components of the OPPS, no 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. We published in the **Federal Register** on November 24, 2006 the CY 2007 OPPS/ASC final rule with comment period (71 FR 67960). 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 2007 OPPS on the basis of claims data from January 1, 2005, through December 31, 2005, and to implement certain provisions of Pub. L. 108–173 and Pub. L. 109–171. In addition, we responded to public comments received on the provisions of the November 10, 2005 final rule with comment period (70 FR 86516) pertaining to the APC assignment of HCPCS codes identified in Addendum B of that rule with the new interim (NI) comment indicator; and public comments received on the August 23, 2006 OPPS/ASC proposed rule for CY 2007 (71 FR 49506).

D. APC Advisory Panel

1. Authority of the APC Panel

Section 1833(t)(9)(A) of the Act, as amended by section 201(h) of the BBRA, and redesignated by section 202(a)(2) of the BBRA, requires that we consult with an outside panel of experts to review the clinical integrity of the payment groups and their weights under the OPPS. The Act further specifies that the panel will act in an advisory capacity. The Advisory Panel on Ambulatory Payment Classification (APC) Groups (the APC Panel), discussed under section I.D.2. of this proposed rule, fulfills these requirements. The APC Panel is not restricted to using data compiled by CMS, and may use data collected or developed by organizations outside the Department in conducting its review.

2. Establishment of the APC Panel

On November 21, 2000, the Secretary signed the initial charter establishing the APC Panel. This expert panel, which may be composed of up to 15 representatives of providers subject to the OPPS (currently employed full-time, not as consultants, in their respective areas of expertise), reviews clinical data and advises CMS about the clinical integrity of the APC groups and their weights. For purposes of this Panel, consultants or independent contractors are not considered to be full-time employees. The APC Panel is technical in nature, and is governed by the provisions of the Federal Advisory Committee Act (FACA). Since its initial chartering, the Secretary has renewed the APC Panel's charter three times: on November 1, 2002; on November 1, 2004; and effective November 21, 2006. The current charter specifies, among other requirements, that the APC Panel continue to be technical in nature; be governed by the provisions of the FACA; may convene up to three meetings per year; has a Designated Federal Officer (DFO); and is chaired by a Federal official designated by the Secretary.

The current APC Panel membership and other information pertaining to the APC Panel, including its charter, **Federal Register** notices, 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, February 28, and March 1, 2001. Since the initial meeting, the APC Panel has held 11 subsequent meetings, with the last meeting taking place on March 7 and 8, 2007. Prior to each meeting, we publish a notice in the **Federal Register** to announce the meeting, and when necessary to solicit and announce nominations for the APC Panel's membership.

The APC Panel has established an operational structure that, in part, includes the use of three subcommittees to facilitate its required APC review process. The three current subcommittees are the Data Subcommittee, the Observation and Visit Subcommittee, and the Packaging Subcommittee. The Data Subcommittee is responsible for studying the data issues confronting the APC Panel, and for recommending options for resolving them. The Observation and Visit 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 Packaging Subcommittee 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. Each of these subcommittees was established by a majority vote from the full APC Panel during a scheduled APC Panel meeting, and their continuation as subcommittees was approved at the March 2007 APC Panel meeting. All subcommittee recommendations are discussed and voted upon by the full APC Panel.

Discussions of the recommendations resulting from the APC Panel's March

2007 meeting are included in the sections of this proposed rule that are specific to each recommendation. For discussions of earlier APC Panel meetings and recommendations, we reference previous hospital OPPS final rules or the Web site mentioned earlier in this section.

E. Provisions of the Medicare Improvements and Extension Act Under Division B of Title I of the Tax Relief and Health Care Act of 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, included the following provisions affecting the OPPS:

1. Section 107(a) of the MIEA–TRHCA amended section 1833(t)(16)(C) of the Act to extend the period for payment of brachytherapy devices based on the hospital's charges adjusted to cost for 1 additional year, through December 31, 2007.

2. Section 107(b)(1) of the MIEA–TRHCA amended section 1833(t)(2)(H) of the Act by adding stranded and non-stranded devices furnished on or after July 1, 2007, as additional classifications of brachytherapy devices for which separate payment groups must be established for payment under the OPPS. Section 107(b)(2) of the MIEA–TRCHA provides that the Secretary may implement the section 107(b)(1) amendment to section 1833(t)(2)(H) of the Act ''by program instruction or otherwise.''

3. Section 109(a) of the MIEA–TRHCA added new paragraph (17) to section 1833(t) of the Act which authorizes the Secretary, beginning in 2009 and each subsequent year, to reduce the OPPS full annual update by 2.0 percentage points if a hospital paid under the OPPS fails to submit data as required by the Secretary in the form and manner specified on selected measures of quality of care, including medication errors. In accordance with this provision, the selected measures are those that are appropriate for the measurement of quality of care furnished by hospitals in the outpatient setting, that reflect consensus among affected parties and, to the extent feasible and practicable, that include measures set forth by one or more of the national consensus entities, and that may be the same as those required for reporting by hospitals paid under the IPPS. This provision specifies that a reduction for 1 year cannot be taken into account when computing the OPPS update for a subsequent year. In addition, this provision requires the Secretary to establish a process for making the submitted data available for public review.

F. Summary of the Major Contents of This Proposed Rule

In this proposed rule, we are setting forth proposed changes to the Medicare hospital OPPS for CY 2008. These changes would be effective for services furnished on or after January 1, 2008. We are also setting forth proposed changes to the Medicare ASC payment system for CY 2008. These changes would be effective for services furnished on or after January 1, 2008. The following is a summary of the major changes that we are proposing to make:

1. Proposed Updates Affecting OPPS Payments

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

- The methodology used to recalibrate the proposed APC relative payment weights.
- The proposed payment for partial hospitalization services, including the proposed separate threshold for outlier payments for CMHCs.
- The proposed update to the conversion factor used to determine payment rates under the OPPS.
- 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.
- The proposed update of statewide average default CCRs.
- The proposed application of hold harmless transitional outpatient payments (TOPs) for certain small rural hospitals.
- 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. Proposed OPPS Ambulatory Payment Classification (APC) Group Policies

In section III. of this proposed rule, we discuss the proposed additions of new procedure codes to the APCs; our proposal to establish a number of new APCs; and our analyses of Medicare claims data and certain recommendations of the APC Panel. We also discuss the application of the 2 times rule and proposed exceptions to it; proposed changes to specific APCs; and the proposed movement of procedures from New Technology APCs to clinical APCs.

3. Proposed OPPS Payment for Devices

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

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

In section V. of this proposed rule, we discuss the proposed CY 2008 OPPS payment for drugs, biologicals, and radiopharmaceuticals, including the proposed payment for drugs, biologicals, and radiopharmaceuticals with and without pass-through status.

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

In section VI. of this proposed rule, we discuss the estimate of CY 2008 OPPS transitional pass-through spending for drugs, biologicals, and devices.

6. Proposed OPPS Payment for Brachytherapy Sources

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

7. Proposed OPPS Coding and Payment for Drug Administration Services

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

8. Proposed OPPS Hospital Coding and Payments for Visits

In section IX. of this proposed rule, we set forth our proposed changes to policies for the coding and reporting of clinic and emergency department visits and critical care services on claims paid under the OPPS.

9. Proposed OPPS Payment for Blood and Blood Products

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

10. Proposed OPPS Payment for Observation Services

In section XI. of this proposed rule, we discuss the proposed payment policies for observation services furnished to patients on an outpatient basis.

11. Proposed Procedures That Will Be Paid Only as Inpatient Services

In section XII. of this proposed rule, we discuss the procedures that we are

proposing to remove from the inpatient list and assign to APCs.

12. Proposed Nonrecurring Technical and Policy Changes

In section XIII. of this proposed rule, we set forth our proposals for nonrecurring technical and policy changes and clarifications relating to outpatient hospital services and supplies incident to a physician service; payment for interrupted procedures prior to and after the administration of anesthesia; transitional adjustments to payments for covered outpatient services furnished by small rural hospitals and SCHs located in rural areas; and reporting requirements for wound care services, cardiac rehabilitation services, and bone marrow and stem cell processing services.

13. Proposed OPPS Payment Status and Comment Indicators

In section XIV. of this proposed rule, we discuss proposed changes to the definitions of status indicators assigned to APCs and present our proposed comment indicators for the OPPS/ASC final rule with comment period.

14. OPPS Policy and Payment Recommendations

In section XV. of this proposed rule, we address recommendations made by MedPAC and the APC Panel regarding the OPPS for CY 2008.

15. Proposed Update of the Revised ASC Payment System

In section XVI. of this proposed rule, we discuss the proposed update of the revised ASC payment system payment rates for CY 2008. We also discuss our proposed changes to our regulations § 414.22 (b)(5)(i)(A) and (B) regarding physician payment for performing noncovered ASC surgical procedures in ASCs. In addition, we are proposing to revise the definitions of ''radiology and certain other imaging services'' and ''outpatient prescription drugs'' when provided integral to an ASC covered surgical procedure.

16. Reporting Quality Data for Annual Payment Rate Updates

In section XVII. of this proposed rule, we discuss the proposed quality measures for reporting hospital outpatient quality data for CY 2009 and subsequent years and set forth the requirements for data collection and submission for the annual payment update. We also briefly discuss the legislative provisions of the MIEA–TRHCA that give the Secretary authority to develop quality measures for reporting by ASCs.

17. Proposed Changes Affecting Necessary Provider Critical Access Hospitals (CAHs) and Hospital Conditions of Participation (CoPs)

In section XVIII. of this proposed rule, we discuss our proposed changes affecting necessary provider designations for CAHs that are being recertified when the CAH enters into a new co-location arrangement with another hospital or CAH or when the CAH creates or acquires an off-campus location. We also discuss our proposed changes relating to several hospital CoPs to require the completion of physical examinations and medical histories, and documentation in the medical records, for patients after admission and prior to surgery or a procedure requiring anesthesia services and for postanesthesia evaluations of patients before discharge or transfer from the postanesthesia recovery area.

18. Regulatory Impact Analysis

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

II. Proposed Updates Affecting OPPS Payments

A. Proposed Recalibration of APC Relative Weights

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

1. Database Construction

a. Database Source and Methodology

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

We are proposing to use the same basic methodology that we described in the April 7, 2000 OPPS final rule with comment period to recalibrate the APC relative payment weights for services furnished on or after January 1, 2008, and before January 1, 2009. That is, we are proposing to recalibrate the relative payment weights for each APC based on claims and cost report data for outpatient services. We are proposing to use the most recent available data to construct the database for calculating APC group weights. For the purpose of recalibrating the proposed APC relative payment weights for CY 2008, we used approximately 131 million final action claims for hospital OPD services furnished on or after January 1, 2006, and before January 1, 2007. (For exact counts of claims used, we refer readers to the claims accounting narrative under supporting documentation for this proposed rule on the CMS Web site at *http://www.cms.hhs.gov/HospitalOutpatientPPS/HORD/).* Of the 131 million final action claims for services provided in hospital outpatient settings, approximately 101 million claims were of the type of bill potentially appropriate for use in setting rates for OPPS services (but did not necessarily contain services payable under the OPPS). Of the 101 million claims, approximately 46 million 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). We were able to use approximately 50 million whole claims of the approximately 54 million claims that remained to set the OPPS APC relative weights we are proposing for the CY 2008 OPPS. From the 50 million whole claims, we created approximately 88 million single records, of which approximately 58 million were ''pseudo'' single claims (created from multiple procedure claims using the process we discuss in this section). Approximately 822,000 claims trimmed out on cost or units in excess of ±3 standard deviations from the geometric mean, yielding approximately 87 million single bills used for median setting. Ultimately, we were able to use for proposed CY 2008 ratesetting some portion of 92 percent of the CY 2006 claims containing services payable under the OPPS.

The proposed APC relative weights and payments for CY 2008 in Addenda A and B to this proposed rule were calculated using claims from this period that were processed before January 1, 2007, 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 which we are proposing to convert to relative payment weights for purposes of calculating the CY 2008 payment rates.

b. Proposed Use of Single and Multiple Procedure Claims

For CY 2008, in general, we are proposing 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. We have received many requests asking that we ensure that the data from claims that contain charges for multiple procedures are included in the data from which we calculate the relative payment weights. Requesters believe that relying solely on single procedure claims to recalibrate APC relative payment weights fails to take into account data for many frequently performed procedures, particularly those commonly performed in combination with other procedures. They believe that if a service is frequently performed in combination with others, the individual services are more complex and more resource-intensive than if they were performed alone. Stakeholders have suggested that including data from multiple procedure claims could increase the median cost estimates for the individual services. They believe that depending upon single procedure claims alone results in basing relative payment weights on the least costly services that are not representative of the typical services, thereby introducing downward bias to the medians on which the weights are based.

We generally use single procedure claims to set the median costs for APCs because we believe that it is important that the OPPS relative weights on which payment rates are based be appropriate when one and only one procedure is furnished and because we are, so far, unable to ensure that packaged costs can be appropriately allocated across multiple procedures performed on the same date of service. 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. We engaged in several efforts this year to improve our use of multiple procedure claims for ratesetting. As we have for several years, we continue to use date of service stratification and a list of codes to be bypassed to convert multiple procedure claims to ''pseudo'' single procedure claims. We also continued our internal efforts to better understand the patterns of services and costs from multiple bills toward the goal of using more multiple bill information by assessing the amount of packaging in the multiple bills and, specifically, by exploring the amount of packaging for drug administration services in the single and multiple bill claims. Moreover, in many cases, the proposed expansion of packaging also enables the use of more claims data by enabling us to treat claims with multiple procedure codes as single claims. We refer readers to section II.A.4. of this proposed rule for a full discussion of this proposal for CY 2008.

(1) Proposed Use of Date of Service Stratification and a Bypass List To Increase the Amount of Data Used To Determine Medians

By bypassing specified codes that we believe do not have significant packaged costs, we are able to use more data from multiple procedure claims. In many cases, this enables us to create multiple ''pseudo'' single claims from claims that, as submitted, contained multiple separately paid procedures on the same claim. We refer to these newly created single procedure claims as ''pseudo'' single claims because they were submitted by providers as multiple procedure claims. The history of our use of a bypass list to generate ''pseudo'' single claims is well documented, most recently in the CY 2007 OPPS/ASC final rule with comment period (71 FR 67969 through 67970).

The date of service stratification and bypass list process we used for the CY 2007 OPPS (combined with the packaging changes we are proposing in section II.A.4. of this proposed rule) resulted in our being able to use some part of approximately 92 percent of the total claims that are eligible for use in the OPPS ratesetting and modeling for this proposed rule. This process enabled us to create, for CY 2008 approximately 58 million ''pseudo'' singles and approximately 30 million ''natural'' single bills. For this proposed rule, ''pseudo'' single procedure bills represented 66 percent of all single bills used to calculate median costs. This compares favorably to the CY 2007 OPPS final rule data in which ''pseudo'' single bills represented 68 percent of all single bills used to calculate the median costs on which the CY 2007 OPPS payment rates were based. We believe that the reduction in the percent of ''pseudo'' single bills and the corresponding increase in the proportion of ''natural'' single bills occurred largely because of our proposal to increase packaging as discussed in section II.A.4. of this proposed rule. In many cases, the packaging proposal for CY 2008 enabled us to use claims that would otherwise have been considered to be multiple procedure claims and, absent the proposal for additional packaging, could have been used for ratesetting only if we had been able to create ''pseudo'' single claims from them.

For CY 2008, we are proposing to bypass 425 HCPCS codes that are identified in Table 1 of this proposed rule. We are proposing to continue the use of the codes on the CY 2007 OPPS bypass list but to remove codes we are proposing to package for CY 2008. We also are proposing to remove codes that were on the CY 2007 bypass list that ceased to meet the empirical criteria under the proposed packaging changes when clinical review confirmed that their removal would be appropriate in the context of the full proposal for the CY 2008 OPPS. Since the inception of the bypass list, we have calculated the percent of natural single bills that contained packaging for each code and the amount of packaging in each ''natural'' single bill for each code. We retained the codes on the previous year's bypass list and used the update year's data to determine whether it would be appropriate to add additional codes to the previous year's bypass list. The entire list (including the codes that remained on the bypass list from prior years) was open to public comment. For this CY 2008 proposed rule, we explicitly reviewed all ''natural'' single bills against the empirical criteria for all codes on the CY 2007 bypass list because of the proposal for greater packaging discussed in section II.A.4. of this proposed rule, as this effort increased the packaging associated with some codes. We removed 106 HCPCS codes from the CY 2007 bypass list for the CY 2008 proposal. We note also that many of the codes we are proposing to newly package for CY 2008 were on the bypass list used for setting the OPPS payment rates for CY 2007 and are no longer proposed for bypass because we are proposing to package them, as discussed in more detail below. We also are proposing to add to the bypass list HCPCS codes that, using the proposed rule data, meet the same previously established empirical criteria for the bypass list that are reviewed below or which our clinicians believe would have little associated packaging if the services were correctly coded.

The CY 2008 packaging proposal minimally reduced the percentage of total claims that we were able to use, in whole or in part, from 93 percent for CY 2007 to 92 percent for this proposed rule. The proposed packaging approach increased the number of ''natural'' single bills, in spite of reducing the

universe of codes requiring single bills for ratesetting, but reduced the number of ''pseudo'' single bills. More ''natural'' single procedure bills can be created by the packaging of codes that always appear with another procedure because these dependent services are supportive of and ancillary to the primary independent procedures for which payment is being made. A claim containing two independent procedure codes on the same date of service and not on the bypass list previously could not be used for ratesetting, but packaging the cost of one of the codes on the claim frees the claim to be used to calculate the median cost of the procedure that is not packaged. On the other hand, our proposed packaging approach reduced the number of codes eligible for the bypass list because of the limitation on packaging set by our previously established empirical criteria. A smaller bypass list and the presence of greater packaging on claims reduced the final number of ''pseudo'' single claims. In prior years, roughly 68 percent of single bills were ''pseudo'' single bills, but based on the CY 2008 proposed rule data, 66 percent of single bills were ''pseudo'' singles. Moreover, the number of ''natural'' single bills and ''pseudo'' single bills are reduced by the volume of services that we are proposing to package. Hence, our CY 2008 proposal to package payment for some HCPCS codes with relatively high frequencies would eliminate for ratesetting the number of available ''natural'' and ''pseudo'' single bills attributable to the codes that we are proposing to package.

As in prior years, we are proposing to use the following empirical criteria to determine the additional codes to add to the CY 2007 bypass list to create the CY 2008 bypass list. We assume that the representation of packaging on the single claims for any given code is comparable to packaging for that code in the multiple claims:

- There are 100 or more single claims for the code. This number of single claims ensures that observed outcomes are sufficiently representative of packaging that might occur in the multiple claims.
- Five percent or fewer of the single claims for the code have packaged costs on that single claim for the code. This criterion results in limiting the amount of packaging being redistributed to the payable procedure remaining on the claim after the bypass code is removed and ensures that the costs associated with the bypass code represent the cost of the bypassed service.
- The median cost of packaging observed in the single claims is equal to or less than $50. This limits the amount of error in redistributed costs.
- The code is not a code for an unlisted service.

In addition, we are proposing to add to the bypass list codes that our clinicians believe have minimal associated packaging based on their clinical assessment of the full CY 2008 OPPS proposal. We note that this list contains bypass codes that are appropriate to claims for services in CY 2006 and, therefore, includes codes that have been deleted for CY 2007. Moreover, there are codes on the bypass list that are new for CY 2007 and which are appropriate additions to the bypass list in preparation for use of the CY 2007 claims for creation of the CY 2009 OPPS.

In order to keep the established empirical criteria for the bypass list constant, we are seeking public comment on whether we should adjust the $50 packaging cost criterion for inflation each year and, if so, recommendations for the source of the adjustment. Adding an inflation adjustment factor would ensure that the same amount of packaging associated with candidate codes for the bypass list is reviewed each year relative to nominal costs.

TABLE 1.—PROPOSED CY 2008 BYPASS CODES FOR CREATING ''PSEUDO'' SINGLE CLAIMS FOR CALCULATING MEDIAN COSTS

HCPCS code	Short descriptor
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.
17003 ...	Destruct premalg les, 2–14.
31231 ...	Nasal endoscopy, dx.
31579 ...	Diagnostic laryngoscopy.
51798 ...	Us urine capacity measure.
54240 ...	Penis study.
56820 ...	Exam of vulva 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.
70250 ...	X-ray exam of skull.
70260 ...	X-ray exam of skull.

TABLE 1.—PROPOSED CY 2008 BYPASS CODES FOR CREATING ''PSEUDO'' SINGLE CLAIMS FOR CALCULATING MEDIAN COSTS—Continued

HCPCS code	Short descriptor
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.
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.
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.

TABLE 1.—PROPOSED CY 2008 BYPASS CODES FOR CREATING ''PSEUDO'' SINGLE CLAIMS FOR CALCULATING MEDIAN COSTS—Continued

HCPCS code	Short descriptor
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.
76020 ...	X-rays for bone age.
76040 ...	X-rays, bone evaluation.
76061 ...	X-rays, bone survey.
76062 ...	X-rays, bone survey.
76065 ...	X-rays, bone evaluation.
76066 ...	Joint survey, single view.
76070 ...	Ct bone density, axial.
76071 ...	Ct bone density, peripheral.
76075 ...	Dxa bone density, axial.
76076 ...	Dxa bone density/peripheral
76077 ...	Dxa bone density/v-fracture.
76078 ...	Radiographic absorptiometry.
76100 ...	X-ray exam of body section.
76400 ...	Magnetic image, bone marrow.
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.
76770 ...	Us exam abdo back wall, comp.
76775 ...	Us exam abdo back wall, lim.
76778 ...	Us exam kidney transplant.
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.

TABLE 1.—PROPOSED CY 2008 BYPASS CODES FOR CREATING ''PSEUDO'' SINGLE CLAIMS FOR CALCULATING MEDIAN COSTS—Continued

HCPCS code	Short descriptor
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.
76999 ...	Echo examination procedure.
77300 ...	Radiation therapy dose plan.
77301 ...	Radiotherapy dose plan, imrt.
77315 ...	Teletx isodose plan complex.
77326 ...	Brachytx isodose calc simp.
77327 ...	Brachytx isodose calc interm.
77328 ...	Brachytx isodose plan compl.
77331 ...	Special radiation dosimetry.
77336 ...	Radiation physics consult.
77370 ...	Radiation physics consult.
77401 ...	Radiation treatment delivery.
77402 ...	Radiation treatment delivery.
77403 ...	Radiation treatment delivery.
77404 ...	Radiation treatment delivery.
77407 ...	Radiation treatment delivery.
77408 ...	Radiation treatment delivery.
77409 ...	Radiation treatment delivery.
77411 ...	Radiation treatment delivery.
77412 ...	Radiation treatment delivery.
77413 ...	Radiation treatment delivery.
77414 ...	Radiation treatment delivery.
77416 ...	Radiation treatment delivery.
77418 ...	Radiation tx delivery, imrt.
77470 ...	Special radiation treatment.
77520 ...	Proton trmt, simple w/o comp.
77523 ...	Proton trmt, intermediate.
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.
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.
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.

TABLE 1.—PROPOSED CY 2008 BYPASS CODES FOR CREATING ''PSEUDO'' SINGLE CLAIMS FOR CALCULATING MEDIAN COSTS—Continued

HCPCS code	Short descriptor
88305 ...	Tissue exam by pathologist.
88307 ...	Tissue exam by pathologist.
88311 ...	Decalcify tissue.
88312 ...	Special stains.
88313 ...	Special stains.
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.
88365 ...	Insitu hybridization (fish).
88368 ...	Insitu hybridization, manual.
88399 ...	Surgical pathology procedure.
89049 ...	Chct for mal hyperthermia.
89230 ...	Collect sweat for test.
89240 ...	Pathology lab procedure.
90761 ...	Hydrate iv infusion, add-on.
90766 ...	Ther/proph/dg iv inf, add-on.
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, w/e&m.
90810 ...	Intac psytx, off, 20–30 min.
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.
92081 ...	Visual field examination(s).
92082 ...	Visual field examination(s).
92083 ...	Visual field examination(s).
92135 ...	Opthalmic dx imaging.
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.
92286 ...	Internal eye photography.
92520 ...	Laryngeal function studies.
92541 ...	Spontaneous nystagmus test.
92546 ...	Sinusoidal rotational test.
92548 ...	Posturography.
92552 ...	Pure tone audiometry, air.
92553 ...	Audiometry, air & bone.
92555 ...	Speech threshold audiometry.

TABLE 1.—PROPOSED CY 2008 BYPASS CODES FOR CREATING ''PSEUDO'' SINGLE CLAIMS FOR CALCULATING MEDIAN COSTS—Continued

HCPCS code	Short descriptor
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.
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.
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.
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.
95165 ...	Antigen therapy services.
95805 ...	Multiple sleep latency test.
95806 ...	Sleep study, unattended.
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.

TABLE 1.—PROPOSED CY 2008 BYPASS CODES FOR CREATING ''PSEUDO'' SINGLE CLAIMS FOR CALCULATING MEDIAN COSTS—Continued

HCPCS code	Short descriptor
95900 ...	Motor nerve conduction test.
95921 ...	Autonomic nerv function test.
95925 ...	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.
96415 ...	Chemo, iv infusion, addl hr.
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.
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.
0144T ...	CT heart wo dye; qual calc.
C8951 ..	IV inf, tx/dx, each addl hr.
C8955 ..	Chemotx adm, IV inf, addl hr.
G0008 ..	Admin influenza virus vac.
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.
G0332 ..	Preadmin IV immunoglobulin.
G0340 ..	Robt lin-radsurg fractx 2–5.
G0344 ..	Initial preventive exam.
G0365 ..	Vessel mapping hemo access.
G0367 ..	EKG tracing for initial prev.
G0376 ..	Smoke/tobacco counseling >10.
M0064 ..	Visit for drug monitoring.
Q0091 ..	Obtaining screen pap smear.

(2) Exploration of Allocation of Packaged Costs to Separately Paid Procedure Codes

During its August 23–24, 2006 meeting, the APC Panel recommended that CMS provide claims analysis of the contributions of packaged costs (including packaged revenue code charges and charges for packaged HCPCS codes) to the median cost of each drug administration service. (We refer readers to Recommendation #28 in the August 23–24, 2006 meeting recommendation summary on the CMS Web site at: *http://www.cms.hhs.gov/FACA/05_AdvisoryPanelonAmbulatoryPaymentClassificationGroups.asp#TopOfPage*.) In our continued effort to better understand the multiple claims in order to extract single bill information from them, we examined the extent to which the packaging in multiple procedure claims differs from the packaging in the single procedure claims on which we base the median costs both in general and more specifically for drug administration services. We performed this analysis using the claims data on which we based the CY 2007 OPPS/ASC final rule with comment period. We examined the amount of packaging in multiple procedure versus single procedure claims in general and in claims for drug administration services in particular. We conducted this analysis without taking into account the proposed packaging approach presented in this proposed rule. However, we do not expect the services newly proposed for packaged payment to commonly appear with a drug administration service. Therefore, we believe that the analysis conducted on the CY 2007 final rule with comment period data is sufficient to inform our development of this proposed rule.

In general, we do not believe that the proportionate amount of packaged costs in the multiple bills relative to the number of primary services is greater than that in the single bills. The costs in uncoded revenue codes and HCPCS codes with a packaged status indicator account for 22 percent of observed costs in the universe of all CY 2005 claims that we used to model the CY 2007 OPPS (including both the single and multiple procedure bills). Similarly, the costs in uncoded revenue codes and HCPCS codes with a packaged status indicator account for 18 percent of the total cost in the subset of CY 2005 single bills that we used to calculate the median costs on which the relative weights are based.

However, the bypass methodology creates a ''pseudo'' single bill for all claims for services or items on the bypass list, and these ''pseudo'' single bills have no associated packaging, by definition of the application of the bypass list. Excluding the total cost associated with bypass codes, 28 percent of observed costs in the single

bills are attributable to packaged services, and 29 percent of observed costs across all claims are attributable to packaged services. Therefore, we conclude that, in general, the extent of packaging in all bills is similar to the amount of packaging in the single procedure bills we use to set median costs for most APCs.

We recognize that aggregate numbers do not address the packaging associated with single and multiple procedure claims for specific services. We have received comments stating that the amount of packaging in the single bills for drug administration services is not representative of the typical packaged costs of these drug administration services, which are usually performed in combination with one another, because the single bills represent less complex and less resource-intensive services than the usual cases.

We published a study in the CY 2007 OPPS/ASC final rule with comment period (71 FR 68120 through 68121) that discussed the amount of packaging on the single bills for drug administration procedure codes, and we promised to replicate that study for the APC Panel. We discussed the results of this study with the APC Panel at its March 2007 meeting, in accordance with the APC Panel's August 2006 recommendation. Table 2 below shows the drug administration HCPCS codes and their descriptors, status indicators, deleted code status, and CY 2007 APC assignments in columns 1, 2, 3, and 4, respectively. HCPCS codes for additional hours of infusion services are not presented because these codes were included on the CY 2007 bypass list and, therefore, we explicitly associated no packaged costs with them, as discussed in the CY 2007 OPPS/ASC final rule with comment period (71 FR 68117 through 68118). Column 6 of the table contains the number of single bills relative to total occurrences of the code in the CY 2005 claims, and column 8 shows the percentage of single bills used to set payment rates. Drug administration services demonstrate reasonable single bill representation in comparison with other OPPS services. Single bills for drug administration constitute, roughly, 30 percent of all observed occurrences of drug administration services, varying by code from 7 to 55 percent. Columns 10 through 13 of the table show measures of central tendency for packaged costs as a percentage of total cost on each single claim. Columns 10 and 11 show the mean and median of all packaged costs as a percentage of total costs, and columns 12 and 13 break out the costs of packaged drug HCPCS codes and uncoded pharmacy revenue code charges for revenue codes in the 0250 series (Pharmacy), 0260 series (IV Therapy), and 0630 series (Pharmacy—Extension). These columns demonstrate that packaged costs substantially contribute to median cost estimates for the majority of drug administration HCPCS codes.

For all single bills for CPT code 90780 (Intravenous infusion for therapy/diagnosis, administered by physician or under direct supervision of physician; up to one hour), on average, packaged costs were 31 percent of total cost (median 27 percent). For the same code, packaged drug and pharmacy costs comprised, on average, 23 percent of total costs (median 15 percent). Single bills make up 34 percent of all line-item occurrences of the service, suggesting that this single bill median cost was fairly robust and probably captured packaging adequately. On the other hand, CPT code 90784 (Therapeutic, prophylactic or diagnostic injection (specify material injected); subcutaneous or intramuscular) demonstrates limited packaging (median 0 percent and mean 17 percent), and the median cost for the code is derived from only 7 percent of all occurrences of the code. Across all drug administration codes, over half show significant median packaged costs largely attributable to packaged drug and pharmacy costs.

TABLE 2.—PACKAGED COST DATA FOR CY 2005 SINGLE CLAIMS FOR DRUG ADMINISTRATION SERVICES

HCPCS code	Short descriptor	SI	Deleted code	APC	Single bills	Total frequency	Percent single bills	Median cost ($)	All packaged costs as a percent of total cost		Packaged drug and pharmacy costs as a percent of total cost	
									Median	Mean	Median	Mean
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)
90780 ..	IV infusion therapy, 1 hour	S ...	X	0440	1,008,055	2,974,785	33.9	110.43	27.1	30.8	15.3	22.6
90782 ..	Injection, sc/im	S ...	X	0437	1,326,094	2,894,231	45.8	24.77	0.0	10.1	0.0	8.7
90783 ..	Injection, ia	S ...	X	0438	427	3,012	14.2	51.35	0.0	10.9	0.0	6.8
90784 ..	Injection, iv	S ...	X	0438	183,096	2,812,204	6.5	49.54	0.0	16.7	0.0	9.7
90788 ..	Injection of antibiotic	S ...	X	0437	19,400	141,293	13.7	45.96	24.6	32.3	20.7	30.4
96400 ..	Chemotherapy, sc/im	S ...	.....	0438	57,472	81,546	70.5	51.98	0.0	6.3	0.0	4.5
96405 ..	Chemo intralesional, up to 7	S ...	.....	0438	142	181	78.5	193.65	0.0	12.0	0.0	10.5
96406 ..	Chemo intralesional over 7	S ...	.....	0438	2	7	28.6	46.42	0.0	0.0	0.0	0.0
96408 ..	Chemotherapy, push technique.	S ...	.....	0439	21,113	134,447	15.7	96.85	10.6	21.3	2.4	13.6
96410 ..	Chemotherapy, infusion method.	S ...	.....	0441	161,872	555,170	29.2	151.55	21.4	27.0	12.4	19.6
96414 ..	Chemo, infuse method add-on.	S ...	.....	0441	2,370	14,561	16.3	182.89	15.4	23.0	8.6	15.6
96420 ..	Chemo, ia, push tecnique ...	S ...	.....	0439	170	933	18.2	99.86	9.6	27.6	4.2	15.4
96422 ..	Chemo ia infusion up to 1 hr.	S ...	.....	0441	556	1,814	30.7	162.94	45.9	46.5	31.0	35.1
96425 ..	Chemotherapy, infusion method.	S ...	.....	0441	149	557	26.8	216.68	29.4	33.5	14.7	24.4
96440 ..	Chemotherapy, intracavitary	S ...	.....	0439	38	104	36.5	37.12	0.0	2.1	0.0	1.5
96445 ..	Chemotherapy, intracavitary	S ...	.....	0439	43	137	31.4	61.98	23.8	25.0	23.7	21.1
96450 ..	Chemotherapy, into CNS	S ...	.....	0441	394	869	45.3	160.03	25.8	28.7	2.0	8.3
96520 ..	Port pump refill & main	S ...	.....	0440	9,771	23,928	40.8	140.66	29.0	31.5	16.8	23.6
96530 ..	Syst pump refill & main	S ...	.....	0440	8,334	19,283	43.2	100.00	7.4	22.2	0.7	13.7
96542 ..	Chemotherapy injection	S ...	.....	0438	511	929	55.0	51.56	0.0	10.8	0.0	6.5

By definition, we are unable to precisely assess the amount of packaging associated with drug administration codes in the multiple bills. As a proxy, we estimated packaging as a percent of total cost on

each claim for two subsets of claims. Both analyses suggest the presence of moderate packaged costs, especially drug and pharmacy costs, associated with drug administration services in the multiple bills. Table 3 below shows measures of central tendency for packaging percentages in the multiple bills or portions of multiple bills remaining after ''pseudo'' singles have been created. We refer to this group of the multiple bills as the ''hardcore'' multiple bills. For the first subset of ''hardcore'' multiple bills with only drug administration codes, that is, where multiple drug administration codes are the only separately paid procedure codes on the claim (defined as procedure codes with a status indicator of ''S,'' ''T,'' ''V,'' ''X,'' or ''P''), we estimate that packaged costs are 22 percent of total costs (27 percent, on average), where total costs consist of costs for all payable codes. Costs for packaged drug HCPCS codes and pharmacy revenue codes comprise 13 percent of total cost at the median (19 percent, on average). For the second subset of ''hardcore'' multiple bills with any drug administration code, that is, where a drug administration code appears with other payable codes (largely radiology services and visits), we estimate packaged costs are 13 percent of total cost at the median (19 percent, on average). Costs for packaged drugs and pharmacy revenue codes comprise 6 percent of total cost at the median (10 percent, on average). The amount of packaging in both proxy measures, but especially the first subset, closely resembles the packaged costs as a percentage of drug administration costs observed in the single bills for drug administration services. While finding a way to accurately use data from the ''hardcore'' multiple bills to estimate drug administration median costs undoubtedly would impact medians, these comparisons suggest that the multiple bill data probably would support current median estimates.

TABLE 3.—PACKAGED COSTS ON MULTIPLE BILL CLAIMS FOR DRUG ADMINISTRATION SERVICES

Total frequency	All packaged costs as a percent of total cost		Packaged drug and pharmacy costs as a percent of total cost	
	Median	Mean	Median	Mean
Subset 1: ''Hardcore'' Multiple Claims with Only Drug Administration Codes				
693,925	21.6	26.8	12.7	19.3
Subset 2: ''Multiple'' Claims with At Least One Drug Administration Code				
4,816,338	13.2	19.4	5.8	10.0

We have received several comments over the past few years offering algorithms for packaging the costs associated with specific revenue codes or packaged drugs with certain drug administration codes. Because of the complexity of even routine OPPS claims, prior research suggests that such algorithms have limited power to generate additional single bill claims and do little to change median cost estimates. We continue to look for simple, but powerful, methodologies like the bypass list and packaging of HCPCS codes for additional ancillary and supportive services to assign packaged costs to all services within the ''hardcore'' multiple bills. Ideally, these methodologies should be intuitive to the provider community, easily integrated into the complexity of OPPS median cost estimation, and simple to maintain from year to year. We solicit and will carefully consider methodologies for creation of single bills that meet these criteria.

c. Proposed Calculation of CCRs

We calculate hospital-specific overall CCRs and hospital-specific departmental CCRs for each hospital for which we have claims data in the period of claims being used to calculate the median costs that we convert to scaled relative weights for purposes of setting the OPPS payment rates. We apply 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.hhs.gov/HospitalOutpatientPPS/03_crosswalk.asp#TopOfPage*. Comments on the proposed configuration of the crosswalk for CY 2008 should be included with comments on this section of this proposed rule. We calculate CCRs for the standard and nonstandard cost centers accepted by the electronic cost report database. In general, the most detailed level at which we calculate CCRs is the hospital-specific departmental level.

Following the expiration of most medical devices from pass-through status in CY 2003, prior to which devices were paid at charges reduced to cost using the hospital's overall CCR, we received comments that our OPPS cost estimates for device implantation procedures systematically underestimate the cost of the devices included in the packaged payment for the procedures. Commenters informed us that hospitals routinely mark up charges for low cost items to a much greater extent than they mark up high cost items, and that these items are often combined in a single cost center on their Medicare cost report. Commenters stated that when items with widely varying costs are combined in a single cost center using that cost center's CCR to estimate costs from charges for those items, this approach will overestimate the cost of low cost items and underestimate the cost of high cost items. This is commonly known as ''charge compression.'' They stated that, in the case of implantable devices, the charges for both high cost devices and low cost supplies typically are reported under the medical supply revenue code series and that the costs of both typically are reported in the medical supply cost center on the cost report. Commenters stated that the application of one medical supply CCR to charges for all items reported under the medical supply revenue code underestimates the cost of expensive medical supplies and overestimates the cost of inexpensive supplies. They indicated that when these costs are packaged into the costs of the procedures in which they are used, the result is inaccurate median costs for the HCPCS codes and APCs, and thus the standard OPPS ratesetting methodology systematically distorts

relative payment weights for procedures using devices.

In CY 2006, the device industry commissioned a study to interpolate a device-specific CCR from the medical supply CCR, using publicly available hospital claim and Medicare cost report data rather than proprietary data on device costs. After reviewing the device industry's data analysis and study model, CMS contracted with RTI International (RTI) to study the impact of charge compression on the cost-based weight methodology adopted in the FY 2007 IPPS final rule, to evaluate this model and to propose solutions. For more information, interested individuals can view RTI's report on the CMS Web site at: *http://www.cms.hhs.gov/reports/downloads/Dalton.pdf*.

Any study of cost estimation in general, and charge compression specifically, has obvious importance for both the OPPS and the IPPS. RTI's research explicitly focused on the IPPS for several reasons, which include greater Medicare expenditure under the IPPS, a desire to evaluate the model quickly given IPPS regulation deadlines, and a focus on other components of the new FY 2007 IPPS cost-based weight methodology (CMS Contract No. 500–00–0024–T012, ''A Study of Charge Compression in Calculating DRG Relative Weights,'' page 5). The study first addressed the possibility of cross-aggregation bias in the CCRs used to estimate costs under the IPPS created by the IPPS methodology of aggregating cost centers into larger departments before calculating CCRs. The report also addressed potential bias created by estimating costs using a CCR that reflects the combined costs and charges of services with wide variation in the amount of hospital markup. In its assessment of the latter, RTI targeted its attempt to identify the presence of charge compression to those cost centers presumably associated with revenue codes demonstrating significant IPPS expenditures and utilization. RTI assessed the correlation between cost report CCRs and the percent of charges in a cost center attributable to a set of similar services represented by a group of revenue codes. RTI did not examine the correlation between CCRs and revenue codes without significant IPPS expenditures or a demonstrated concentration in a specific Diagnosis Related Group (DRG). For example, RTI did not examine revenue code groups within the pharmacy cost center with low proportionate inpatient charges that might be important to the OPPS, such as ''Pharmacy Incident to Radiology.'' RTI states this limitation in its study and specifically recommends that disaggregated CCRs be reestimated for outpatient hospital charges.

Cost report CCRs combine both inpatient and outpatient services. Ideally, RTI would be able to examine the correlation between CCRs for Medicare inpatient services and inpatient claim charges and the correlation between CCRs for Medicare outpatient services and outpatient claim charges. However, the comprehensive nature of the cost report CCR (which combines inpatient and outpatient services) argues for an analysis of the correlation between CCRs and combined inpatient and outpatient claim charges. As noted, the RTI study accepted some measurement error in its analysis by matching an ''all charges'' CCR to inpatient estimates of charges for groups of similar services represented by revenue codes because of short timelines and because inpatient costs dominate outpatient costs in many ancillary cost centers. We believe that CCR adjustments used to calculate payment should be based on the comparison of cost report CCRs to combined inpatient and outpatient charges. An ''all charges'' model would reduce measurement error and estimate adjustments to disaggregated CCRs that could be used in both hospital inpatient and outpatient payment systems.

RTI made several short-term recommendations for improving the accuracy of DRG weight estimates from a cost-based methodology to address bias in combining cost centers and charge compression that could be considered in the context of OPPS policy. We discuss each recommendation within the context of the OPPS and provide our assessment of its application to the OPPS. We do not discuss RTI's recommendations to change cost report policy, which, by definition, would not have an effect on payment weight estimates until several years in the future.

(1) RTI recommends expansion of the number of CCRs used under the IPPS (RTI study, pages 11 and 85). Our OPPS methodology is already more specific than the RTI recommendation. To the extent possible, the OPPS uses hospital-specific cost centers, both standard and nonstandard, to reduce charges to estimated costs and, therefore, the OPPS ratesetting methodology is already more specific than the RTI recommendation.

(2) RTI recommends disaggregation of emergency department and blood products from the ''other services'' CCR used in the IPPS (RTI study, pages 11 and 85). Because we use standard and nonstandard cost center data, our OPPS methodology already comports with this RTI recommendation. Further, we estimate a CCR for blood that is often higher than that in the cost report based on a special methodology that is discussed further in section X of this proposed rule. Therefore, the OPPS is already meeting, and in several cases exceeding, the RTI recommendation for specificity with regard to estimating the costs associated with emergency department and blood product services.

(3) RTI recommends reclassification of intermediate care charges from the intensive care unit to the routine cost center (RTI study, pages 10 and 85). This recommendation is not relevant to the OPPS because our methodology for calculating costs under the OPPS relies solely on ancillary cost centers and does not use either cost center included in the recommendation to estimate costs for hospital outpatient services.

(4) RTI recommends establishment of regression-based estimates as a temporary or permanent method for disaggregating national average CCRs for medical supplies, drugs, and radiology services under the IPPS (RTI study, pages 11 and 86). With regard to radiology services, RTI estimated significantly lower CCRs for the cost centers for computed tomography (CT) scans and magnetic resonance imaging (MRI) services. RTI triangulated its findings with lower observed CCRs for the one-third of providers reporting nonstandard cost centers, specifically MRI Scan and CT Scan. However, in using CCRs for nonstandard cost centers, including MRI Scan and CT Scan, the OPPS already has partially implemented RTI's recommendation to use lower CCRs to estimate costs for those OPPS services allocated to these two imaging cost centers.

For reasons discussed in more detail below, we are proposing to develop an all-charges model that would compare variation in CCRs with variation in combined inpatient and outpatient charges for sets of similar services and establish disaggregated CCRs that could be applied to both inpatient and outpatient charges. We are proposing to evaluate the results of that methodology for purposes of determining whether the resulting disaggregated CCRs should be proposed for use in developing the CY 2009 OPPS payment rates. The revised all-charges model and resulting disaggregated CCRs will not be available in time for use in the CY 2008 OPPS/ASC final rule with comment period.

There are several reasons that we are not proposing to use the intradepartmental CCRs that RTI estimated using IPPS charges for the CY 2008 OPPS estimation of median costs. We agree with RTI that the

intradepartmental CCRs it calculated for the IPPS would not always be appropriate for application to the OPPS (RTI study, pages 34 and 35). While RTI recommends that the model be recalibrated for outpatient charges before it is applied to the OPPS, we believe that the combined nature of the CCRs available from the cost report prevents an accurate outpatient recalibration that would be appropriate for the OPPS alone. The addition of outpatient charges could change the variability of combined charges for some groups of services. For example, if hospitals use a high volume of less complex devices with lower charges in the outpatient department, the inclusion or omission of the outpatient charges for these high volume and lower cost devices could change the estimated disaggregated device CCR. Furthermore, RTI's analysis excluded some revenue codes with extensive outpatient charges because these revenue codes play a minor role in the IPPS. Therefore, we believe that an all-charges model examining an expanded subset of revenue codes is most appropriate, and that this model must be developed before we could apply the resulting disaggregated CCRs to the charges for supplies paid under the OPPS.

Moreover, to implement the disaggregated IPPS-based CCRs in the OPPS that RTI estimated for CY 2008 could result in greater instability in relative payment weights for CY 2008 than would otherwise occur. Significant changes in CCRs, both increases and decreases, could prompt the reassignment of services to different APCs due to the new estimates of median costs and require modification of the overall APC structure. Not only might there be significant fluctuations in payment between the CY 2007 and CY 2008 OPPS, but a subsequent change to application of the disaggregated CCRs resulting from development of an all-charges model might also result in significant fluctuations in median costs and increased instability in payments from CY 2008 to CY 2009. Therefore, these sequential changes could result in significant increases in median costs in one year and significant declines in median costs in the next year.

Therefore, we are not proposing to adopt the RTI disaggregated CCRs under the CY 2008 OPPS. We will consider whether it would be appropriate to adopt disaggregated CCRs for the OPPS after we analyze the results of the use of both inpatient and outpatient charges across all payers to recalculate disaggregated CCRs.

2. Proposed Calculation of Median Costs

In this section of this proposed rule, we discuss the use of claims to calculate the proposed OPPS payment rates for CY 2008. The hospital OPPS page on the CMS Web site on which this proposed rule is posted provides an accounting of claims used in the development of the proposed rates on the CMS Web site at: *http://www.cms.hhs.gov/HospitalOutpatientPPS*. The accounting of claims used in the development of this proposed rule is included on the Web site under supplemental materials for the CY 2008 proposed rule. That accounting provides additional detail regarding the number of claims derived at each stage of the process. In addition, below we discuss the files of claims that comprise the data sets that are available for purchase under a CMS data user contract. Our CMS Web site, *http://www.cms.hhs.gov/HospitalOutpatientPPS*, includes information about purchasing the following two OPPS data files: ''OPPS Limited Data Set'' and ''OPPS Identifiable Data Set.''

We used the following methodology to establish the relative weights we are proposing to use in calculating the OPPS payment rates for CY 2008 shown in Addenda A and B to this proposed rule. This methodology is as follows:

We used outpatient claims for the full CY 2006, processed before January 1, 2007, to set the proposed relative weights for CY 2008. To begin the calculation of the relative weights for CY 2008, we pulled all claims for outpatient services furnished in CY 2006 from the national claims history file. This is not the population of claims paid under the OPPS, but all outpatient claims (including, for example, CAH claims and hospital claims for clinical laboratory services for persons who are neither inpatients nor outpatients of the hospital).

We then excluded claims with condition codes 04, 20, 21, and 77. These are claims that providers submitted to Medicare knowing that no payment will be made. For example, providers submit claims with a condition code 21 to elicit an official denial notice from Medicare and document that a service is not covered. We then excluded claims for services furnished in Maryland, Guam, 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 101 million claims that contain hospital bill types paid under the OPPS.

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

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

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

For the CCR calculation process, we used the same general approach as we used in developing the final APC rates for CY 2007, using the revised CCR calculation which 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 2006 before determining whether the CCRs for such hospitals were valid.

We then calculated the CCRs for each cost center and the overall CCR for each hospital for which we had claims data. We did this using hospital-specific data from the Healthcare Cost Report Information System (HCRIS). We used the most recent available cost report data, in most cases, cost reports for CY 2005. We used the most recently submitted cost report to calculate the CCRs to be used to calculate median costs for the proposed CY 2008 OPPS 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 CCR, and we then adjusted the most recent available submitted but not settled cost report using that ratio. We calculated both an overall CCR and cost center-specific CCRs for each hospital. We used the overall CCR calculation discussed in section II.A.1.c. of this proposed rule for all purposes that require use of an overall CCR.

We then flagged CAH claims, which are not paid under the OPPS, and claims from hospitals with invalid CCRs. The latter included claims from hospitals without a CCR; those from hospitals paid an all-inclusive rate; those from hospitals with obviously erroneous CCRs (greater than 90 or less than .0001); and those from hospitals with

overall 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 to match a cost center to every possible revenue code appearing in the outpatient claims, with the top tier being the most common cost center and the last tier being the default CCR. If a hospital's cost center CCR was deleted by trimming, we set the CCR for that cost center to ''missing,'' so that another cost center CCR in the revenue center hierarchy could apply. If no other cost center CCR could apply to the revenue code on the claim, we used the hospital's overall CCR for the revenue code in question. For example, 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 CCR to the clinic revenue code. The hierarchy of CCRs is available for inspection and comment on the CMS Web site: *http://www.cms.hhs.gov/HospitalOutpatientPPS.*

We then converted the charges to costs on each claim by applying the CCR that we believed was best suited to the revenue code indicated on the line with the charge. Table 4 of this proposed rule contains a list of the allowed revenue codes. Revenue codes not included in Table 4 are those not allowed under the OPPS because their services cannot be paid under the OPPS (for example, inpatient room and board charges), and thus charges with those revenue codes were not packaged for creation of the OPPS median costs. One exception is the calculation of median blood costs, as discussed in section X. of this proposed rule.

Thus, we applied CCRs as described above to claims with bill types 12X, 13X, or 14X, excluding all claims from CAHs and hospitals in Maryland, Guam, 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. These claims were combined with the 76X claims identified previously to calculate the partial hospitalization per diem rate.

We then excluded claims without a HCPCS code. We 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 note that the separate file containing partial hospitalization claims is included in the files that are available for purchase as discussed above. Unlike years past, we did not create a separate file of claims containing observation services because we are proposing to package all observation care for the CY 2008 OPPS.

We next copied line-item costs for drugs, blood, and devices (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 and a per day mean and median for drugs, radiopharmaceutical agents, blood and blood products, and devices, including, but not limited to, brachytherapy sources, as well as other information used to set payment rates, such as a unit-to-day ratio for drugs.

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

1. *Single Major Claims:* Claims with a single separately payable procedure (that is, status indicator ''S,'' '' T,'' ''V,'' or ''X'').

2. *Multiple Major Claims:* Claims with more than one separately payable procedure (that is, status indicator ''S,'' ''T,'' ''V,'' or ''X''), or multiple units for one payable procedure. As discussed below, some of these can be used in median setting. We also included in this set claims that contain one unit of one code when the bilateral modifier is appended to the code and the code is one that is conditionally or independently bilateral. In these cases, these claims represent more than one unit of the service described by the code, notwithstanding that only one unit is billed.

3. *Single Minor Claims:* Claims with a single HCPCS code that is assigned to status indicator ''F,'' ''G,'' ''H,'' ''K,'' ''L,'' or ''N.''

4. *Multiple Minor Claims:* Claims with multiple HCPCS codes that are assigned to status indicator ''F,'' ''G,'' ''H,'' ''K,'' ''L,'' or ''N.''

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 are excluded from the files used for the OPPS. Non-OPPS claims have codes paid under other fee schedules, for example, durable medical equipment or clinical laboratory tests, and do not contain either a code for a separately paid service or a code for a packaged service.

We use status indicator ''Q'' in Addendum B to this proposed rule to identify services that receive separate HCPCS code-specific payment when specific criteria are met, and payment for the individual service is packaged in all other circumstances. We are proposing several different sets of criteria to determine whether separate payment would be made for specific services. For example, HCPCS code G0379 (Direct admission of patient for hospital observation care) is assigned to status indicator ''Q'' in Addendum B to this proposed rule because we are proposing that it receive separate payment only if it is billed on the same date of service as HCPCS code G0378 (Hospital observation service, per hour), without any services with status indicator ''T'' or ''V,'' or Critical Care (APC 0617). Proposed payment for observation services is discussed in section XI. of this proposed rule. The specific services in the proposed composite APCs discussed in section II.A.4. of this proposed rule also are assigned to status indicator ''Q'' in Addendum B to this proposed rule because we are proposing that their payment would be bundled into a single composite payment for a combination of major procedures under certain circumstances. These services would only receive separate code-specific payment if certain criteria are met. The same is true for those less intensive outpatient mental health treatment services for which payment is limited to the partial hospitalization per diem rate and which also are assigned to status indicator ''Q'' in Addendum B to this proposed rule. According to longstanding OPPS payment policy (65 FR 18455), payment for these individual mental health services is bundled into a single payment, APC 0034 (Mental Health Services Composite), when the sum of the individual mental health service payments for all of these mental health services provided on the same day would exceed payment for a day of partial hospitalization services. However, the largest number of specific HCPCS codes identified by status indicator ''Q'' in Addendum B to this proposed rule are those codes that we identify as ''special'' packaged codes, where we are proposing that a service receives separate payment when it appears on the same day on a claim without another service that is assigned to status indicator ''S,'' ''T,'' ''V,'' or ''X.'' We are proposing to package payment for these HCPCS codes when the code appears on the same date of service with any other service that is

assigned to status indicator ''S,'' ''T,'' ''V,'' or ''X.''

This last and largest subset of conditionally packaged services have to be integrated into the identification of single and multiple bills to ensure that the costs for these services are appropriately packaged when they appear with any other separately paid service. We handle these conditionally packaged services in the data by assigning the HCPCS code an APC and a data status indicator of ''N.'' When the conditionally packaged HCPCS code appears with a HCPCS code with a status indicator of ''S,'' ''T,'' ''V,'' or ''X'' on the same date of service, it is treated as a packaged code. The costs that appear on the line with the code are packaged into the cost of the HCPCS code with a status indicator of ''S,'' ''T,'' ''V,'' or ''X.'' When the conditionally packaged HCPCS code appears by itself, we change the status indicator on the line to the status indicator of the APC to which the conditionally packaged code is assigned, converting the service from a minor to a major procedure. This creates single bills for these conditionally packaged services that are then used to set the median cost for the conditionally packaged code and for the APC to which it is assigned when it is separately paid.

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

In years prior to the CY 2007 OPPS, we made a determination of whether each HCPCS code was a major code or a minor code or a code other than a major or minor code. We used those code-specific determinations to sort claims into the five groups identified above. For the CY 2007 OPPS, we used status indicators to sort the claims into these groups. We defined major procedures as any procedure having a status indicator of ''S,'' ''T,'' ''V,'' or ''X;'' defined minor procedures as any code having a status indicator of ''N;'' and classified ''other'' procedures as any code having a status indicator other than ''S,'' ''T,'' ''V,'' ''X,'' or ''N.'' For the CY 2007 OPPS proposed rule limited data set and identifiable data set, these definitions excluded claims on which hospitals billed drugs and devices without also billing separately paid procedure codes and, therefore, these public use files did not contain all claims used to calculate the drug and device frequencies and medians. We corrected this for the CY 2007 OPPS/ASC final rule with comment period limited data set and identifiable data set by extracting claims containing drugs and devices from the set of ''other'' claims and adding them to the public use files.

At its March 2007 meeting, the APC Panel recommended that CMS edit and return for correction claims that contain a HCPCS code for a separately paid drug or device but that also do not contain a HCPCS code assigned to a procedural APC (that is, those not assigned status indicator ''S,'' ''T,'' ''V,'' or ''X''). The APC Panel stated that this edit should improve the claims data and may increase the number of single bills available for ratesetting. We note that such an edit would be broader than the device-to-procedure code edits we implemented for CY 2007 for selected devices. While we encourage hospitals to code correctly in accordance with CPT, CMS, and local contractor guidance, in general we have historically implemented claims processing edits under the OPPS when we believe that these edits help ensure complete claims data for ratesetting. In the case of such Outpatient Code Editor (OCE) edits for drugs and devices that are separately paid, it is unclear to us that these edits would improve our claims data for median cost calculation because the items receive separate payment and do not result in multiple procedure claims when they are reported. We also are uncertain about the clinical circumstances that could result in a hospital submitting an OPPS claim that only reported a separately paid drug or device. We are soliciting comments specifically on the impact of establishing such edits on hospital billing processes and on related potential improvements to claims data used for median setting.

Therefore, in view of the prior public comments and our desire to ensure that the public data files contain all appropriate data, for the CY 2008 OPPS, we are proposing to define major procedures as HCPCS codes that have a status indicator of ''S,'' ''T,'' ''V,'' or ''X.'' We are proposing to define minor procedures as HCPCS codes that have a status indicator of ''F,'' ''G,'' ''H,'' ''K,'' ''L,'' or ''N'' but, as we discuss above, to make single bills out of any claims for single procedures with a minor code that also has an APC assignment. This ensures that the claims that contain only codes for drugs and biologicals or devices but that do not contain codes for procedures are included in the limited data set and the identifiable data set. It also ensures, as discussed above, that conditionally packaged services that receive separate payment only when they are billed without any other separately payable OPPS services are treated appropriately for purposes of median cost calculations. We are proposing to define ''other'' services as HCPCS codes that have a status indicator other than those defined as major or minor procedures.

We continue to believe that using status indicators, with the proposed changes, is an appropriate way to sort the claims into these groups and also to make our process more transparent to the public. We further believe that this proposed method of sorting claims would enhance the public's ability to derive useful information for analysis and public comment on this proposed rule.

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

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

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

convert to single claims even after applying all of the techniques for creation of ''pseudo'' singles. Among those excluded were claims that contain codes that are viewed as independently or conditionally bilateral and that contain the bilateral modifier (Modifier 50, Bilateral procedure) because the line-item cost for the code represents the cost of two units of the procedure, notwithstanding that the code appears with a unit of one. Therefore, the charge on the line represents the charge for two services rather than a single service and using the line as reported would overstate the cost of a single procedure. We then packaged the costs of packaged HCPCS codes (codes with status indicator ''N'' listed in Addendum B to this proposed rule) and packaged revenue codes into the cost of the single major procedure remaining on the claim.

The list of packaged revenue codes is shown in Table 4 of this proposed rule. At its March 2007 meeting the APC Panel recommended that CMS review the final list of packaged revenue codes for consistency with OPPS policy and ensure that future versions of the OCE edit accordingly. We compared the packaged revenue codes in the OCE to the finalized list of packaged revenue codes for the CY 2007 OPPS (71 FR 67989 through 67990) that we used for packaging costs in median calculation. As a result of that analysis, we are accepting the APC Panel's recommendation and we are proposing to change the list of packaged revenue codes for the CY 2008 OPPS in the following manner. First, we are proposing to remove revenue codes 0274 (Prosthetic/Orthotic devices) and 0290 (Durable Medical Equipment) from the list of packaged revenue codes because we do not permit hospitals to report implantable devices in these revenue codes (Internet Only Manual 100–4, Chapter 4, section 20.5.1.1). We also are proposing to add revenue code 0273 (Take Home Supplies) to the list of packaged revenue codes because we believe that the charges under this revenue code are for the incidental supplies that hospitals sometimes provide for patients who are discharged at a time when it is not possible to secure the supplies needed for a brief time at home. We are proposing to conform the list of packaged revenue codes in the OCE to the OPPS for CY 2008.

We packaged the costs of the HCPCS codes that are shown with status indicator ''N'' into the cost of the independent service to which the packaged service is ancillary or supportive. We refer readers to section II.A.4. of this proposed rule for a more complete discussion of the packaging changes we are proposing for CY 2008.

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 54 million claims were left. Of these 54 million claims, we were able to use some portion of approximately 50 million whole claims (92 percent of approximately 54 million potentially usable claims) to create approximately 88 million single and ''pseudo'' single claims, of which we used 87 million single bills (after trimming out just over 822,000 claims as discussed below) in the CY 2008 median development and for ratesetting.

We also excluded (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 OCE assigns packaging flag number 3 to claims on which hospitals submit token charges for a service with status indicator ''S'' or ''T'' (a major separately paid service under the OPPS) for which the fiscal intermediary is required to allocate the sum of charges for services with a status indicator equaling ''S'' or ''T'' based on the weight for the APC to which each code is assigned. We do not believe that these charges, which were token charges as submitted by the hospital, are valid reflections of hospital resources. Therefore, we deleted these claims. We also deleted claims for which the charges equal the revenue center payment (that is, the Medicare payment) on the assumption that where the charge equals the payment, to apply a CCR to the charge would not yield a valid estimate of relative provider cost.

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

We also excluded claims that were outside 3 standard deviations from the geometric mean of units for each HCPCS code on the bypass list (because, as discussed above, we used claims that contain multiple units of the bypass codes).

We used the remaining claims to calculate the CY 2008 proposed median costs for each separately payable HCPCS code and each APC. The comparison of HCPCS and APC medians determines the applicability of the ''2 times'' rule. Section 1833(t)(2) of the Act provides that, subject to certain exceptions, the items and services within an APC group cannot be considered comparable with respect to the use of resources if the highest median (or mean cost, if elected by the Secretary) for an item or service in the group is more than 2 times greater than the lowest median cost for an item or service within the same group (''the 2 times rule''). Finally, we reviewed the medians and reassigned HCPCS codes to different APCs where we believed that it was appropriate. Section III. of this proposed rule includes a discussion of certain proposed HCPCS code assignment changes that resulted from examination of the medians and for other reasons. The APC medians were recalculated after we reassigned the affected HCPCS codes. Both the HCPCS medians and the APC medians were weighted to account for the inclusion of multiple units of the bypass codes in the creation of ''pseudo'' single bills.

In our review of median costs for HCPCS codes and their assigned APCs, we have frequently noticed that some services are consistently rarely performed in the hospital outpatient setting for the Medicare population. In particular, there are a number of services, such as several procedures related to the care of pregnant women, that have annual Medicare claims volume of 100 or fewer occurrences. By definition, these services also have a small number of single bills from which to estimate median costs. In addition, in some cases, these codes have been historically assigned to clinical APCs where all the services are low volume. Therefore, the median costs for these services and APCs often fluctuate from year to year, in part due to the variability created by such a small number of claims. One of the benefits of basing payment on the median cost of many HCPCS codes with sufficient single bill representation in an APC is that such fluctuation is moderated by the increased number of observations for similar services on which the APC median cost is also based. We considered proposing a distinct methodology for calculation of the

median cost of low total volume APCs in order to provide more stability in payment from year to year for these low total volume services. However, after examination of the low total volume OPPS services and their assigned APCs, we concluded that there were other clinical APCs with higher volumes of total claims to which these low total volume services could be reassigned, while ensuring the continued clinical and resource homogeneity of the clinical APCs to which they would be newly reassigned. Therefore, we believe that it is more appropriate to reconfigure clinical APCs to eliminate most of the low total volume APCs. These low volume services differ from other OPPS services only because they are not often furnished to the Medicare population. Therefore, we are proposing to reconfigure certain clinical APCs for CY 2008 as a way to promote stability and appropriate payment for the services assigned to them, including low total volume services. We believe that these proposed reconfigurations maintain APC clinical and resource homogeneity. We are proposing these changes as an alternative to developing specific quantitative approaches to treating low total volume APCs differently for purposes of median calculation. As a result of this proposal, 3 APCs proposed for CY 2008 (all of which are New Technology APCs) have a total volume of services less than 100, and only 17 APCs have a total volume of less than 1,000, in comparison with CY 2007 where 9 APCs (including 3 New Technology APCs) had a total volume of less than 100 and 36 APCs had a total volume of less than 1,000.

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

TABLE 4.—PROPOSED CY 2008 PACKAGED REVENUE CODES

Revenue code	Description
0250	PHARMACY.
0251	GENERIC.
0252	NONGENERIC.
0254	PHARMACY INCIDENT TO OTHER DIAGNOSTIC.
0255	PHARMACY INCIDENT TO RADIOLOGY.
0257	NONPRESCRIPTION DRUGS.
0258	IV SOLUTIONS.
0259	OTHER PHARMACY.
0260	IV THERAPY, GENERAL CLASS.
0262	IV THERAPY/PHARMACY SERVICES.
0263	SUPPLY/DELIVERY.
0264	IV THERAPY/SUPPLIES.
0269	OTHER IV THERAPY.
0270	M&S SUPPLIES.
0271	NONSTERILE SUPPLIES.
0272	STERILE SUPPLIES.
0273	TAKE HOME SUPPLIES.
0275	PACEMAKER DRUG.
0276	INTRAOCULAR LENS SOURCE DRUG.
0278	OTHER IMPLANTS.
0279	OTHER M&S SUPPLIES.
0280	ONCOLOGY.
0289	OTHER ONCOLOGY.
0343	DIAGNOSTIC RADIOPHARMS.
0344	THERAPEUTIC RADIOPHARMS.
0370	ANESTHESIA.
0371	ANESTHESIA INCIDENT TO RADIOLOGY.
0372	ANESTHESIA INCIDENT TO OTHER DIAGNOSTIC.
0379	OTHER ANESTHESIA.
0390	BLOOD STORAGE AND PROCESSING.
0399	OTHER BLOOD STORAGE AND PROCESSING.
0560	MEDICAL SOCIAL SERVICES.
0569	OTHER MEDICAL SOCIAL SERVICES.
0621	SUPPLIES INCIDENT TO RADIOLOGY.
0622	SUPPLIES INCIDENT TO OTHER DIAGNOSTIC.
0624	INVESTIGATIONAL DEVICE (IDE).
0630	DRUGS REQUIRING SPECIFIC IDENTIFICATION, GENERAL CLASS.
0631	SINGLE SOURCE.
0632	MULTIPLE.
0633	RESTRICTIVE PRESCRIPTION.
0681	TRAUMA RESPONSE, LEVEL I.
0682	TRAUMA RESPONSE, LEVEL II.
0683	TRAUMA RESPONSE, LEVEL III.
0684	TRAUMA RESPONSE, LEVEL IV.
0689	TRAUMA RESPONSE, OTHER.
0700	CAST ROOM.
0709	OTHER CAST ROOM.
0710	RECOVERY ROOM.
0719	OTHER RECOVERY ROOM.
0720	LABOR ROOM.

TABLE 4.—PROPOSED CY 2008 PACKAGED REVENUE CODES—Continued

Revenue code	Description
0721	LABOR.
0762	OBSERVATION ROOM.
0810	ORGAN ACQUISITION.
0819	OTHER ORGAN ACQUISITION.
0942	EDUCATION/TRAINING.

3. Proposed Calculation of OPPS Scaled Payment Weights

Using the median APC costs discussed previously, we calculated the proposed relative payment weights for each APC for CY 2008 shown in Addenda A and B to this proposed rule. In years prior to CY 2007, we standardized all the relative payment weights to APC 0601 (Mid Level Clinic Visit) because it is one of the most frequently performed services in the hospital outpatient setting. We assigned APC 0601 a relative payment weight of 1.00 and divided the median cost for each APC by the median cost for APC 0601 to derive the relative payment weight for each APC.

Beginning with the CY 2007 OPPS, 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 visit APCs. We chose APC 0606 as the base because under our proposal to reconfigure the APCs where clinic visits are assigned for CY 2007, APC 0606 is the middle level clinic visit APC (that is, Level 3 of five levels). We have historically used the median cost of the middle level clinic visit APC (that is APC 0601 through CY 2006) to calculate unscaled weights because mid-level clinic visits are among the most frequently performed services in the hospital outpatient setting. Therefore, to maintain consistency in using 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 APC, proposed APC 0606, to calculate unscaled weights. Following our standard methodology, but using the CY 2007 median for APC 0606, for CY 2007 we assigned APC 0606 a relative payment weight of 1.00 and divided the median cost of each APC by the median cost for APC 0606 to derive the unscaled relative payment weight for each APC. The choice of the APC on which to base the relative weights for all other APCs does not affect the payments made under the OPPS because we scale the weights for budget neutrality. We are again proposing to use APC 0606 as the base for the CY 2008 OPPS relative weights.

Section 1833(t)(9)(B) of the Act requires that APC reclassification and recalibration changes, wage index changes, and other adjustments be made in a manner that assures that aggregate payments under the OPPS for CY 2008 are neither greater than nor less than the aggregate payments that would have been made without the changes. To comply with this requirement concerning the APC changes, we compared aggregate payments using the CY 2007 relative weights to aggregate payments using the CY 2008 proposed relative weights. This year, we included payments to CMHCs in our comparison. Based on this comparison, we adjusted the relative weights for purposes of budget neutrality. The unscaled relative payment weights were adjusted by a weight scaler of 1.3665 for budget neutrality. In addition to adjusting for increases and decreases in weight due to the recalibration of APC medians, the scaler also accounts for any change in the base, other than changes in volume, which are not a factor in the weight scaler.

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

Section 1833(t)(14)(H) of the Act, as added by section 621(a)(1) of Pub. L. 108–173, states that ''Additional expenditures resulting from this paragraph shall not be taken into account in establishing the conversion factor, weighting and other adjustment factors for 2004 and 2005 under paragraph (9) but shall be taken into account for subsequent years.'' Section 1833(t)(14) of the Act provides the payment rates for certain ''specified covered outpatient drugs.'' Therefore, the cost of those specified covered outpatient drugs (as discussed in section V. of this proposed rule) is included in the budget neutrality calculations for the CY 2008 OPPS.

4. Proposed Changes to Packaged Services

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

a. Background

When the Medicare program was first implemented, it paid for hospital services (inpatient and outpatient) based on hospital-specific reasonable costs attributable to furnishing services to Medicare beneficiaries. Later the law was amended to limit payment to the lesser of the hospital's reasonable cost or customary charges for services furnished to Medicare beneficiaries. Specific service-based methodologies were then developed for certain types of services, such as clinical laboratory tests and durable medical equipment, while payments for outpatient surgical procedures and other diagnostic tests were based on a blend of the hospital's aggregate Medicare costs for these services and Medicare's payment for similar services in other ambulatory settings. While this mix of different payment methodologies was in use, hospital outpatient services were growing rapidly following the implementation of the IPPS in 1983. The brisk increase in hospital outpatient services led to an interest in creating payment incentives to promote more efficient delivery of hospital outpatient services through a Medicare prospective payment system for hospital outpatient services, and the final statutory requirements for the OPPS were established by the BBA and the BBRA. During the period of time when different approaches to prospective payment for hospital outpatient services were being considered, a variety of reports to Congress (June 1988, September 1990, and March 1995) discussed three major issues related to defining the unit of payment for the payment system, specifically the extent to which clinically similar procedures should be grouped for payment purposes and the logic that should be used for the groupings; the extent to which payment for minor, ancillary services associated with a significant

procedure should be packaged into a single payment for the procedure (which we refer to as ''packaging''); and the extent to which payment for multiple significant procedures related to an outpatient encounter or to an episode of care should be bundled into a single unit of payment (which we refer to as ''bundling''). Both packaging and bundling were presented as approaches to creating incentives for efficiency, with their potential policy disadvantages including inconsistency with other ambulatory fee schedules, reduced transparency of service-specific payment, and the potential for hospitals shifting the delivery of packaged or bundled services to delivery settings other than the hospital outpatient department (HOPD).

The OPPS, like other prospective payment systems, relies on the concept of averaging, where the payment may be more or less than the estimated costs of providing a service or package of services for a particular patient, but with the exception of outlier cases, it is adequate to ensure access to appropriate care. Decisions about packaging and bundling payment involve a balance between ensuring some separate payment for individual services and establishing incentives for efficiency through larger units of payment. In many situations, the final payment rate for a package of services may do a better job of balancing variability in the relative costs of component services compared to individual rates covering a smaller unit of service without packaging or bundling. Packaging payments into larger payment bundles promotes the stability of payment for services over time, a characteristic that reportedly is very important to hospitals. Unlike packaged services, the costs of individual services typically show greater variation because the higher variability for some component items and services cannot be balanced with lower variability for others and because relative weights are typically estimated using a smaller set of claims. When compared to service-specific payment, packaging or bundling payment for component services may change payment at the hospital level to the extent that there are systematic differences across hospitals in their performance of the services included in that unit of payment. Hospitals spending more per case than payment received would be encouraged to review their service patterns to ensure that they furnish services as efficiently as possible. Similarly, we believe that unpackaging services heightens the hospital's focus on pricing individual services, rather than the efficient delivery of those services. Over the past several years of the OPPS, greater unpackaging of payment has occurred simultaneously with continued tremendous growth in OPPS expenditures as a result of increasing volumes of individual services, as discussed in further detail below. Also discussed in further detail below, most recently in its comments to the CY 2007 OPPS/ASC proposed rule and in the context of this rapid spending growth, the Medicare Payment Advisory Commission (MedPAC) encouraged CMS to broaden the payment bundles under the OPPS to encourage providers to use resources efficiently.

As permitted under section 1833(t)(2)(B) of the Act, the OPPS establishes groups of covered HOPD services, namely APC groups, and uses them as the basic unit of payment. During the evolution of the OPPS over the past 7 years, significant attention has been concentrated on service-specific payment for services furnished to particular patients, rather than on creating incentives for the efficient delivery of services through encounter or episode-of-care-based payment. Overall packaging included in the clinical APCs has decreased, and the procedure groupings have become smaller as the focus has shifted to refining service-level payment. Specifically, in the CY 2003 OPPS, there were 569 APCs, but by CY 2007, the number of APCs had grown to 862, a 51-percent increase in 4 years. Similarly, the percentage of CPT codes for procedural services that receive packaged payment declined by over 10 percent between CY 2003 and CY 2007.

Currently, the APC groups reflect a modest degree of packaging, including packaged payment for minor ancillary services, inexpensive drugs, medical supplies, implantable devices, capital-related costs, operating and recovery room use, and anesthesia services. Bundling payment for multiple significant services provided in the same hospital outpatient encounter or during an episode of care is not currently a common OPPS payment practice, because the APC groups generally reflect only the modest packaging associated with individual procedures or services. Unconditionally packaged services with HCPCS codes are identified by the status indicator ''N.'' Conditionally packaged services, specifically those services whose payment is packaged unless specific criteria for separate payment are met, are assigned to status indicator ''Q.'' To the extent possible, hospitals may use HCPCS codes to report any packaged services that were performed, consistent with CPT or CMS coding guidelines, but packaged costs also may be uncoded and included in specific revenue code charges. Hospitals include charges for packaged services on their claims, and the costs associated with those packaged services are then added into the costs of separately payable procedures on the same claims in establishing payment rates for the separately payable services.

Packaging and bundling 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 costs of purchased 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 services are furnished only when they are important and to carefully scrutinize the services ordered by practitioners to maximize the efficient use of hospital resources. Finally, packaging payments into larger payment bundles promotes the stability of payment for services over time. 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.

b. Addressing Growth in OPPS Volume and Spending

Creating additional incentives for providing only necessary services in the most efficient manner is of vital importance to Medicare today, in view of the recent explosion of growth in program expenditures for hospital outpatient services paid under the OPPS. As illustrated in Table 5 below, total spending has been growing at a rate of roughly 10 percent per year under the OPPS, and the Medicare Trustees project that total spending under the OPPS will increase by more than $3 billion from CY 2007 through CY 2008 to nearly $35 billion. Implementation of the OPPS has not

slowed outpatient spending growth over the past few years; in fact, double-digit spending growth has generally been occurring. We are greatly concerned with this rate of increase in program expenditures under the OPPS.

TABLE 5.—GROWTH IN EXPENDITURES UNDER OPPS FROM CY 2001–CY 2008

[Projected Expenditures for CY 2006–CY 2008, in Billions]

OPPS growth	CY 2001	CY 2002	CY 2003	CY 2004	CY 2005	CY 2006	CY 2007	CY 2008
Incurred Cost	17.702	19.561	21.156	23.866	26.572	29.338	31.641	34.960
Percent Increase	.....	10.5	8.2	12.8	11.3	10.4	7.8	10.5

Source: CY 2007 Medicare Trustees' Report.

As with the other Medicare fee-for-service payment systems that are experiencing rapid spending growth, brisk growth in the intensity and utilization of services is the major reason for the current rates of growth in the OPPS, rather than general price or enrollment changes. Table 6 below illustrates the increases in the volume and intensity of hospital outpatient services over the past several years.

TABLE 6.—PERCENT INCREASE IN VOLUME AND INTENSITY OF HOSPITAL OUTPATIENT SERVICES

	CY 2002	CY 2003	CY 2004	CY 2005	CY 2006 (Est.)	CY 2007 (Est.)	CY 2008 (Est.)
Percent Increase	3.5	2.5	7.6	7.4	8.6	6.4	5.8

Source: CY 2007 Medicare Trustees' Report.

For hospital outpatient services, the volume and intensity of services are estimated to have continued to increase significantly in recent years, at a rate of 8.6 percent between CY 2005 and CY 2006, the last two completed calendar years. As we discussed in the CY 2007 OPPS/ASC final rule with comment period (71 FR 68189 through 68190), the rapid growth in utilization of services under the OPPS shows that Medicare is paying mainly for more services each year, regardless of their quality or impact on beneficiary health. In its March 2007 Report to Congress (pages 55 and 56), MedPAC confirmed that much of the growth in service volume from 2003 to 2005 resulted from increases in the number of services per beneficiary who received care, rather than from increases in the number of beneficiaries served. The MedPAC found that while the rate of growth in service volume declined over that time period, the complexity of services, defined as the sum of the relative payment weights of all OPPS services divided by the volume of all services, increased, and that most of the growth was attributable to the insertion of devices and the provision of complex imaging services. The MedPAC further found that regression analysis suggested that relatively complex hospital outpatient services may be more profitable for hospitals than less complex services. In addition, its analysis indicated that favorable payments for complex services give hospitals an incentive to provide more of those complex services rather than fewer basic services, which increases overall service complexity. The MedPAC expressed concern about this relationship and concluded that the historically large increases in outpatient volume and service complexity suggest a need to recalibrate the OPPS. In the future, MedPAC plans to examine options for recalibrating the payment system to accurately match payments to the costs of individual services (Medicare Payment Advisory Commission Report to the Congress: Medicare Payment Policy, March 2007, pages 55 and 56).

As proposed for the CY 2007 OPPS and finalized for the CY 2009 OPPS, we developed a plan to promote higher quality services under the OPPS, so that Medicare spending would be directed toward those higher quality services (71 FR 68189 through 68197). We believe that Medicare payments should encourage physicians and other providers in their efforts to achieve better health outcomes for Medicare beneficiaries at a lower cost. In the CY 2007 OPPS/ASC final rule with comment period, we discussed the concept of ''value-based purchasing'' in the OPPS as well as in other Medicare payment systems. ''Value-based purchasing'' may use a range of incentives to achieve identified quality and efficiency goals, as a means of promoting better quality of care and more effective resource use in the Medicare payment systems. In developing the concept of value-based purchasing for Medicare, we have been working closely with stakeholder partners.

We continue to believe that the collection and submission of performance data and the public reporting of comparative information are strong incentives for hospital accountability in general and quality improvement in particular, while encouraging the most efficient and effective care. Measurement and reporting can focus the attention of hospitals and consumers on specific goals and on hospitals' performance relative to those goals. Development and implementation of performance measurement and reporting by hospitals can thus produce quality improvement in health care delivery. Hospital performance measures may also provide a foundation for performance-based rather than volume-based payments.

In the CY 2007 OPPS/ASC final rule with comment period, as a first step in the OPPS toward value-based purchasing, we finalized a policy that would employ our equitable adjustment authority under section 1833(t)(2)(E) of the Act to establish an OPPS Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) program based on measures specifically developed to characterize the quality of outpatient care (71 FR 68197). We finalized implementation of the program for CY 2009, when we would implement a 2.0 point reduction to the OPPS conversion factor update for those hospitals that do not meet the specific requirements of the CY 2009 OPPS RHQDAPU program. We described the

CY 2009 program which would be based upon CY 2008 hospital reporting of appropriate measures of the quality of hospital outpatient care that have been carefully developed and evaluated, and endorsed as appropriate, with significant input from stakeholders. We reiterated our belief that ensuring that Medicare beneficiaries receive the care they need and that such services are of high quality are the necessary initial steps to incorporating value-based purchasing into the OPPS. We explained that we are specifically seeking to encourage care that is both efficient and of high quality in the HOPD.

Subsequent to the publication of the CY 2007 OPPS/ASC final rule with comment period, section 109(b) of the MIEA-TRHCA specifies that in the case of a subsection (d) hospital (defined under section 1886(d)(1)(B) of the Act as hospitals that are located in the 50 States or the District of Columbia other than those categories of hospitals or hospital units that are specifically excluded from the IPPS, including psychiatric, rehabilitation, long-term care, children's, and cancer hospitals or hospital units) that does not submit to the Secretary the quality reporting data required for CY 2009 and each subsequent year, the OPPS annual update factor shall be reduced by 2.0 percentage points. The quality reporting program proposed for CY 2008 according to this provision is referred to as the Hospital Outpatient Quality Data Reporting Program (HOP QDRP) and is discussed in detail in section XVII. of this proposed rule.

As the next step in our movement toward value-based purchasing under the OPPS and to complement the HOP QDRP for CY 2009, with measure reporting beginning in CY 2008, we believe it is important to initiate specific payment approaches to explicitly encourage efficiency in the hospital outpatient setting that we believe will control future growth in the volume of OPPS services. While the HOP QDRP will encourage the provision of higher quality hospital outpatient services that lead to improved health outcomes for Medicare beneficiaries, we believe that more targeted approaches are also necessary to encourage increased hospital efficiency. Two alternatives we have considered that would be feasible under current law include establishing a methodology to measure the growth in volume and reduce OPPS payment rates to account for unnecessary increases in volume or developing payment incentives for hospitals to ensure that they provide necessary services as efficiently as possible.

With respect to the first alternative, section 1833(t)(2)(F) of the Act requires us to establish a methodology for controlling unnecessary increases in the volume of covered OPPS services, and section 1833(t)(9)(C) of the Act authorizes us to adjust the update to the conversion factor if, under section 1833(t)(2)(F) of the Act, we determine that there is growth in volume that exceeds established tolerances. As we indicated in the September 8, 1998 proposed rule proposing the establishment of the OPPS (63 FR 47585), we considered creating a system that mirrors the sustainable growth rate (SGR) methodology applied to the MPFS update to control unnecessary growth in service volume. However, implementing such a system could have the potentially undesirable effect of escalating service volume as payment rates stagnate and hospital costs rise, thus actually resulting in a growth in volume rather than providing an incentive to control volume. Therefore, this approach to addressing the volume growth under the OPPS could inadvertently result in the exact opposite of our desired outcome.

The second alternative we considered is to expand the packaging of supportive ancillary services and ultimately bundle payment for multiple independent services into a single OPPS payment. We believe that this would create incentives for hospitals to monitor and adjust the volume and efficiency of services themselves, by enabling them to manage their resources with maximum flexibility. Instead of external controls on volume, we believe that it is preferable for the OPPS to create payment incentives for hospitals to carefully scrutinize their service patterns to ensure that they furnish only those services that are necessary for high quality care and to ensure that they provide care as efficiently as possible. Specifically, we believe that increased packaging and bundling are the most appropriate payment strategies to establish such incentives in a prospective payment system, and that this approach is clearly preferable to the establishment of an SGR or other methodology that seeks to control spending by addressing significant growth in volume and program spending with lower payments.

In its October 6, 2006 letter of comment on the CY 2007 OPPS/ASC proposed rule, MedPAC urged us to establish broader payment bundles in both the revised ASC and hospital outpatient prospective payment systems to promote efficient resource use and better align the two payment systems. In particular, our proposal for the CY 2008 revised ASC payment system proposed to package payment for all items and services directly related to the provision of covered surgical procedures into the ASC facility payment for the associated surgical procedure (71 FR 49468). These other items and services included all drugs, biologicals, contrast agents, implantable devices, and diagnostic services such as imaging. Because a number of these items and services are separately paid under the OPPS and the proposal included the establishment of most ASC payment weights based on the procedures' corresponding OPPS payment weights, MedPAC encouraged us to align the payment bundles in the two payment systems by increasing the size of the payment bundles under the OPPS.

Moreover, MedPAC staff indicated in testimony at the January 9, 2007 MedPAC public meeting that the growth in OPPS spending and volume raises questions about whether the OPPS should be changed to encourage greater efficiency (page 390 of the January 9, 2007 MedPAC meeting transcript available at *http://www.medpac.gov*). MedPAC staff explained at that time that MedPAC intends to perform a long-term assessment of the design of the OPPS, including considering the bundling of payments for procedures and visits furnished over a period of time into a single payment, assessing whether there should be an expenditure target for hospital outpatient services, evaluating whether payments for multiple imaging services provided in the same session should be discounted, and reviewing the methodology used by CMS to determine relative payment weights for hospital outpatient services. We welcome MedPAC's study of these areas, particularly with regard to how we might develop appropriate payment rates for larger bundles of services.

Because we believe it is important that the OPPS create enhanced incentives for hospitals to provide only necessary, high quality care and to provide that care as efficiently as possible, we have given considerable thought to how we could increase packaging under the OPPS in a manner that would not place hospitals at substantial financial risk but which would create incentives for efficiency and volume control, while providing hospitals with flexibility to provide care in the most appropriate way for each Medicare beneficiary. We are considering the possibility of greater bundling of payment for major hospital outpatient services, which could result in establishing OPPS payments for episodes of care, and for this reason we particularly welcome MedPAC's

exploration of how such an approach might be incorporated into the OPPS payment methodology. We are particularly concerned about the potential for shifting higher cost bundled services to other ambulatory settings, and we welcome ideas on deterring such activity. We are currently considering the complex policy issues related to the possible development and implementation of a bundled payment policy for hospital outpatient services that involves significant services provided over a period of time which could be paid through an episode-based payment methodology, but we consider this possible approach to be a long-term policy objective. We encourage public comments regarding the specific hospital outpatient services, clinical and financial issues, ratesetting methodologies, and operational challenges we should consider in our exploratory work in this area.

We also are examining how we might possibly establish payments for same-day care encounters, building upon the current use of APCs for payment through greater packaging of supportive ancillary services. This could include conditional packaging of supportive ancillary services into payment for the procedure that is the reason for the OPPS encounter (for example, diagnostic tests performed on the day of a scheduled procedure). Another approach could include creation of composite APCs for frequently performed combinations of surgical procedures (for example, one APC payment for multiple cardiac electrophysiologic procedures performed on the same date). Not only could these encounter-based payment groups create enhanced incentives for efficiency, but they may also enable us to utilize for ratesetting many of the multiple procedure claims that are not now used in our establishment of OPPS rates for single procedures. (We refer readers to section II.A.1.b. of this proposed rule for a more detailed discussion of the treatment of multiple procedure claims in the ratesetting process.) For CY 2008, we are proposing two new composite APCs for CY 2008 payment of combinations of services in two clinical care areas, as discussed under section II.A.4.d. of this proposed rule. We look forward to receiving public comment on this proposal as we explore the possibility of moving toward basing OPPS payment on larger packages and bundles of services provided in a single hospital outpatient encounter.

We intend to involve the APC Panel in our future exploration of how we can develop encounter-based and episode-based payment groups, and we look forward to the findings and recommendations of MedPAC in this area. This is a significant change in direction for the OPPS, and we specifically seek the recommendations of all stakeholders with regard to which ancillary services could be packaged and those combinations of services provided in a single encounter or over time that could be bundled together for payment. We are hopeful that expanded packaging and, ultimately, greater bundling under the OPPS may result in sufficient moderation of growth in volume and spending that further controls would not be needed. However, if spending were to continue to escalate at the current rates, even after we have exhausted our options for increased packaging and bundling, we are considering multiple options under our authority to address these issues, including the possibility of imposing external controls that could link growth in volume to reduced payments under the OPPS in the future.

c. Proposed Packaging Approach

With the exception of the two composite APCs that we are proposing for CY 2008 and discuss in detail in section II.A.4.d. of this proposed rule, we are not currently prepared to propose an episode-based or fully developed encounter-based payment methodology for CY 2008 as our next step in value-based purchasing for the OPPS. However, in reviewing our approach to revising payment packages and bundles, we have examined services currently provided under the OPPS, looking for categories of ancillary items and services for which we believe payment could be appropriately packaged into larger payment packages for the encounter. For this first step in creating larger payment groups, we examined the HCPCS code definitions (including CPT code descriptors) to see whether there were categories of codes for which packaging would be a logical expansion of the longstanding packaging policy that has been a part of the OPPS since its inception. In general, we have often packaged the costs of selected HCPCS codes into payment for services reported with other HCPCS codes where we believed that one code reported an item or service that was integral to the provision of care that was reported by another HCPCS code.

As an example of a previous change in the OPPS packaging status for a HCPCS code that is ancillary and supportive, under the CY 2007 OPPS, we note that CPT code 93641 (Electrophysiologic evaluation of single or dual chamber pacing cardioverter defibrillator leads including defibrillation threshold evaluation (induction of arrhythmia, evaluate of sensing an pacing for arrhythmia termination) at the time of initial implantation or replacement; with testing of single chamber or dual chamber cardioverter defibrillator) went from separate to packaged payment. This service is only performed during the course of a surgical procedure for implantation or replacement of implantable cardioverter-defibrillator (ICD) leads, and these surgical implantation procedures are currently assigned to APC 0106 (Insertion/Replacement/Repair of Pacemaker and/or Electrodes) and APC 0108 (Insertion/Replacement/Repair of Cardioverter-Defibrillator Leads). We considered the electrophysiologic evaluation service (CPT code 93641) to be an ancillary supportive service that may be performed only in the same operative session as a procedure that could otherwise be performed independently of the electrophysiologic evaluation service. In this particular case, the APC Panel recommended for CY 2007 that we package payment for this diagnostic test and we adopted that recommendation for the CY 2007 OPPS. Making this payment change in this specific case resulted in the availability of significantly more claims data and, therefore, establishment of more valid and representative estimated median costs for the lead insertion and electrophysiologic evaluation services furnished in the single hospital encounter.

In the case of much of the care furnished in the HOPD, we believe that it is appropriate to view a complete service as potentially being reported by a combination of two or more HCPCS codes, rather than a single code, and to establish payment policy that supports this view. Ideally, we would consider a complete HOPD service to be the totality of care furnished in a hospital outpatient encounter or in an episode of care. In general, we believe that it is particularly appropriate to package payment for those items and services that are typically ancillary and supportive into the payment for the primary diagnostic or therapeutic modalities in which they are used. As a significant first step towards creating payment units that represent larger units of service, we examined whether there are categories of HCPCS codes that are typically ancillary and supportive to diagnostic and therapeutic modalities.

Specifically, as our initial substantial step toward creating larger payment groups for hospital outpatient care, we are proposing to package payment for

items and services in the seven categories listed below into the payment for the primary diagnostic or therapeutic modality to which we believe these items and services are typically ancillary and supportive. 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 the HCPCS codes that 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. We are proposing to assign status indicator ''N'' to those HCPCS codes that we believe are always integral to the performance of the primary modality and to package their costs into the costs of the separately paid primary services with which they are billed. We are proposing to assign status indicator ''Q'' to those HCPCS codes that we believe are typically integral to the performance of the primary modality and to package payment for their costs into the costs of the separately paid primary services with which they are usually billed but to pay them separately in those uncommon cases in which no other separately paid primary service is furnished in the hospital outpatient encounter.

For ease of reference in our subsequent discussion in each of the seven areas, we refer to the HCPCS codes for which we are proposing to package (or conditionally package) payment as dependent services. We use the term ''independent service'' to refer to the HCPCS codes that represent the primary therapeutic or diagnostic modality into which we are proposing to package payment for the dependent service. We note that, 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'' in this proposed rule.

Specifically, we are proposing to package the payment for HCPCS codes describing the dependent items and services in the following seven categories into the payment for the independent services with which they are furnished:

- Guidance services.
- Image processing services.
- Intraoperative services.
- Imaging supervision and interpretation services.
- Diagnostic radiopharmaceuticals.
- Contrast media and.
- Observation services.

We identify the HCPCS codes we are proposing to package for CY 2008, explain our rationale for proposing to package the codes in these categories, provide examples of how HCPCS and APC median costs and payments would change under these proposals, and discuss the impact of these changes in the discussion below under each category.

The median costs of services at the HCPCS level for many separately paid procedures change as a result of this proposal because we are proposing to change the composition of the payment packages associated with the HCPCS codes. Moreover, as a result of changes to the HCPCS median costs, we are proposing to reassign some HCPCS codes to different clinical APCs for CY 2008 to avoid 2 times violations and to ensure continuing clinical and resource homogeneity of the APCs. Therefore, the APC median costs change not only as a result of the increased packaging itself but also as a result of the migration of HCPCS codes into and out of APCs through APC reconfiguration. The file of HCPCS code and APC median costs resulting from our proposal is found under supporting documentation for this proposed rule on the CMS Web site at *http://www.cms.hhs.gov/HospitalOutpatientPPS/HORD/list.asp#TopOfPage*.

Review of the HCPCS median costs indicates that, while the proposed median costs rise for some HCPCS codes as a result of increased packaging that expands the costs included in the payment packages, there are also cases in which the proposed median costs decline as a result of these proposed changes. While it seems intuitive to believe that the proposed median costs of the remaining separately paid services should rise when the costs of services previously paid separately are packaged into larger payment groups, it is more challenging to understand why the proposed median costs of separately paid services would not change or would decline when the costs of previously paid services are packaged.

Medians are generally more stable than means because they are less sensitive to extreme observations, but medians typically do not reflect subtle changes in cost distributions. The OPPS' use of medians rather than means usually results in relative weight estimates being less sensitive to packaging decisions. Specifically, the median cost for a particular independent procedure generally will be higher as a result of added packaging, but also could change little or be lower because median costs typically do not reflect small distributional changes and also because changes to the packaged HCPCS codes affect both the number and composition of single bills and the mix of hospitals contributing those single bills. Such a decline, no change, or an increase in the median cost at the HCPCS code level could result from a change in the number of single bills used to set the median cost. With greater packaging, more ''natural'' single bills are created for some codes but fewer ''pseudo'' single bills are created. Thus, some APCs gain single bills and some lose single bills due to packaging changes, as well as to the reassignment of some codes to different APCs. When more claims from a different mix of providers are used to set the median cost for the HCPCS code, the median cost could move higher or lower within the array of per claim costs.

Similarly, proposed revisions to APC assignments that are necessary to resolve 2 times violations that could arise as a result of changes in the HCPCS median cost for one or more codes due to additional packaging may also result in increases or decreases to APC median costs and, therefore, to increases or decreases in the payments for HCPCS codes that would not be otherwise affected except for the CY 2008 proposed packaging approach for the seven categories of items and services.

We have examined the proposed aggregate impact of making these changes on payment for CY 2008. Because the OPPS is a budget neutral payment system in which the amount of payment weight in the system is annually adjusted for changes in expenditures created by changes in APC weights and codes (but is not currently adjusted based on estimated growth in service volume), the effects of the packaging changes we are proposing result in changes to scaled weights and, therefore, to the payment rates for all separately paid procedures. These changes result from both shifts in median costs as a result of increased packaging, changes in multiple procedure discounting patterns, and a higher weight scaler that is applied to all unscaled APC weights. (We refer readers to section II.A.3. of this proposed rule for an explanation of the weight scaler.) In a budget neutral system, the monies previously paid for services that are now proposed to be packaged are not lost, but are redistributed to all other services. A higher weight scaler would increase payment rates relative to observed median costs for independent services by redistributing the lost weight of packaged items that historically have

been paid separately and the lost weight when the median costs of independent services do not completely reflect the full incremental cost of the packaged services. The impact of this proposed change on proposed CY 2008 OPPS payments is discussed in section XXII B. of this proposed rule, and the impact on various classifications of hospitals is shown in Column 2B in Table 67 in that section.

We estimate that our CY 2008 proposal would redistribute approximately 1.2 percent of the estimated CY 2007 base year expenditures under the OPPS. The monies associated with this redistribution would be in addition to any increase that would otherwise occur due to a proposed higher median cost for the APC as a result of the expanded payment package. If the relative weight for a particular APC decreases as a result of the proposed packaging approach, the increased weight scaler may or may not result in a relative weight that is equal to or greater than the relative weight that would occur without the proposed packaging approach. In general, the packaging that we are proposing would have more effect on payment for some services than on payment for others because the dependent items and services that we are proposing for packaging are furnished more often with some independent services than with others. However, because of the amount of payment weight that would be redistributed by this proposal, there would be some impact on payments for all OPPS services whose rates are set based on payment weights, and the impact on any given hospital would vary based on the mix of services furnished by the hospital.

The following discussion separately addresses each of the seven categories of items and services for which we are proposing to package payment under the CY 2008 OPPS as part of our packaging proposal. Many codes that we are proposing to package for CY 2008 could fit into more than one of those seven categories. For example, CPT code 93325 (Doppler echocardiography color flow velocity mapping (List separately in addition to codes for echocardiography)) could be included in both the intraoperative and image processing categories. Therefore, for organizational purposes, both to ensure that each code appears in only one category and to facilitate discussion of our CY 2008 proposal, we have created a hierarchy of categories that determines which category each code appropriately falls into. This hierarchy is organized from the most clinically specific to the most general type of category. The hierarchy of categories is as follows: guidance services, image processing services, intraoperative services, and imaging supervision and interpretation services. Therefore, while CPT code 93325 may logically be grouped with either imaging processing services or intraoperative services, it is treated as an image processing service because that group is more clinically specific and precedes intraoperative services in the hierarchy. We did not believe it was necessary to include diagnostic radiopharmaceuticals, contrast media, or observation categories in this list because those services generally map to only one of those categories. We note that there is no cost estimation or payment implications related to the assignment of a HCPCS code for purposes of discussion to any specific category.

(1) Guidance Services

We are proposing to package payment for HCPCS guidance codes for CY 2008, specifically those codes that are reported for supportive guidance services, such as ultrasound, fluoroscopic, and stereotactic navigation services, that aid the performance of an independent procedure. We performed a broad search for such services, relying upon the American Medical Association's (AMA's) CY 2007 book of CPT codes and the CY 2007 book of Level II HCPCS codes, which identified specific HCPCS codes as guidance codes. Moreover, we performed a clinical review of all HCPCS codes to capture additional codes that are not necessarily identified as ''guidance'' services but describe services that provide directional information during the course of performing an independent procedure. For example, we are proposing to package CPT code 61795 (Stereotactic computer-assisted volumetric (navigational) procedure, intracranial, extracranial, or spinal (List separately in addition to code for primary procedure)) because we consider it to be a guidance service that provides three-dimensional information to direct the performance of intracranial or other diagnostic or therapeutic procedures. We also included HCPCS codes that existed in CY 2006 but were deleted and were replaced in CY 2007. We included the CY 2006 HCPCS codes because we are proposing to use the CY 2006 claims data to calculate the CY 2008 OPPS median costs on which the CY 2008 payment rates would be based. Many, although not all, of the CPT guidance codes we identified are designated by CPT as add-on codes that are to be reported in addition to the CPT code for the primary procedure. We also note that there are a number of CPT codes describing independent surgical procedures but which the code descriptors indicate that guidance is included in the code reported for the surgical procedure if it is used and, therefore, packaged payment is already made for the associated guidance service under the OPPS. For example, the independent procedure described by CPT code 55873 (Cryosurgical ablation of the prostate (includes ultrasonic guidance for interstitial cryosurgical probe placement)) already includes the ultrasound guidance that may be used. We believe packaging payment for every guidance service under the OPPS would provide consistently packaged payment for all these services that are used to direct independent procedures, even if they are currently separately reported.

Because these dependent guidance procedures support the performance of an independent procedure and they are generally provided in the same operative session as the independent procedure, we believe that it would be appropriate to package their payment into the OPPS payment for the independent procedure performed. However, guidance services differ from some of the other categories of services that we are proposing to package for CY 2008. Hospitals sometimes may have the option of choosing whether to perform a guidance service immediately preceding or during the main independent procedure, or not at all, unlike many of the imaging supervision and interpretation services, for example, which are generally always reported when the independent procedure is performed. Once a hospital decides that guidance is appropriate, the hospital may have several options regarding the type of guidance service that can be performed. For example, when inserting a central venous access device, hospitals have the option of using no guidance, ultrasound guidance, or fluoroscopic guidance, and the selection in any specific case will depend upon the specific clinical circumstances of the device insertion procedure. In fact, the historical hospital claims data demonstrate that various guidance services for the insertion of these devices, which have historically received packaged payment under the OPPS, are used frequently for the insertion of vascular access devices.

Thus, we recognize hospitals have several options regarding the performance and types of guidance services they use. However, we believe that hospitals utilize the most appropriate form of guidance for the specific procedure that is performed.

We do not want to create payment incentives to use guidance for all independent procedures or to provide one form of guidance instead of another. Therefore, by proposing to package payment for all forms of guidance, we are specifically encouraging hospitals to utilize the most cost effective and clinically advantageous method of guidance that is appropriate in each situation by providing them with the maximum flexibility associated with a single payment for the independent procedure. Similarly, hospitals may appropriately not utilize guidance services in certain situations based on clinical indications.

Because guidance services can be appropriately reported in association with many independent procedures, under our proposed packaging of guidance services for CY 2008, the costs associated with guidance services would be mapped to a larger number of independent procedures than some other categories of codes that we are proposing to package. For example, CPT code 76001 (Fluoroscopy, physician time more than one hour, assisting a non-radiologic physician (e.g., nephrostolithotomy, ERCP, bronchoscopy, transbronchial biopsy)) can be reported with a wide range of services. According to the CPT code descriptor, these procedures include nephrostolithotomy, which may be reported with CPT code 50080 (Percutaneous nephrostolithotomy or pyelostolithotomy, with or without dilation, endoscopy, lithotripsy, stenting, or basket extraction; up to 2 cm), and endoscopic retrograde cholangiopancreatography, which may be reported with CPT code 43260 (Endoscopic retrograde cholangiopancreatography (ERCP); diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)). Therefore, the cost of the fluoroscopic guidance would be reflected in the payment for each of these independent services, in addition to numerous other procedures, rather than in the payment for only one or two independent services, as is the case for some of the other categories of codes that we are proposing to package for CY 2008.

In addition, because independent procedures such as CPT code 20610 (Arthrocentesis, aspiration and/or injection; major joint or bursa (e.g., shoulder, hip, knee joint, subacromial bursa)) may be reported with or without guidance, the cost for the guidance will be reflected in the median cost for the independent procedure as a function of the frequency that guidance is reported with that procedure. As we stated previously, the median cost for a particular independent procedure generally will be higher as a result of added packaging, but also could change little or be lower because median costs typically do not reflect small distributional changes and because changes to the packaged HCPCS codes affect both the number and composition of single bills and the mix of hospitals contributing those single bills. In fact, the CY 2007 CPT book indicates that if guidance is performed with CPT code 20610, it may be appropriate to bill CPT code 76942 (Ultrasonic guidance for needle placement (e.g. biopsy, aspiration, injection, localization device), imaging supervision and interpretation); 77002 (Fluoroscopic guidance for needle placement (e.g. biopsy, aspiration, injection, localization device)); 77012 (Computed tomography guidance for needle placement (e.g. biopsy, aspiration, injection, localization device), radiological supervision and interpretation); or 77021 (Magnetic resonance guidance for needle placement (e.g., for biopsy, needle aspiration, injection, or placement of localization device) radiological supervision and interpretation). The CY 2007 CPT book also implies that it is not always clinically necessary to use guidance in performing an arthrocentesis described by CPT code 20610.

The guidance procedures that we are proposing to package for CY 2008 vary in their resource costs. Resource cost was not a factor we considered when proposing to package guidance procedures. Notably, most of the guidance procedures are relatively low cost in comparison to the independent services they frequently accompany.

The codes we are proposing to identify as guidance codes for CY 2008 that would receive packaged payment are listed in Table 8 below.

Several of these codes, including CPT code 76937 (Ultrasound guidance for vascular access requiring ultrasound evaluation of potential access sites, documentation of selected vessel patency, concurrent realtime ultrasound visualization of vascular needle entry, with permanent recording and reporting (List separately in addition to code for primary procedure)), are already unconditionally (that is, always) packaged under the CY 2007 OPPS, where they have been assigned to status indicator ''N.'' Payment for these services is currently made as part of the payment for the separately payable, independent services with which they are billed. No separate payment is made for services that we have assigned to status indicator ''N.'' We are not proposing status indicator changes for the five guidance procedures that were unconditionally packaged for CY 2007.

We are proposing to change the status indicators for 31 guidance procedures from separately paid to unconditionally packaged (status indicator ''N'') for the CY 2008 OPPS. We believe that these services are always integral to and dependent upon the independent services that they support and, therefore, their payment would be appropriately packaged because they would generally be performed on the same date and in the same hospital as the independent services.

We are proposing to change the status indicator for 1 guidance procedure from separately paid to conditionally packaged (status indicator ''Q''), and we will treat it as a ''special'' packaged code for the CY 2008 OPPS, specifically, CPT code 76000 (Fluoroscopy (separate procedure), up to 1 hour physician time, other than 71023 or 71034 (e.g. cardiac fluoroscopy)). This code was discussed in the past with the Packaging Subcommittee of the APC Panel which determined that, consistent with its code descriptor as a separate procedure, this procedure could sometimes be provided alone, without any other services on the claim. We believe that this procedure would usually be provided by a hospital as guidance in conjunction with another significant independent procedure on the same date of service but may occasionally be provided without another independent service. As a ''special'' packaged code, if the fluoroscopy service were billed without any other service assigned to status indicator ''S,'' ''T,'' ''V,'' or ''X'' reported on the same date of service, under our proposal we would not treat the fluoroscopy procedure as a dependent service for purposes of payment. If we were to unconditionally package payment for this procedure, treating it as a dependent service, hospitals would receive no payment at all when providing this service alone, although the procedure would not be functioning as a guidance service in that case. However, according to our proposal, its conditionally packaged status with its designation as a ''special'' packaged code would allow payment to be provided for this ''Q'' status fluoroscopy procedure, in which case it would be treated as an independent service under these limited circumstances. On the other hand, when the fluoroscopy service is furnished as a guidance procedure on the same day and in the same hospital as independent, separately paid services that are assigned to status indicator ''S,''

''T,'' ''V,'' or ''X,'' we are proposing to package payment for it as a dependent service. In all cases, we are proposing that hospitals that furnish independent services on the same date as dependent guidance services must bill them all on the same claim. We believe that when dependent guidance services and independent services are furnished on the same date and in the same facility, they are part of a single complete hospital outpatient service that is reported with more than one HCPCS code, and no separate payment should be made for the guidance service which supports the independent service.

We have calculated the median costs on which the proposed CY 2008 payment rates are based using the packaging status of each code as provided in Table 8 below. As we discussed earlier in more detail, this has the effect of both changing the median cost for the independent service into which the cost of the dependent service is packaged and also of redistributing payment that would otherwise have been made separately for the service we are proposing to newly package for CY 2008.

For example, CPT code 76940 (Ultrasound guidance for, and monitoring of, parenchymal tissue ablation) is assigned to APC 0268 (Level I Ultrasound Guidance Procedures) for CY 2007. We are proposing to discontinue APC 0268 for CY 2008 and to provide packaged payment for the HCPCS codes that were previously assigned to APC 0268. CPT code 76940 was billed with CPT code 47382 (Ablation, one or more liver tumor(s), percutaneous, radiofrequency) 148 times in the CY 2008 OPPS proposed rule claims data, and 42 percent of the claims for CPT code 76940 reported CPT code 47382 on the same date of service. Similarly, we note that almost 19 percent of the claims for CPT code 47382 also reported the ultrasound guidance service described by CPT code 76940. Under our proposed policy for the CY 2008 OPPS, we are proposing to expand the packaging associated with CPT code 47382 so that payment for the ultrasound guidance, if performed, would be packaged into the payment for the liver tumor ablation. Specifically, we would package payment for CPT code 76940 so that under the CY 2008 OPPS, the dependent procedure, in this case ultrasound guidance, would receive packaged payment through the separate OPPS payment for the independent procedure, in this case, the liver tumor ablation. The payment rates for this example associated with our CY 2008 proposal are outlined in Table 7 below.

In this case, the proposed CY 2008 median cost for APC 0423 (Level II Percutaneous Abdominal and Biliary Procedures) to which CPT code 47382 is assigned is $2,775.33, while the CY 2007 median cost of APC 0423 is $2,283.08 and of APC 0268 is $72.61. However, as discussed in section II.A.4.c. of this proposed rule concerning our general proposed packaging approach, the added effect of the budget neutrality adjustment that would result from the aggregate effects of the CY 2008 packaging proposal (were there no further budget neutrality adjustment for other reasons) significantly changes the final payment rates relative to median cost estimates. Table 7 presents a comparison of the CY 2007 payment for CPT codes 47382 and 76940, where CPT code 76940 is paid separately, to the CY 2008 payment we are proposing for CPT codes 47382 and 76940, where payment for CPT code 76940 would be packaged. This example cannot demonstrate the overall impact of packaging guidance services on payment to any given hospital because each individual hospital's case-mix and billing patterns would be different. The overall impact of packaging payment for CPT code 76940, as well as all the other proposed packaging changes we are proposing for CY 2008, can only be assessed in the aggregate for classes of hospitals. Section XXII.B. of this proposed rule displays the overall impact of APC weight recalibration and packaging changes we are proposing by classes of hospitals, and the OPPS Hospital-Specific Impacts—Provider-Specific Data file presents our estimates of CY 2008 hospital payment for those hospitals we include in our ratesetting and payment simulation database. The hospital-specific impacts file can be found on the CMS Web site at *http://www.cms.hhs.gov/HospitalOutpatientPPS/* under supporting documentation for this proposed rule.

TABLE 7.—EXAMPLE OF THE EFFECTS OF THE CY 2008 PACKAGING PROPOSAL ON PAYMENT FOR CPT CODES 76940 AND 47382

HCPCS code	Short descriptor	Sum of CY 2007 payment (76940 paid separately)	Sum of CY 2008 proposed payment (76940 packaged)
76940	Us guide, tissue ablation spine (dependent service)	$73.04	$0.00
47382	Percut ablate liver rf (independent service)	2,296.47	2,810.08
Total Payment		2,369.51	2,810.08

The estimated overall impact of these changes presented in section XXII.B. of this proposed rule is based on the assumption that hospital behavior would not change with regard to when these dependent services are performed on the same date and by the same hospital that performs the independent services. To the extent that hospitals could change their behavior and perform the guidance services more or less frequently, on subsequent dates, or at settings outside of the hospital, the data would show such a change in practice in future years and that change would be reflected in future budget neutrality adjustments. However, with respect to guidance services in particular, we believe that hospitals are limited in the extent to which they could change their behavior with regard to how they furnish these services. By their definition, these guidance services generally must be furnished on the same date and at the same operative location as the independent procedure in order for the guidance service to meaningfully contribute to the treatment of the patient in directing the performance of the independent procedure. We do not believe the clinical characteristics of the guidance services reported with the guidance HCPCS codes listed in Table 8 below will change in the immediate future.

As we indicated earlier, in all cases we are proposing that hospitals that furnish the guidance service on the same date as the independent service

must bill both services on the same claim. We expect to carefully monitor any changes in billing practices on a service-specific and hospital-specific basis to determine whether there is reason to request that Quality Improvement Organizations (QIOs) review the quality of care furnished or to request that Program Safeguard Contractors review the claims against the medical record.

TABLE 8.—GUIDANCE HCPCS CODES PROPOSED FOR PACKAGED PAYMENT IN CY 2008

HCPCS code	Short descriptor	CY 2007 SI	CY 2007 APC	Proposed CY 2008 SI	Proposed CY 2008 APC	Inactive HCPCS Code effective 1/1/2008 or earlier (listed on the same line as its replacement code)	Short descriptor of the inactive HCPCS code
19295	Place breast clip, precut	S	0657	N	n/a		
61795	Brain surgery using computer	S	0302	N	n/a		
62160	Neuroendoscopy add-on	T	0122	N	n/a		
76000	Fluoroscope examination	X	0272	Q	0272		
76001	Fluoroscope exam, extensive	N	n/a	N	n/a		
76930	Echo guide, cardiocentesis	S	0268	N	n/a		
76932	Echo guide for heart biopsy	S	0309	N	n/a		
76936	Echo guide for artery repair	S	0309	N	n/a		
76937	Us guide, vascular access	N	n/a	N	n/a		
76940	Us guide, tissue ablation	S	0268	N	n/a		
76941	Echo guide for transfusion	S	0268	N	n/a		
76942	Echo guide for biopsy	S	0268	N	n/a		
76945	Echo guide, villus sampling	S	0268	N	n/a		
76946	Echo guide for amniocentesis	S	0268	N	n/a		
76948	Echo guide, ova aspiration	S	0309	N	n/a		
76950	Echo guidance radiotherapy	S	0268	N	n/a		
76965	Echo guidance radiotherapy	S	0308	N	n/a		
76975	GI endoscopic ultrasound	S	0266	N	n/a		
76998	Us guide, intraop	S	0266	N	n/a	76986	Ultrasound guide intraoper.
77001	Fluoro guide for vein device	N	n/a	N	n/a	75998	Fluoro guide for vein device.
77002	Needle localization by xray	N	n/a	N	n/a	76003	Needle localization by xray.
77003	Fluoroguide for spine inject	N	n/a	N	n/a	76005	Fluoroguide for spine inject.
77011	Ct scan for localization	S	0283	N	n/a	76355	Ct scan for localization.
77012	Ct scan for needle biopsy	S	0283	N	n/a	76360	Ct scan for needle biopsy.
77013	Ct guide for tissue ablation	S	0333	N	n/a	76362	Ct guide for tissue ablation.
77014	Ct scan for therapy guide	S	0282	N	n/a	76370	Ct scan for therapy guide.
77021	Mr guidance for needle place	S	0335	N	n/a	76393	Mr guidance for needle place.
77022	Mri for tissue ablation	S	0335	N	n/a	76394	Mri for tissue ablation.
77031	Stereotact guide for brst bx	X	0264	N	n/a	76095	Stereotactic breast biopsy.
77032	Guidance for needle, breast	X	0263	N	n/a		
77417	Radiology port film(s)	X	0260	N	n/a		
77421	Stereoscopic x-ray guidance	S	0257	N	n/a		
95873	Guide nerv destr, elec stim	S	0215	N	n/a		
95874	Guide nerv destr, needle emg	S	0215	N	n/a		
0054T	Bone surgery using computer	S	0302	N	n/a		
0055T	Bone surgery using computer	S	0302	N	n/a		
0056T	Bone surgery using computer	S	0302	N	n/a		

(2) Image Processing Services

We are proposing to package payment for ''image processing'' HCPCS codes for CY 2008, specifically those codes that are reported as supportive dependent services to process and integrate diagnostic test data in the development of images, performed concurrently or after the independent service is complete. We performed a broad search for such services, relying upon the AMA's CY 2007 book of CPT codes and the CY 2007 book of Level II HCPCS codes, which identified specific codes as ''processing'' codes. In addition, we performed a clinical review of all HCPCS codes to capture additional codes that we consider to be image processing. For example, we are proposing to package payment for CPT code 93325 (Doppler echocardiography color flow velocity mapping (List separately in addition to codes for echocardiography)) because it is an image processing procedure, even though the code descriptor does not specifically indicate it as such.

An image processing service processes and integrates diagnostic test data that were captured during another independent procedure, usually one that is separately payable under the OPPS. The image processing service is not necessarily provided on the same date of service as the independent procedure. In fact, several of the image processing services that we are proposing to package for CY 2008 do not need to be provided face-to-face with the patient in the same encounter as the independent service. While this approach to service delivery may be administratively advantageous from a hospital's perspective, providing separate payment for each image processing service whenever it is performed is not consistent with encouraging value-based purchasing under the OPPS. We believe it is important to package payment for supportive dependent services that accompany independent services but that may not need to be provided face-to-face with the patient in the same

encounter because the supportive services utilize data that were collected during the preceding independent services and packaging their payment encourages the most efficient use of hospital resources. We are particularly concerned with any continuance of current OPPS payment policies that could encourage certain inefficient and more costly service patterns. As stated above, packaging encourages hospitals to establish protocols that ensure that services are furnished only when they are medically necessary and to carefully scrutinize the services ordered by practitioners to minimize unnecessary use of hospital resources. Our standard methodology to calculate median costs packages the costs of dependent services with the costs of independent services on ''natural'' single claims across different dates of service, so we are confident that we would capture the costs of the supportive image processing services for ratesetting when they are packaged according to our CY 2008 proposal, even if they were provided on a different date than the independent procedure.

We list the image processing services that would be packaged for CY 2008 in Table 10 below. As these services support the performance of an independent service, we believe it would be appropriate to package their payment into the OPPS payment for the independent service provided.

As many independent services may be reported with or without image processing services, the cost of the image processing services will be reflected in the median cost for the independent HCPCS code as a function of the frequency that image processing services are reported with that particular HCPCS code. Again, while the median cost for a particular independent procedure generally will be higher as a result of added packaging, it could also change little or be lower because median costs typically do not reflect small distributional changes and because changes to the packaged HCPCS codes affect both the number and composition of single bills and the mix of hospitals contributing those single bills. For example, CPT code 70450 (Computed tomography, head or brain; without contrast material) may be provided alone or in conjunction with CPT code 76376 (3D rendering with interpretation and reporting of computed tomography, magnetic resource imaging, ultrasound, or other tomographic modality; not requiring image postprocessing on an independent workstation). In fact, CPT code 70450 was provided approximately 1.5 million times based on CY 2008 proposed rule claims data. CPT code 76376 was provided with CPT code 70450 less than 2 percent of the total instances that CPT code 70450 was billed. Therefore, as the frequency of CPT code 76376 provided in conjunction with CPT code 70450 increases, the median cost for CPT code 70450 would be more likely to reflect that additional cost.

The image processing services that we are proposing to package vary in their hospital resource costs. Resource cost was not a factor we considered when proposing to package supportive image processing services. Notably, the majority of image processing services that we are proposing to package have modest median costs in relationship to the cost of the independent service that they typically accompany.

Several of these codes, including CPT code 76350 (Subtraction in conjunction with contrast studies), are already unconditionally (that is, always) packaged under the CY 2007 OPPS, where they have been assigned to status indicator ''N.'' Payment for these services is made as part of the payment for the separately payable, independent services with which they are billed. No separate payment is made for services that we have assigned to status indicator ''N.'' We are not proposing status indicator changes for the four image processing services that were unconditionally packaged for CY 2007.

We are proposing to change the status indicator for seven image processing services from separately paid to unconditionally packaged (status indicator ''N'') for the CY 2008 OPPS. We believe that these services are always integral to and dependent upon the independent service that they support and, therefore, their payment would be appropriately packaged. We have calculated the median costs on which the proposed CY 2008 payment rates are based using the packaging status of each code as provided in Table 10 below. As we discuss above in more detail, this has the effect of both changing the median cost for the independent service into which the cost of the dependent service is packaged and also of redistributing payment that would otherwise have been made separately for the service we are proposing to newly package for CY 2008.

For example, CPT code 93325 (Doppler echocardiography color flow velocity mapping (List separately in addition to codes for echocardiography)) is assigned to APC 0697 (Level I Echocardiogram Except Transesophageal) for CY 2007. The proposed CY 2008 median cost of APC 0697 is $302.40. CPT code 93325 was billed with CPT code 93350 (Echocardiography, transthoracic, real-time with image documentation (2D), with or without M-mode recording, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report) approximately 43,000 times in the CY 2008 OPPS proposed rule data, and 5 percent of the claims for CPT code 93325 reported CPT code 93350 on the same date of service. Similarly, we note that almost 35 percent of the claims for CPT code 93350 also reported the image processing service described by CPT code 93325. Because CPT code 93350 is designated by CPT as an add-on code to a stress test service, as would be expected, we also observed that a CPT code for a stress test, most commonly CPT code 93017 (Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; with physician supervision, with interpretation and report) was also frequently reported on the same claim on the same day as both of the other two CPT codes. CPT code 93017 is assigned to APC 0100 (Cardiac Stress Tests) with a proposed CY 2008 median cost of $180.10. Under our proposed policy for the CY 2008, we are proposing to expand the packaging associated with the independent stress test and echocardiography services so that payment for the echocardiography color flow velocity mapping, if performed, would be packaged. Specifically, we would package payment for CPT code 93325, the echocardiography color flow velocity mapping, so that this dependent procedure would receive packaged payment through the separate OPPS payments for the independent procedures, here the stress test and echocardiography services. The payment rates for this example associated with our CY 2008 proposal are outlined in Table 9 below.

In this case, the proposed CY 2008 median cost for APC 0100 to which CPT code 93017 is assigned is $180.10. The proposed CY 2008 median cost for APC 0697, to which CPT code 93350 is assigned, is $302.40. The CY 2007 median cost for APC 0100 is $154.83 and the median cost for APC 0697 is $97.61. However, as discussed in section II.A.4.c. of this proposed rule concerning our general proposed packaging approach, the added effect of the budget neutrality adjustment that would result from the aggregate effects of the CY 2008 packaging proposal

(were there no further budget neutrality adjustment for other reasons) significantly changes the final payment rates relative to the median cost estimates. Table 9 presents a comparison of payments for CPT codes 93017, 93350, and 93325 in CY 2007, where payment for CPT code 93325 is made separately, to our CY 2008 proposed payments for CPT codes 93017, 93350, and 93325, where payment for CPT code 93325 would be packaged. This example cannot demonstrate the overall impact of packaging image processing services on payment to any given hospital because each individual hospital's case-mix and billing patterns would be different. The overall impact of packaging payment for CPT code 93325, as well as the proposed packaging changes that we are proposing for CY 2008, can only be assessed in the aggregate for classes of hospitals. Section XXII.B. of this proposed rule displays the overall impact of APC weight recalibration and packaging changes that we are proposing by classes of hospitals, and the OPPS Hospital-Specific Impacts—Provider-Specific Data file presents our estimates of CY 2008 hospital payment for those hospitals we include in our ratesetting and payment simulation database. The hospital-specific impacts file can be found on the CMS Web site at *http://www.cms.hhs.gov/HospitalOutpatientPPS/* under supporting documentation for this proposed rule.

TABLE 9.—EXAMPLE OF THE EFFECTS OF THE CY 2008 PACKAGING PROPOSAL ON PAYMENT FOR CPT CODES 93325, 93350, AND 93017

HCPCS code	Short descriptor	Sum of CY 2007 payment (93325 paid separately)	Sum of CY 2008 proposed payment (93325 Packaged)
93325	Doppler color flow add-on (dependent service)	$98.18	$0.00
93350	Echo transthoracic (independent service)	197.64	306.18
93017	Cardiovascular stress test (independent service)	155.74	182.36
Total Payment		451.56	488.54

The estimated overall impact of these proposed changes presented in section XXII.B. of this proposed rule is based on the assumption that hospital behavior would not change with regard to how often these dependent image processing services are performed in conjunction with the independent services. To the extent that hospitals could change their behavior and perform the image processing services more or less frequently, the data would show such a change in practice in future years and that change would be reflected in future budget neutrality adjustments.

As we indicated earlier, in all cases we are proposing that hospitals that furnish the image processing procedure in association with the independent service must bill both services on the same claim. We expect to carefully monitor any changes in billing practices on a service-specific and hospital-specific basis to determine whether there is reason to request that QIOs review the quality of care furnished or to request that Program Safeguard Contractors review the claims against the medical record.

TABLE 10.—IMAGE PROCESSING HCPCS CODES PROPOSED FOR PACKAGED PAYMENT IN CY 2008

HCPCS code	Short descriptor	CY 2007 SI	CY 2007 APC	Proposed CY 2008 SI	Inactive CPT code effective 1/1/08 or earlier (listed on the same line as its replacement code	Short descriptor of the inactive CPT code
76125	Cine/video x-rays add-on	X	0260	N		
76350	Special x-ray contrast study	N	n/a	N		
76376	3d render w/o postprocess	X	0340	N		
76377	3d rendering w/postprocess	S	0282	N		
93325	Doppler color flow add-on	S	0697	N		
93613	Electrophys map 3d, add-on	T	0087	N		
95957	EEG digital analysis	S	0214	N		
0159T	Cad breast MRI	N	n/a	N		
0174T	Cad cxr remote	N	n/a	N	0152T	Computer chest add-on.
0175T	Cad cxr with interp	N	n/a	N	0152T	Computer chest add-on.
G0288	Recon, CTA for surg plan	S	0417	N		

(3) Intraoperative Services

We are proposing to package payment for ''intraoperative'' HCPCS codes for CY 2008, specifically those codes that are reported for supportive dependent diagnostic testing or other minor procedures performed during independent procedures. We performed a broad search for possible intraoperative HCPCS codes, relying upon the AMA's CY 2007 book of CPT codes and the CY 2007 book of Level II HCPCS codes, to identify specific codes as ''intraoperative'' codes. Furthermore, we performed a clinical review of all HCPCS codes to capture additional supportive diagnostic testing or other minor intraoperative or intraprocedural codes that are not necessarily identified as ''intraoperative'' codes. For example, we are proposing to package payment for CPT code 95955 (Electroencephalogram (EEG) during

nonintracranial surgery (e.g., carotid surgery)) because it is a minor intraoperative diagnostic testing procedure even though the code descriptor does not indicate it as such. Although we use the term ''intraoperative'' to categorize these procedures, we also have included supportive dependent services in this group that are provided during an independent procedure, although that procedure may not necessarily be a surgical procedure. These dependent services clearly fit into this category because they are provided during, and are integral to, an independent procedure, like all the other intraoperative codes, but the independent procedure they accompany may not necessarily be a surgical procedure. For example, we are proposing to package HCPCS code G0268 (Removal of impacted cerumen (one or both ears) by physician on same date of service as audiologic function testing). While specific audiologic function testing procedures are not surgical procedures performed in an operating room, they are independent procedures that are separately payable under the OPPS, and HCPCS code G0268 is a supportive dependent service always provided in association with one of these independent services. All references to ''intraoperative'' below refer to services that are usually or always provided during a surgical procedure or other independent procedure.

By definition, a service that is performed intraoperatively is provided during and, therefore, on the same date of service as another procedure that is separately payable under the OPPS. Because these intraoperative services support the performance of an independent procedure and they are provided in the same operative session as the independent procedure, we believe it would be appropriate to package their payment into the OPPS payment for the independent procedure performed. Therefore, we are not proposing to package payment for CY 2008 for those diagnostic services, such as CPT code 93005 (Electrocardiogram, routine ECG with at least 12 leads; tracing only, without interpretation and report) that are sometimes or only rarely performed and reported as supportive services in association with other independent procedures. Instead, we are proposing to include those HCPCS codes that are usually or always performed intraoperatively, based upon our review of the codes described above. The intraoperative services that we are proposing to package vary in hospital resource costs. Resource cost was not a factor we considered when determining which supportive intraoperative procedures to package.

The codes we are proposing to identify as intraoperative services for CY 2008 that would receive packaged payment under the OPPS are listed in Table 12 below.

Several of these codes, including CPT code 93640 (Electrophysiologic evaluation of single or dual chamber pacing cardioverter-defibrillator leads including defibrillation threshold evaluation (induction of arrhythmia, evaluation of sensing and pacing for arrhythmia termination) at the time of initial implantation or replacement), are already unconditionally (that is, always) packaged under the CY 2007 OPPS, where they have been assigned to status indicator ''N.'' Payment for these services is made through the payment for the separately payable, independent services with which they are billed. No separate payment is made for services that we have assigned to status indicator ''N.'' We are not proposing status indicator changes for the five diagnostic intraoperative services that were unconditionally packaged for CY 2007.

We are proposing to change the status indicator for 34 intraoperative services from separately paid to unconditionally packaged (status indicator ''N'') for the CY 2008 OPPS. We believe that these services are always integral to and dependent upon the independent services that they support and, therefore, their payment would be appropriately packaged because they would generally be performed on the same date and in the same hospital as the independent services.

We are also proposing to change the status indicator for one intraoperative procedure from unconditionally packaged to conditionally packaged (status indicator ''Q'') as a ''special'' packaged code for the CY 2008 OPPS, specifically, CPT code 0126T (Common carotid intima-media thickness (IMT) study for evaluation of atherosclerotic burden or coronary heart disease risk factor assessment). This code was discussed in the past with the Packaging Subcommittee of the APC Panel which determined that, consistent with its code descriptor as a separate procedure, this procedure could sometimes be provided alone, without any other OPPS services on the claim. We believe that this procedure would usually be provided by a hospital in conjunction with another independent procedure on the same date of service but may occasionally be provided without another independent service. As a ''special'' packaged code, if the study were billed without any other service assigned to status indicator ''S,'' ''T,'' ''V,'' or ''X'' reported on the same date of service, under our proposal we would not treat the IMT study as a dependent service for purposes of payment. If we were to continue to unconditionally package payment for this procedure, treating it as a dependent service, hospitals would receive no payment at all when providing this service alone, although the procedure would not be functioning as an intraoperative service in that case. However, according to our proposal, its conditionally packaged status as a ''special'' packaged code would allow payment to be provided for this ''Q'' status IMT study when provided alone, in which case it would be treated as an independent service under these limited circumstances. On the other hand, when this service is furnished as an intraoperative procedure on the same day and in the same hospital as independent, separately paid services that are assigned to status indicator ''S,'' ''T,'' ''V,'' or ''X,'' we are proposing to package payment for it as a dependent service. In all cases, we are proposing that hospitals that furnish independent services on the same date as this IMT procedure must bill them all on the same claim. We believe that when dependent and independent services are furnished on the same date and in the same facility, they are part of a single complete hospital outpatient service that is reported with more than one HCPCS code, and no separate payment should be made for the intraoperative procedure that supports the independent service.

We have calculated the median costs on which the proposed CY 2008 payment rates are based using the packaging status of each code as provided in Table 12 below. As we discuss above in more detail, this has the effect of both changing the median cost for the independent service into which the cost of the dependent service is packaged and also of redistributing payment that would otherwise have been made separately for the service we are proposing to newly package for CY 2008.

For example, CPT code 92547 (Use of vertical electrodes (List separately in addition to code for primary procedure)) is assigned to APC 0363 (Level I Otorhinolaryngologic Function Tests) for CY 2007. The proposed CY 2008 median cost of APC 0363 is $53.73. CPT code 92547 was billed with CPT code 92541 (Spontaneous nystagmus test, including gaze and fixation nystagmus, with recording) 6,056 times in the CY 2008 OPPS proposed rule data, and 97

percent of the claims for CPT code 92547 reported CPT code 92541 on the same date of service. Similarly, we note that over half of the claims for CPT code 92541 also reported the service described by CPT code 92547. Under our proposed policy for the CY 2008 OPPS, we are proposing to expand the packaging associated with the independent nystagmus test so that payment for the use of vertical electrodes, if used, would be packaged. Specifically, we would package payment for CPT code 92547 so that under the CY 2008 OPPS the commonly billed dependent procedure, the use of vertical electrodes, would receive packaged payment through the separate OPPS payment for the independent procedure, in this case the nystagmus test. The payment rates for this example associated with our CY 2008 proposal are outlined in Table 11 below.

In this case, the proposed CY 2008 median cost for APC 0363, to which CPT code 92541 is assigned, is $53.73, while the CY 2007 median cost of this APC with status indicator ''S'' and to which both CPT codes 92547 and 02541 are assigned is $52.09. However, as discussed in the section II.A.4. of this proposed rule concerning our general proposed packaging approach, the added effect of the budget neutrality adjustment that would result from the aggregate effects of the complete CY 2008 packaging proposal (were there no further budget neutrality adjustment for other reasons) significantly changes the final payment rates relative to median cost estimates. Table 11 presents a comparison of payment for CPT codes 92541 and 92547 in CY 2007, where CPT code 92547 is paid separately, to our CY 2008 proposed payment for CPT codes 92541 and 92547, where payment for CPT code 92547 would be packaged. This example cannot demonstrate the overall impact of packaging intraoperative services on payment to any given hospital because each individual hospital's case-mix and billing patterns would be different. The overall impact of packaging payment for CPT code 92547, as well as all other packaging changes we are proposing for CY 2008, can only be assessed in the aggregate for classes of hospitals. Section XXII.B. of this proposed rule displays the overall impact of APC weight recalibration and packaging changes we are proposing by classes of hospitals, and the OPPS Hospital-Specific Impacts—Provider-Specific Data file presents our estimates of CY 2008 hospital payment for those hospitals we include in our ratesetting and payment simulation database. The hospital-specific impacts file can be found on the CMS Web site at *http://www.cms.hhs.gov/HospitalOutpatientPPS/* under supporting documentation for this proposed rule.

TABLE 11.— EXAMPLE OF THE EFFECTS OF THE CY 2008 PACKAGING PROPOSAL ON PAYMENT FOR CPT CODES 92541 AND 92547

HCPCS Code	Short descriptor	Sum of CY 2007 payment (92547 paid separately)	Sum of CY 2008 proposed payment (92547 packaged)
92541	Spontaneous nystagmus study (independent service)	$52.40	$54.41
92547	Supplemental electrical test (dependent service)	52.40	0.00
Total Payment		104.80	54.41

The estimated overall impact of these proposed changes is based on the assumption that hospital behavior would not change with regard to when these dependent intraoperative services are performed on the same date and by the same hospital that performs the independent services. To the extent that hospitals could change their behavior and perform the intraoperative services more or less frequently, on subsequent dates, or at settings outside of the hospital, the data would show such a change in practice in future years and that change would be reflected in future budget neutrality adjustments. However, with respect to intraoperative services in particular, we believe that hospitals are limited in the extent to which they could change their behavior with regard to how they furnish these services. By their definition, these intraoperative services generally must be furnished on the same date and at the same operative location as the independent procedure in order to be considered intraoperative. For these codes, we assume that both the dependent and independent services would be furnished on the same date in the same hospital, and hospitals should bill them on the same claim with the same date of service.

As we indicated earlier, in all cases we are proposing that hospitals that furnish the intraoperative procedure on the same date as the independent service must bill both services on the same claim. We expect to carefully monitor any changes in billing practices on a service-specific and hospital-specific basis to determine whether there is reason to request that QIOs review the quality of care furnished or to request that Program Safeguard Contractors review the claims against the medical record.

TABLE 12.—INTRAOPERATIVE HCPCS CODES PROPOSED FOR PACKAGED PAYMENT IN CY 2008

HCPCS Code	Short descriptor	CY 2007 SI	CY 2007 APC	Proposed CY 2008 SI
20975	Electrical bone stimulation	X	0340	N
31620	Endobronchial us add-on	S	0670	N
37250	Iv us first vessel add-on	S	0416	N
37251	Iv us each add vessel add-on	S	0416	N
58110	Bx done w/colposcopy add-on	T	0188	N
67299	Eye surgery procedure	T	0235	N
73530	X-ray exam of hip	X	0261	N
74300	X-ray bile ducts/pancreas	X	0263	N

TABLE 12.—INTRAOPERATIVE HCPCS CODES PROPOSED FOR PACKAGED PAYMENT IN CY 2008—Continued

HCPCS Code	Short descriptor	CY 2007 SI	CY 2007 APC	Proposed CY 2008 SI
74301	X-rays at surgery add-on	X	0263	N
75898	Follow-up angiography	X	0263	N
78020	Thyroid met uptake	S	0399	N
78478	Heart wall motion add-on	S	0399	N
78480	Heart function add-on	S	0399	N
78496	Heart first pass add-on	S	0399	N
92547	Supplemental electrical test	X	0363	N
92978	Intravasc us, heart add-on	S	0670	N
92979	Intravasc us, heart add-on	S	0416	N
93320	Doppler echo exam, heart	S	0697	N
93321	Doppler echo exam, heart	S	0697	N
93571	Heart flow reserve measure	S	0670	N
93572	Heart flow reserve measure	S	0416	N
93609	Map tachycardia, add-on	T	0087	N
93613	Electrophys map 3d, add-on	T	0087	N
93621	Electrophysiology evaluation	T	0085	N
93622	Electrophysiology evaluation	T	0085	N
93623	Stimulation, pacing heart	T	0087	N
93631	Heart pacing, mapping	T	0087	N
93640	Evaluation heart device	N	n/a	N
93641	Electrophysiology evaluation	N	n/a	N
93662	Intracardiac ecg (ice)	S	0670	N
95829	Surgery electrocorticogram	S	0214	N
95920	Intraop nerve test add-on	S	0216	N
95955	EEG during surgery	S	0213	N
95999	Neurological procedure	S	0215	N
96020	Functional brain mapping	X	0373	N
0126T	Chd risk imt study	N	n/a	Q
0173T	Iop monit io pressure	N	n/a	N
G0268	Removal of impacted wax md	X	0340	N
G0275	Renal angio, cardiac cath	N	n/a	N
G0278	Iliac art angio, cardiac cath	N	n/a	N

(4) Imaging Supervision and Interpretation Services

We are proposing to change the packaging status of many imaging supervision and interpretation codes for CY 2008. We define ''imaging supervision and interpretation codes'' as HCPCS codes for services that are defined as ''radiological supervision and interpretation'' in the radiology series, 70000 through 79999, of the AMA's CY 2007 book of CPT codes, with the addition of some services in other code ranges of CPT, Category III CPT tracking codes, or Level II HCPCS codes that are clinically similar or directly crosswalk to codes defined as radiological supervision and interpretation services in the CPT radiology range. We also included HCPCS codes that existed in CY 2006 but were deleted and were replaced in CY 2007. We included the CY 2006 HCPCS codes because we are proposing to use the CY 2006 claims data to calculate the CY 2008 OPPS median costs on which the CY 2008 payment rates would be based.

In its discussion of ''radiological supervision and interpretation,'' CPT indicates that ''when a procedure is performed by two physicians, the radiologic portion of the procedure is designated as 'radiological supervision and interpretation'.'' In addition, CPT guidance notes that, ''When a physician performs both the procedure and provides imaging supervision and interpretation, a combination of procedure codes outside the 70000 series and imaging supervision and interpretation codes are to be used.'' In the hospital outpatient setting, the concept of one or more than one physician performing related procedures does not apply to the reporting of these codes, but the radiological supervision and interpretation codes clearly are established for reporting in association with other procedural services outside the CPT 70000 series. Because these imaging supervision and interpretation codes are always reported for imaging services that support the performance of an independent procedure and they are, by definition, always provided in the same operative session as the independent procedure, we believe that it would be appropriate to package their payment into the OPPS payment for the independent procedure performed.

In addition to radiological supervision and interpretation codes in the radiology range of CPT codes, there are CPT codes in other series that describe similar procedures that we are proposing to include in the group of imaging supervision and interpretation codes proposed for packaging under the CY 2008 OPPS. For example, CPT code 93555 (Imaging supervision, interpretation and report for injection procedure(s) during cardiac catheterization; ventricular and/or atrial angiography) whose payment under the OPPS is currently packaged, is commonly reported with an injection procedure code, such as CPT code 93543 (Injection procedure during cardiac catheterization; for selective left ventricular or left atrial angiography), whose payment is also currently packaged under the OPPS, and a cardiac catheterization procedure code, such as CPT code 93526 (Combined right heart catheterization and retrograde left heart catheterization), that is separately paid. In the case of cardiac catheterization, CPT code 93555 describes an imaging supervision and interpretation service in support of the cardiac catheterization procedure, and this dependent service is clinically quite similar to radiological supervision and interpretation codes in the radiology range of CPT. Payment for the cardiac catheterization imaging

supervision and interpretation services has been packaged since the beginning of the OPPS. Therefore, in developing this proposal for the CY 2008 proposed rule, we conducted a comprehensive clinical review of all Category I and Category III CPT codes and Level II HCPCS codes to identify all codes that describe imaging supervision and interpretation services. The codes we are proposing to identify as imaging supervision and interpretation codes for CY 2008 that would receive packaged payment are listed in Table 14 below.

Several of these codes, including CPT code 93555 discussed above, are already unconditionally (that is, always) packaged under the CY 2007 OPPS, where they have been assigned to status indicator ''N.'' Payment for these services is made as part of the payment for the separately payable, independent services with which they are billed. No separate payment is made for services that we have assigned to status indicator ''N.'' We are not proposing status indicator changes for the six imaging supervision and interpretation services that were unconditionally packaged for CY 2007.

We are proposing to change the status indicator for 33 imaging supervision and interpretation services from separately paid to unconditionally packaged (status indicator ''N'') for the CY 2008 OPPS. We believe that these services are always integral to and dependent upon the independent services that they support and, therefore, their payment would be appropriately packaged because they would generally be performed on the same date and in the same hospital as the independent services.

We are proposing to change the status indicator for 93 imaging supervision and interpretation services from separately paid to conditionally packaged (status indicator ''Q'') as ''special'' packaged codes for the CY 2008 OPPS. These services may occasionally be provided at the same time and at the same hospital with one or more other procedures for which payment is currently packaged under the OPPS, most commonly injection procedures, and in these cases we would not treat the imaging supervision and interpretation services as dependent services for purposes of payment. If we were to unconditionally package payment for these imaging supervision and interpretation services as dependent services, hospitals would receive no payment at all for providing the imaging supervision and interpretation service and the other minor procedure(s). However, according to our proposal, their conditional packaging status as ''special'' packaged codes would allow payment to be provided for these ''Q'' status imaging supervision and interpretation services as independent services in these limited circumstances, and for which payment for the accompanying minor procedure would be packaged. However, when these imaging supervision and interpretation dependent services are furnished on the same day and in the same hospital as independent separately paid services, specifically, any service assigned to status indicator ''S,'' ''T,'' ''V,'' or ''X,'' we are proposing to package payment for them as dependent services. In all cases, we are proposing that hospitals that furnish the independent services on the same date as the dependent services must bill them all on the same claim. We believe that when the dependent and independent services are furnished on the same date and in the same hospital, they are part of a single complete hospital outpatient service that is reported with more than one HCPCS code, and no separate payment should be made for the imaging supervision and interpretation service that supports the independent service.

In the case of services for which we are proposing conditional packaging, we would expect that, although these services would always be performed in the same session as another procedure, in some cases that other procedure's payment would also be packaged. For example, CPT code 73525 (Radiological examination, hip, arthrography, radiological supervision and interpretation) and CPT code 27093 (Injection procedure for hip arthrography; without anesthesia) could be provided in a single hospital outpatient encounter and reported as the only two services on a claim. In the case where only these two services were performed, the conditionally packaged status of CPT code 73525 would appropriately allow for its separate payment as an independent imaging supervision and interpretation arthrography service, into which payment for the dependent injection procedure would be packaged.

We have calculated the median costs on which the proposed CY 2008 payment rates are based using the packaging status of each code as provided in Table 14 below. As we discuss above in more detail, this has the effect of both changing the median cost for the independent service into which the cost of the dependent service is packaged and also of redistributing payment that would otherwise have been made separately for the service we are proposing to newly package for CY 2008.

For example, CPT code 72265 (Myelography, lumbosacral, radiological supervision and interpretation) is assigned to APC 0274 (Myelography) for CY 2007. The proposed CY 2008 median cost of APC 0274 is $245.38. CPT code 72265 was billed with CPT code 72132 (Computed tomography, lumbar spine; with contrast material) 20,233 times in the CY 2008 OPPS proposed rule data, and 62 percent of the claims for CPT code 72265 reported CPT code 72132 on the same date of service. Similarly, we note that over half of the claims for CPT code 72132 also reported the myelography service described by CPT code 72265. As would be expected, we also observed that a CPT code for the clinically necessary intrathecal injection, specifically CPT code 62284 (Injection procedure for myelography and/or computed tomography, spinal (other than C1–C2 and posterior fossa)) was also frequently reported on the same claim on the same day as both of the other two CPT codes. Payment for CPT code 62284 is already packaged under the OPPS for CY 2007, as is payment for most HCPCS codes that describe dependent injection procedures that accompany independent procedures. Under our proposed policy for the CY 2008 OPPS, we are proposing to expand the packaging associated with the independent spinal computed tomography (CT) scan so that payment for both the associated injection procedure and the related myelography service, if performed, would be packaged. Specifically, we would package payment for CPT code 72265 when it appears on the same claim with a separately paid service such as CPT code 72132, so that, under the CY 2008 OPPS, both commonly billed dependent procedures, the injection procedure and the myelography service, would receive packaged payment through the separate OPPS payment for the independent procedure, the CT scan. The payment rates for this example associated with our CY 2008 proposal are outlined in Table 13 below. The proposed conditionally packaged status for CPT code 72265 would ensure that if lumbosacral myelography was performed alone, separate payment for the myelography service would be made under the OPPS as the myelography service would not be a dependent service in that situation.

The proposed policy would result in no separate payment for CPT code 72265 when it is billed on the same day and by the same hospital as any separately paid service, such as CPT code 72132. Moreover, as discussed

later in this section, the proposed policy would provide packaged payment for the contrast agent that is required to perform the independent computed tomography service. For purposes of the example in Table 13 below, we include the payment for HCPCS code Q9947 (Low osmolar contrast material 200–249 mg/ml iodine concentration, per ml) which was reported on about one-third of the CY 2008 proposed rule claims for CPT code 72132. To calculate the CY 2007 payment for the contrast agent, we multiplied the mean number of units per day from our CY 2008 proposed rule data (48.3) by the April 2007 per unit payment rate for HCPCS code Q9947 ($1.33).

In this case, the proposed CY 2008 median cost for APC 0316 (Level II Computed Tomography with Contrast) to which CPT code 72132 is assigned is $741.80. The CY 2007 median cost for APC 0283 to which CPT code 72132 is assigned is $249.48 and the median cost of APC 0274 to which CPT code 72265 is assigned is $156.10. However, as discussed in section II.A.4.c. of this proposed rule concerning our general proposed packaging approach, the added effect of the budget neutrality adjustment that would result from the aggregate effects of the CY 2008 packaging proposal (were there no further budget neutrality adjustment for other reasons) significantly changes the final payment rates relative to median cost estimates. Table 13 presents a comparison of payment for CPT codes 72132 and 72265 and HCPCS code Q9947 in CY 2007, where CPT code 72265 and HCPCS code Q9947 are paid separately, to our CY 2008 proposed payment for CPT codes 72132 and 77265 and HCPCS code Q9947, where payment for CPT code 72265 and HCPCS code Q9947 would be packaged. This example cannot demonstrate the overall impact of packaging imaging supervision and interpretation services on payment to any given hospital because each individual hospital's case-mix and billing patterns would be different. The overall impact of packaging payment CPT code 77265 when it appears with any other separately paid service, as well as all other packaging changes that we are proposing for CY 2008, can only be assessed in aggregate for classes of hospitals. Section XXII.B. of this proposed rule displays the overall impact of APC weight recalibration and packaging changes we are proposing by classes of hospitals, and the OPPS Hospital-Specific Impacts—Provider-Specific Data file presents our estimates of CY 2008 hospital payment for those hospitals we include in our ratesetting and payment simulation database. The hospital-specific impacts file can be found on the CMS Web site at *http://www.cms.hhs.gov/HospitalOutpatientPPS/* under supporting documentation for this proposed rule.

TABLE 13.—EXAMPLE OF THE EFFECTS OF THE CY 2008 PACKAGING PROPOSAL ON PAYMENT FOR CPT CODES 72265 AND 72132 AND HCPCS CODE Q9947

HCPCS code	Short descriptor	Sum of CY 2007 payment (72265 paid separately)	Sum of CY 2008 proposed payment (72265 packaged)
62284	Injection for myelogram (dependent service)	$0.00	$0.00
Q9947*	LOCM 200–249mg/ml iodine, 1ml (dependent service)	64.24	0.00
72265	Contrast x-ray lower spine (dependent service)	157.01	0.00
72132	CT lumbar spine w/dye (independent service)	250.94	751.09
Total Payment		472.14	751.09

* Based on the mean number of units per day from our CY 2008 proposed rule data (48.3) and the April 2007 per unit payment rate for Q9947 ($1.33).

The estimated overall impact of these changes presented in XXII.B. of this proposed rule is based on the assumption that hospital behavior would not change with regard to when these dependent services are performed on the same date and by the same hospital that performs the independent services. To the extent that hospitals could change their behavior and perform the imaging supervision and interpretation services more or less frequently, on subsequent dates, or at settings outside of the hospital, the data would show such a change in practice in future years and that change would be reflected in future budget neutrality adjustments. However, with respect to the imaging supervision and interpretation services in particular, we believe that hospitals are limited in the extent to which they could change their behavior with regard to how they furnish these services. By their definition, these imaging and supervision services generally must be furnished on the same date and at the same operative location as the independent procedure in order for the imaging service to meaningfully contribute to the diagnosis or treatment of the patient. For those radiological supervision and interpretation codes in the radiology range of CPT in particular, if the same physician is able to perform both the procedure and the supervision and interpretation as stated by CPT, we assume that both the dependent and independent services would be furnished on the same date in the same hospital, and hospitals should bill them on the same claim with the same date of service.

As we indicated earlier in this section, in all cases we are proposing that hospitals that furnish the imaging supervision and interpretation service on the same date as the independent service must bill both services on the same claim. We expect to carefully monitor any changes in billing practices on a service-specific and hospital-specific basis to determine whether there is reason to request that QIOs review the quality of care furnished or to request that Program Safeguard Contractors review the claims against the medical record.

TABLE 14.—IMAGING SUPERVISION AND INTERPRETATION HCPCS CODES PROPOSED FOR PACKAGED PAYMENT IN CY 2008

HCPCS code	Short descriptor	CY 2007 SI	CY 2007 APC	Proposed CY 2008 SI	Proposed CY 2008 APC	Inactive CPT code effective 1/1/2008 or earlier (listed on the same line as its replacement code)	Short descriptor of the inactive CPT code
70010	Contrast x-ray of brain	S	0274	Q	0274		
70015	Contrast x-ray of brain	S	0274	Q	0274		
70170	X-ray exam of tear duct	X	0264	Q	0264		
70332	X-ray exam of jaw joint	S	0275	Q	0275		
70373	Contrast x-ray of larynx	X	0263	Q	0263		
70390	X-ray exam of salivary duct	X	0263	Q	0263		
71040	Contrast x-ray of bronchi	X	0263	Q	0263		
71060	Contrast x-ray of bronchi	X	0263	Q	0263		
71090	X-ray & pacemaker insertion	X	0272	N	n/a		
72240	Contrast x-ray of neck spine	S	0274	Q	0274		
72255	Contrast x-ray, thorax spine	S	0274	Q	0274		
72265	Contrast x-ray, lower spine	S	0274	Q	0274		
72270	Contrast x-ray, spine	S	0274	Q	0274		
72275	Epidurography	S	0274	N	n/a		
72285	X-ray c/t spine disk	S	0388	Q	0388		
72291	Perq vertebroplasty, fluor	S	0274	N	n/a	76012	Perq vertebroplasty, fluor.
72292	Perq vertebroplasty, ct	S	0274	N	n/a	76013	Perq vertebroplasty, ct.
72295	X-ray of lower spine disk	S	0388	Q	0388		
73040	Contrast x-ray of shoulder	S	0275	Q	0275		
73085	Contrast x-ray of elbow	S	0275	Q	0275		
73115	Contrast x-ray of wrist	S	0275	Q	0275		
73525	Contrast x-ray of hip	S	0275	Q	0275		
73542	X-ray exam, sacroiliac joint	S	0275	Q	0275		
73580	Contrast x-ray of knee joint	S	0275	Q	0275		
73615	Contrast x-ray of ankle	S	0275	Q	0275		
74190	X-ray exam of peritoneum	S	0264	Q	0264		
74235	Remove esophagus obstruction	S	0257	N	n/a		
74305	X-ray bile ducts/pancreas	X	0263	N	n/a		
74320	Contrast x-ray of bile ducts	X	0264	Q	0264		
74327	X-ray bile stone removal	S	0296	N	n/a		
74328	X-ray bile duct endoscopy	N	n/a	N	n/a		
74329	X-ray for pancreas endoscopy	N	n/a	N	ma		
74330	X-ray bile/panc endoscopy	N	n/a	N	n/a		
74340	X-ray guide for GI tube	X	0272	N	n/a		
74350	X-ray guide, stomach tube	X	0263	N	n/a		
74355	X-ray guide, intestinal tube	X	0263	N	n/a		
74360	X-ray guide, GI dilation	S	0257	N	n/a		
74363	X-ray, bile duct dilation	S	0297	N	n/a		
74425	Contrast x-ray, urinary tract	S	0278	Q	0278		
74430	Contrast x-ray, bladder	S	0278	Q	0278		
74440	X-ray, male genital tract	S	0278	Q	0278		
74445	X-ray exam of penis	S	0278	Q	0278		
74450	X-ray, urethra/bladder	S	0278	Q	0278		
74455	X-ray, urethra/bladder	S	0278	Q	0278		
74470	X-ray exam of kidney lesion	X	0263	Q	0263		
74475	X-ray control, cath insert	S	0297	Q	0297		
74480	X-ray control, cath insert	S	0296	Q	0296		
74485	X-ray guide, GU dilation	S	0296	Q	0296		
74740	X-ray, female genital tract	X	0264	Q	0264		
74742	X-ray, fallopian tube	X	0264	N.			
75600	Contrast x-ray exam of aorta	S	0280	Q	0280		
75605	Contrast x-ray exam of aorta	S	0280	Q	0280		
75625	Contrast x-ray exam of aorta	S	0280	Q	0280		
75630	X-ray aorta, leg arteries	S	0280	Q	0280		
75635	Ct angio abdominal arteries	S	0662	Q	0662		
75650	Artery x-rays, head & neck	S	0280	Q	0280		
75658	Artery x-rays, arm	S	0279	Q	0279		
75660	Artery x-rays, head & neck	S	0668	Q	0668		
75662	Artery x-rays, head & neck	S	0280	Q	0280		
75665	Artery x-rays, head & neck	S	0280	Q	0280		
75671	Artery x-rays, head & neck	S	0280	Q	0280		

TABLE 14.—IMAGING SUPERVISION AND INTERPRETATION HCPCS CODES PROPOSED FOR PACKAGED PAYMENT IN CY 2008—Continued

HCPCS code	Short descriptor	CY 2007 SI	CY 2007 APC	Proposed CY 2008 SI	Proposed CY 2008 APC	Inactive CPT code effective 1/1/2008 or earlier (listed on the same line as its replacement code)	Short descriptor of the inactive CPT code
75676	Artery x-rays, neck	S	0280	Q	0280		
75680	Artery x-rays, neck	S	0280	Q	0280		
75685	Artery x-rays, spine	S	0280	Q	0280		
75705	Artery x-rays, spine	S	0668	Q	0668		
75710	Artery x-rays, arm/leg	S	0280	Q	0280		
75716	Artery x-rays, arms/legs	S	0280	Q	0280		
75722	Artery x-rays, kidney	S	0280	Q	0280		
75724	Artery x-rays, kidneys	S	0280	Q	0280		
75726	Artery x-rays, abdomen	S	0280	Q	0280		
75731	Artery x-rays, adrenal gland	S	0280	Q	0280		
75733	Artery x-rays, adrenals	S	0668	Q	0668		
75736	Artery x-rays, pelvis	S	0280	Q	0280		
75741	Artery x-rays, lung	S	0279	Q	0279		
75743	Artery x-rays, lungs	S	0280	Q	0280		
75746	Artery x-rays, lung	S	0279	Q	0279		
75756	Artery x-rays, chest	S	0279	Q	0279		
75774	Artery x-ray, each vessel	S	0279	N	n/a		
75790	Visualize A–V shunt	S	0279	Q	0279		
75801	Lymph vessel x-ray, arm/leg	X	0264	Q	0264		
75803	Lymph vessel x-ray,arms/legs	X	0264	Q	0264		
75805	Lymph vessel x-ray, trunk	X	0264	Q	0264		
75807	Lymph vessel x-ray, trunk	X	0264	Q	0264		
75809	Nonvascular shunt, x-ray	X	0263	Q	0263		
75810	Vein x-ray, spleen/liver	S	0279	Q	0279		
75820	Vein x-ray, arm/leg	S	0668	Q	0668		
75822	Vein x-ray, arms/legs	S	0668	Q	0668		
75825	Vein x-ray, trunk	S	0279	Q	0279		
75827	Vein x-ray, chest	S	0279	Q	0279		
75831	Vein x-ray, kidney	S	0279	Q	0279		
75833	Vein x-ray, kidneys	S	0279	Q	0279		
75840	Vein x-ray, adrenal gland	S	0280	Q	0280		
75842	Vein x-ray, adrenal glands	S	0280	Q	0280		
75860	Vein x-ray, neck	S	0668	Q	0668		
75870	Vein x-ray, skull	S	0668	Q	0668		
75872	Vein x-ray, skull	S	0279	Q	0279		
75880	Vein x-ray, eye socket	S	0668	Q	0668		
75885	Vein x-ray, liver	S	0280	Q	0280		
75887	Vein x-ray, liver	S	0279	Q	0279		
75889	Vein x-ray, liver	S	0280	Q	0280		
75891	Vein x-ray, liver	S	0279	Q	0279		
75893	Venous sampling by catheter	Q	0668	Q	0668		
75894	X-rays, transcath therapy	S	0298	N	n/a		
75896	X-rays, transcath therapy	S	0263	N	n/a		
75901	Remove cva device obstruct	X	0263	N	n/a		
75902	Remove cva lumen obstruct	X	0263	N	n/a		
75940	X-ray placement, vein filter	S	0298	N	n/a		
75945	Intravascular us	S	0267	Q	0267		
75946	Intravascular us add-on	S	0266	N	n/a		
75960	Transcath iv stent rs&i	S	0668	N	n/a		
75961	Retrieval, broken catheter	S	0668	N	n/a		
75962	Repair arterial blockage	S	0668	Q	0668		
75964	Repair Artery blockage, each	S	0668	N	n/a		
75966	Repair arterial blockage	S	0668	Q	0668		
75968	Repair Artery blockage, each	S	0668	N	n/a		
75970	Vascular biopsy	S	0668	N	n/a		
75978	Repair venous blockage	S	0668	Q	0668		
75980	Contrast xray exam bile duct	S	0297	N	n/a		
75982	Contrast xray exam bile duct	S	0297	N	n/a		
75984	Xray control catheter change	X	0263	N	n/a		
75989	Abscess drainage under x-ray	N		N	n/a		
75992	Atherectomy, x-ray exam	S	0668	N	n/a		
75993	Atherectomy, x-ray exam	S	0668	N	n/a		
75994	Atherectomy, x-ray exam	S	0668	N	n/a		

TABLE 14.—IMAGING SUPERVISION AND INTERPRETATION HCPCS CODES PROPOSED FOR PACKAGED PAYMENT IN CY 2008—Continued

HCPCS code	Short descriptor	CY 2007 SI	CY 2007 APC	Proposed CY 2008 SI	Proposed CY 2008 APC	Inactive CPT code effective 1/1/2008 or earlier (listed on the same line as its replacement code)	Short descriptor of the inactive CPT code
75995	Atherectomy, x-ray exam	S	0668	N	n/a		
75996	Atherectomy, x-ray exam	S	0668	N	n/a		
76080	X-ray exam of fistula	X	0263	Q	0263		
76975	GI endoscopic ultrasound	S	0266	Q	0266		
77053	X-ray of mammary duct	X	0263	Q	0263	76086	X-ray of mammary duct.
77054	X-ray of mammary ducts	X	0263	Q	0263	76088	X-ray of mammary ducts.
93555	Imaging, cardiac cath	N	n/a	N	n/a		
93556	Imaging, cardiac cath	N	n/a	N	n/a		

(5) Diagnostic Radiopharmaceuticals

For CY 2008, we are proposing to change the packaging status of diagnostic radiopharmaceuticals as part of our overall enhanced packaging approach for the CY 2008 OPPS. 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 supportive items and services into the payment for the independent procedure or service with which they are associated encourages hospital efficiencies and also enables hospitals to manage their resources with maximum flexibility. As we stated in the CY 2007 OPPS/ASC final rule with comment period, we believe that a policy to package payment for additional radiopharmaceuticals (other than those already packaged when their per day costs are below the packaging threshold for OPPS drugs, biologicals, and radiopharmaceuticals based on data for the update year) is consistent with OPPS packaging principles and would provide greater administrative simplicity for hospitals (71 FR 68094).

All nuclear medicine procedures require the use of at least one radiopharmaceutical, and there are only a small number of radiopharmaceuticals that may be appropriately billed with each diagnostic nuclear medicine procedure. While examining the CY 2005 hospital claims data in preparation for the CY 2007 OPPS/ASC proposed rule, we identified a significant number of diagnostic nuclear medicine procedure claims that were missing HCPCS codes for the associated radiopharmaceutical. At that time, we believed that there could be two reasons for the presence of these claims in the data. One reason could be that the radiopharmaceutical used for the procedure was packaged under the OPPS and, therefore, some hospitals may have decided not to include the specific radiopharmaceutical HCPCS code and an associated charge on the claim. A second reason could be that the hospitals may have incorporated the cost of the radiopharmaceutical into the charges for the associated nuclear medicine procedures. A third possibility not offered in the CY 2007 OPPS/ASC proposed rule is that hospitals may have included the charges for radiopharmaceuticals on an uncoded revenue code line.

In the CY 2007 OPPS/ASC proposed rule, we did not propose packaging payment for radiopharmaceuticals with per day costs above the $55 CY 2007 packaging threshold because we indicated that we were concerned that payments for certain nuclear medicine procedures could potentially be less than the costs of some of the packaged radiopharmaceuticals, especially those that are relatively expensive. At the same time, we also noted the GAO's comment in reference to the CY 2006 OPPS proposed rule that stated a methodology that includes packaging all radiopharmaceutical costs into the payments for the nuclear medicine procedures may result in payments that exceed hospitals' acquisition costs for certain radiopharmaceuticals because there may be more than one radiopharmaceutical that may be used for a particular procedure. We also expressed concern that packaging payment for additional radiopharmaceuticals could provoke treatment decisions that may not reflect use of the most clinically appropriate radiopharmaceutical for a particular nuclear medicine procedure in any specific case (71 FR 68094).

After considering this issue further and examining our CY 2006 claims data for the CY 2008 OPPS update, we believe that it is most appropriate to package payment for some radiopharmaceuticals, specifically diagnostic radiopharmaceuticals, into the payment for diagnostic nuclear medicine procedures for CY 2008. We expect that packaging would encourage hospitals to use the most cost efficient diagnostic radiopharmaceutical products that are clinically appropriate. We anticipate that hospitals would continue to provide care that is aligned with the best interests of the patient. Furthermore, we believe that it would be the intent of most hospitals to provide both the diagnostic radiopharmaceutical and the associated diagnostic nuclear medicine procedure at the time the diagnostic radiopharmaceutical is administered and not to send patients to a different provider for administration of the radiopharmaceutical. We do not believe that our packaging proposal would limit beneficiaries' ability to receive clinically appropriate diagnostic procedures. Again, the OPPS is a system of averages, and payment in the aggregate is intended to be adequate, although payment for any one service may be higher or lower than a hospital's actual costs in that case.

For CY 2008, we have separated radiopharmaceuticals into two groupings. The first group includes diagnostic radiopharmaceuticals, while

the second group includes therapeutic radiopharmaceuticals. We identified all diagnostic radiopharmaceuticals as those Level II HCPCS codes that include the term ''diagnostic'' along with a radiopharmaceutical in their long code descriptors. Therefore, we were able to distinguish therapeutic radiopharmaceuticals from diagnostic radiopharmaceuticals as those Level II HCPCS codes that have the term ''therapeutic'' along with a radiopharmaceutical in their long code descriptors. There currently are no HCPCS C-codes used to report radiopharmaceuticals under the OPPS. For CY 2008, we are proposing to package payment for all diagnostic radiopharmaceuticals that are not otherwise packaged according to the proposed CY 2008 packaging threshold for drugs, biologicals, and radiopharmaceuticals. We are proposing this packaging approach for diagnostic radiopharmaceuticals, while we are proposing to continue to pay separately for therapeutic radiopharmaceuticals with an average per day cost of more than $60 as discussed in section V.B.3. of this proposed rule. In that section, we review our reasons for treating diagnostic radiopharmaceuticals (as well as contrast media) differently from other types of specified covered outpatient drugs identified in section 1833(t)(B) of the Act.

Diagnostic radiopharmaceuticals are always intended to be used with a diagnostic nuclear medicine procedure. In examining our CY 2006 claims data, we were able to match most diagnostic radiopharmaceuticals to their associated diagnostic procedures and most diagnostic nuclear medicine procedures to their associated diagnostic radiopharmaceuticals in the vast majority of single bills used for ratesetting. We estimate that less than 5 percent of all claims with a diagnostic radiopharmaceutical had no corresponding diagnostic nuclear medicine procedure. In addition, we found that only about 13 percent of all single bills with a diagnostic nuclear medicine procedure code had no corresponding diagnostic radiopharmaceutical billed. These statistics indicate that, in a majority of our single bills for diagnostic nuclear medicine procedures, a diagnostic radiopharmaceutical HCPCS code is included on the single bill. Table 15 presents the top 20 diagnostic nuclear medicine procedures in terms of the overall frequency with which they are reported in the OPPS claims data. Among these high volume diagnostic nuclear medicine procedures, their single bills include a HCPCS code for a diagnostic radiopharmaceutical at least 84 percent of the time for 19 out of the top 20 procedures. More specifically, 84 to 86 percent of the single bills for 4 diagnostic nuclear medicine procedures include a diagnostic radiopharmaceutical, 87 to 89 percent of the single bills for 8 diagnostic nuclear medicine procedures include a diagnostic radiopharmaceutical, and 90 percent or more of the single bills for 7 diagnostic nuclear medicine procedures include a diagnostic radiopharmaceutical.

TABLE 15.—TOP 20 DIAGNOSTIC NUCLEAR MEDICINE PROCEDURES SORTED BY CY 2006 OPPS TOTAL VOLUME

HCPCS code	Short descriptor	SI	APC	Total line-item frequency	Single bills with a radiopharmaceutical as a percent of all single bills	Single bills as a percent of total line-item frequency
78465	Heart image (3d), multiple	S	0377	566,252	88	9
78306	Bone imaging, whole body	S	0396	368,452	90	76
78815	Tumorimage pet/ct skul-thigh	S	0308	122,126	100	84
78223	Hepatobiliary imaging	S	0394	69,066	85	90
78315	Bone imaging, 3 phase	S	0396	56,524	89	88
78464	Heart image (3d), single	S	0398	35,866	93	29
78472	Gated heart, planar, single	S	0398	32,154	89	80
78264	Gastric emptying study	S	0395	31,190	88	94
78812	Tumor image (pet)/skul-thigh	S	0308	27,345	100	86
78007	Thyroid image, mult uptakes	S	0391	23,703	84	96
78195	Lymph system imaging	S	0400	20,187	89	18
78585	Lung V/Q imaging	S	0378	20,036	91	48
78070	Parathyroid nuclear imaging	S	0391	18,752	94	84
78006	Thyroid imaging with uptake	S	0390	18,613	86	95
78300	Bone imaging, limited area	S	0396	18,333	89	90
78320	Bone imaging (3D)	S	0396	16,710	84	35
78588	Perfusion lung image	S	0378	14,323	88	48
78707	K flow/funct image w/o drug	S	0404	13,820	89	90
78580	Lung perfusion imaging	S	0401	13,011	66	19
78816	Tumor image pet/ct full body	S	0308	12,349	100	86

Among the lower volume diagnostic nuclear medicine procedures (which are outside the top 20 in terms of volume), there is still good representation of diagnostic radiopharmaceutical HCPCS codes on the single bills for most procedures. About 40 percent of the low volume diagnostic nuclear medicine procedures have at least 80 percent of the single bills for that diagnostic procedure that include a diagnostic radiopharmaceutical HCPCS code; about 37 percent of the low volume diagnostic procedures have between 50 to 79 percent of the single bills that include a diagnostic radiopharmaceutical HCPCS code; and about 23 percent of the low volume diagnostic procedures have less than 50 percent of the single bills that include a diagnostic radiopharmaceutical HCPCS code. For the few diagnostic nuclear medicine procedures where less than 50 percent of the single bills include a diagnostic radiopharmaceutical HCPCS code, we believe there could be several reasons why the percentage of single bills for the diagnostic nuclear medicine procedure with a diagnostic radiopharmaceutical HCPCS code is low.

As noted earlier, it is possible that hospitals may be including the charge for the radiopharmaceutical in the

charge for the diagnostic nuclear medicine procedure itself or on an uncoded revenue code line instead of reporting charges for a specific diagnostic radiopharmaceutical HCPCS code. We found that 24 percent of all single bills for a diagnostic nuclear medicine procedure but without a coded diagnostic radiopharmaceutical had uncoded costs in a revenue code that might contain diagnostic radiopharmaceutical costs, specifically, revenue codes 0254 (Drugs Incident to Other Diagnostic Services), 0255 (Drugs Incident to Radiology), 0343 (Diagnostic Radiopharmaceuticals), 0621 (Supplies Incident to Radiology), and 0622 (Supplies Incident to Other Diagnostic Services). In comparison, we found that only 2 percent of diagnostic nuclear medicine single bills with a nuclear medicine procedure and a coded diagnostic radiopharmaceutical had uncoded costs in these revenue codes. It is also possible that some of these procedures typically use a diagnostic radiopharmaceutical subject to packaged payment under the CY 2006 OPPS, and hospitals may have chosen not to report a separate charge for the diagnostic radiopharmaceutical. Payment for diagnostic radiopharmaceuticals commonly used with some diagnostic nuclear medicine procedures would already be packaged because these diagnostic radiopharmaceuticals' average per day cost were less than $50 in CY 2006. The CY 2008 proposal to package additional diagnostic radiopharmaceuticals would have little impact on the payment for those diagnostic procedures that typically use inexpensive diagnostic radiopharmaceuticals that would be packaged under our proposed CY 2008 packaging threshold of $60, except to the extent that the budget neutrality adjustment due to the broader packaging proposal leads to an increase in the scaler and an increase in the payment for procedures in general.

At its March 2007 meeting, the APC Panel recommended that CMS work with stakeholders on issues related to payment for radiopharmaceuticals, including evaluating claims data for different classes of radiopharmaceuticals and ensuring that a nuclear medicine procedure claim always includes at least one reported radiopharmaceutical agent. We are accepting the APC Panel's recommendation, and we specifically welcome public comment on the hospitals' burden involved should we require such precise reporting. We also are seeking comment on the importance of such a requirement in light of our above discussion on the representation of diagnostic radiopharmaceuticals in the single bills for diagnostic nuclear medicine procedures, the presence of uncoded revenue code charges specific to diagnostic radiopharmaceuticals on claims without a coded diagnostic radiopharmaceutical, and our proposal to package payment for all diagnostic radiopharmaceuticals.

It has come to our attention that several diagnostic radiopharmaceuticals may be used for multiple day studies; that is, a particular diagnostic radiopharmaceutical may be administered on one day and a related diagnostic nuclear medicine procedure may be performed on a subsequent day. While we understand that multiple day episodes for diagnostic radiopharmaceuticals and the related diagnostic nuclear medicine procedures occur, we expect that this would be a small proportion of all diagnostic nuclear medicine imaging procedures. We estimate that, roughly, 15 diagnostic radiopharmaceuticals have a half-life longer than one day such that they could support diagnostic nuclear medicine scans on different days. We believe these diagnostic radiopharmaceuticals would be concentrated in a specific set of diagnostic procedures. Excluding the 5 percent of diagnostic radiopharmaceutical claims with no matching diagnostic nuclear medicine scan for the same beneficiary, we found that a diagnostic nuclear medicine scan was reported on the same day as a coded diagnostic radiopharmaceutical 90 percent or more of the time for 10 of these 15 diagnostic radiopharmaceuticals. Further, between 80 and 90 percent single bills for each of the remaining 5 diagnostic radiopharmaceuticals had a diagnostic nuclear medicine scan on the same day. In the ''natural'' single bills we use for ratesetting, we package payment across dates of service. In light of such high percentages of extended half-life diagnostic radiopharmaceuticals with same day diagnostic nuclear medicine scans and the ability of ''natural'' singles to package costs across days, we believe that our standard OPPS ratesetting methodology of using median costs calculated from claims data adequately captures the costs of diagnostic radiopharmaceuticals associated with diagnostic nuclear medicine procedures that are not provided on the same date of service.

This packaging proposal reduces the overall frequency of single bills for diagnostic nuclear medicine procedures, but the percent of single bills out of total claims remains robust for the majority of diagnostic nuclear medicine procedures. Typically, packaging more procedures should improve the number of single bill claims from which to derive median cost estimates because packaging reduces the number of separately paid procedures on a claim, thereby creating more single procedure bills. In the case of diagnostic nuclear medicine procedures, packaging diagnostic radiopharmaceuticals reduces the overall number of single bills available to calculate median costs by increasing packaged costs that previously were ignored in the bypass process. In prior years, we did not consider the costs of radiopharmaceuticals when we used our bypass methodology to extract ''pseudo'' single claims because we assumed that the cost of radiopharmaceutical overhead and handling would be included in the line-item charge for the radiopharmaceutical, and the diagnostic radiopharmaceuticals were subject to potential separate payment if their mean per day cost fell above the packaging threshold. The bypass process sets empirical and clinical criteria for minimal packaging for a specific list of procedures and services in order to assign packaged costs to other procedures on a claim and is discussed at length in section II.A.1. of this proposed rule. Generally, changing the status of diagnostic radiopharmaceuticals to packaged increases packaging on each claim. This could make it both harder for nuclear medicine procedures to qualify for the bypass list and more difficult to assign packaging to individual diagnostic nuclear medicine procedures, resulting in a possible reduction of the number of ''pseudo'' singles that are produced by the bypass process. Notwithstanding this potentiality, diagnostic nuclear medicine procedures continue to have good representation in the single bills. On average, single bills as a percent of total occurrences remains substantial at 55 percent for individual procedures. We discuss our process for ratesetting, including the construction and use of single and multiple bills, in greater detail in section II.A.1. of this proposed rule.

We believe our CY 2006 claims data support our CY 2008 proposal to package payment for all diagnostic radiopharmaceuticals and lead to proposed payment rates for diagnostic nuclear medicine procedures that appropriately reflect payment for the costs of the diagnostic radiopharmaceuticals that are administered to carry out those diagnostic nuclear medicine procedures. Among the top 20 high volume

diagnostic nuclear medicine procedures, at least 84 percent of the single bills for almost every diagnostic nuclear medicine procedure included a diagnostic radiopharmaceutical HCPCS code. While a diagnostic radiopharmaceutical, by definition, would be anticipated to accompany 100 percent of the diagnostic nuclear medicine procedures, it is not unexpected that while percentages in our claims data are high, they are less than 100 percent. As noted previously, we have heard anecdotal reports that some hospitals may include the charges for diagnostic radiopharmaceuticals in their charge for the diagnostic nuclear medicine procedure or on an uncoded revenue code line, rather than reporting a HCPCS code for the diagnostic radiopharmaceutical. Thus, it is likely that the frequency of diagnostic radiopharmaceutical costs reflected in our claims data are even higher than the percentages indicate. Furthermore, we note that the OPPS ratesetting methodology is based on medians, which are less sensitive to extremes than means and typically do not reflect subtle changes in cost distributions. Therefore, to the extent that the vast majority of single bills for a particular diagnostic nuclear medicine procedure include a diagnostic radiopharmaceutical HCPCS code, the fact that the percentage is somewhat less than 100 percent is likely to have minimal impact on the median cost of the procedure in most cases. Even in those few instances where we have a low total number of single bills, largely because of low overall volume, we have ample representation of diagnostic radiopharmaceutical HCPCS codes on the single bills for the majority of lower volume nuclear medicine procedures. We also continue to have reasonable representation of single bills out of total claims in general. Finally, as noted previously, to the extent that the diagnostic radiopharmaceuticals commonly used with a particular diagnostic nuclear medicine procedure are already packaged, the proposal to package additional diagnostic radiopharmaceuticals would have little impact on the payment for these procedures.

We have calculated the median costs on which we are proposing to base the CY 2008 payment rates using the packaging status of each diagnostic radiopharmaceutical HCPCS code as provided in Table 17 below. As we discussed earlier in more detail, this has the effect of both changing the median cost for the independent service (the diagnostic nuclear medicine procedure) into which the cost of the dependent service (the diagnostic radiopharmaceutical) is packaged and also of redistributing payment that would otherwise have been made separately for the service we are proposing to newly package for CY 2008.

For example, HCPCS code A9552 (Fluorodeoxyglucose F–18 FDG, Diagnostic, per study dose, up to 45 millicuries) that describes the diagnostic radiopharmaceutical commonly called FDG is frequently billed with CPT code 78815 (Tumor imaging, positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization; skull base to mid-thigh). HCPCS code A9552 is assigned to APC 1651 (F18 fdg) for CY 2007. HCPCS code A9552 was billed with CPT code 78815 101,242 times in the single bills available for this CY 2008 proposed rule, and 97 percent of the single bills for CPT code 78815 also reported HCPCS code A9552. Under our proposed policy for CY 2008, we are proposing to package payment for HCPCS code A9552 into the payment for separately payable procedures that are provided in conjunction with HCPCS code A9552. In this example, HCPCS code A9552 would receive packaged payment through the separate OPPS payment for CPT code 78815. CPT code 78815 is assigned to APC 1511 (New Technology—Level XI ($900–$1000)) for CY 2007 with a CY 2007 median cost for PET/CT procedures of $850.36 and to APC 0308 (Non-Myocardial Positron Emission Tomography (PET) Imaging) for CY 2008 with a proposed CY 2008 APC median cost of $1,093.52.

The proposed CY 2008 payment rates associated with this example are outlined in Table 16 below. The table indicates that the proposed CY 2008 payment rate for the skull base to mid-thigh PET/CT scan would be substantially higher than the CY 2007 payment amount for that code. The proposed increase for the PET/CT scan is slightly more than the estimated average CY 2007 payment for the separately payable FDG (paid in CY 2007 at charges reduced to cost).

This example cannot demonstrate the overall impact of packaging diagnostic radiopharmaceuticals on payment to any given hospital because each individual hospital's case mix and billing patterns would be different. The overall impact of packaging diagnostic radiopharmaceuticals, as well as all other packaging changes proposed for CY 2008, can only be assessed in the aggregate for each hospital. Section XXII.B. of this proposed rule displays the overall impact of APC weight recalibration and packaging changes that we are proposing by classes of hospitals, and the OPPS Hospital-Specific Impacts—Provider-Specific Data file presents our estimates of CY 2008 hospital payment for those hospitals we include in our ratesetting and payment simulation database. The hospital-specific impacts file can be found on the CMS Web site at *http://www.cms.hhs.gov/HospitalOutpatientPPS/* under supporting documentation for this proposed rule.

TABLE 16.—EXAMPLE OF THE EFFECTS OF THE CY 2008 PACKAGING PROPOSAL ON PAYMENT FOR HCPCS CODE A9552 AND CPT CODE 78815

HCPCS code	Short descriptor	Sum of CY 2007 payment (A9552 paid separately at cost)	Sum of CY 2008 proposed payment (A9552 packaged)
A9552	F18 fdg (dependent service)	*$279.29	0.00
78815	Tumor image pet/ct skul-thigh (independent service)	950.00	1,107.22
Total Payment		1,229.29	1,107.22

*Estimated average CY 2007 payment at charges reduced to cost.

The estimated overall impact of these changes that we are proposing for CY 2008 is based on the assumption that hospital behavior would not change with regard to when the dependent diagnostic radiopharmaceuticals are provided by the same hospital that performs the independent services. In order to provide diagnostic nuclear medicine procedures under this proposal, hospitals would either need to administer the necessary diagnostic radiopharmaceuticals themselves or refer patients elsewhere for the administration of the diagnostic radiopharmaceuticals. In the latter case, claims data would show such a change in practice in future years and that change would be reflected in future ratesetting. However, with respect to diagnostic radiopharmaceuticals, we believe that hospitals are limited in the extent to which they could change their behavior with regard to how they furnish these items because diagnostic radiopharmaceuticals are typically provided on the same day as a diagnostic nuclear medicine procedure. It would be difficult for Hospital A to send patients to receive diagnostic radiopharmaceuticals from Hospital B and then have the patients return to Hospital A for the diagnostic nuclear medicine procedure in the appropriate timeframe (given the radiopharmaceutical's half life) to perform a high quality study. We would expect that hospitals would always bill the diagnostic radiopharmaceutical on the same claim as the other independent services for which the radiopharmaceutical was administered.

As we indicate above, in all cases, we are proposing that hospitals that furnish diagnostic radiopharmaceuticals in association with diagnostic nuclear medicine procedures bill both the item and the procedure on the same claim so that the costs of the diagnostic radiopharmaceuticals can be appropriately packaged into payment for the diagnostic nuclear medicine procedure. We expect to carefully monitor any changes in billing practices on a service-specific and hospital-specific basis to determine whether there is reason to request that QIOs review the quality of care furnished or to request that Program Safeguard Contractors review the claims against the medical record.

TABLE 17.—DIAGNOSTIC RADIOPHARMACEUTICAL HCPCS CODES PROPOSED FOR PACKAGED PAYMENT IN CY 2008

HCPCS code	Short descriptor	CY 2007 SI	CY 2007 APC	CY 2008 proposed SI
A4641	Radiopharm dx agent noc	N	n/a	N
A4642	In111 satumomab	H	0704	N
A9500	Tc99m sestamibi	H	1600	N
A9502	Tc99m tetrofosmin	H	0705	N
A9503	Tc99m medronate	N	n/a	N*
A9504	Tc99m apcitide	N	n/a	N*
A9505	TL201 thallium	H	1603	N
A9507	In111 capromab	H	1604	N
A9508	I131 iodobenguate, dx	H	1045	N
A9510	Tc99m disofenin	N	n/a	N*
A9512	Tc99m pertechnetate	N	n/a	N*
A9516	I123 iodide cap, dx	H	9148	N
A9521	Tc99m exametazime	H	1096	N
A9524	I131 serum albumin, dx	H	9100	N
A9526	Nitrogen N–13 ammonia	H	0737	N
A9528	Iodine I–131 iodide cap, dx	H	1088	N
A9529	I131 iodide sol, dx	N	n/a	N
A9531	I131 max 100uCi	N	n/a	N*
A9532	I125 serum albumin, dx	N	n/a	N
A9536	Tc99m depreotide	H	0739	N
A9537	Tc99m mebrofenin	N	n/a	N*
A9538	Tc99m pyrophosphate	N	n/a	N*
A9539	Tc99m pentetate	H	0722	N*
A9540	Tc99m MAA	N	n/a	N*
A9541	Tc99m sulfur colloid	N	n/a	N*
A9542	In111 ibritumomab, dx	H	1642	N
A9544	I131 tositumomab, dx	H	1644	N
A9546	Co57/58	H	0723	N
A9547	In111 oxyquinoline	H	1646	N
A9548	In111 pentetate	H	1647	N
A9550	Tc99m gluceptate	H	0740	N
A9551	Tc99m succimer	H	1650	N
A9552	F18 fdg	H	1651	N
A9553	Cr51 chromate	H	0741	N
A9554	I125 iothalamate, dx	N	n/a	N
A9555	Rb82 rubidium	H	1654	N
A9556	Ga67 gallium	H	1671	N
A9557	Tc99m bicisate	H	1672	N
A9558	Xe133 xenon 10mci	N	n/a	N*
A9559	Co57 cyano	H	0724	N
A9560	Tc99m labeled rbc	H	0742	N
A9561	Tc99m oxidronate	N	n/a	N*
A9562	Tc99m mertiatide	H	0743	N
A9565	In111 pentetreotide	H	1677	N
A9566	Tc99m fanolesomab	H	1678	N
A9567	Technetium TC–99m aerosol	H	0829	N*

TABLE 17.—DIAGNOSTIC RADIOPHARMACEUTICAL HCPCS CODES PROPOSED FOR PACKAGED PAYMENT IN CY 2008—Continued

HCPCS code	Short descriptor	CY 2007 SI	CY 2007 APC	CY 2008 proposed SI
A9568	Tc99m arcitumomab	H	1648	N

* Indicates that the radiopharmaceutical would have been packaged under the $60 packaging threshold methodology in CY 2008, even in the absence of the broader packaging proposal for radiopharmaceuticals.

(6) Contrast Agents

For CY 2008, we are proposing to package payment for all contrast media into their associated independent diagnostic and therapeutic procedures as part of our proposed packaging approach for the CY 2008 OPPS. As noted in section II.A.4.c. of this proposed rule, packaging the costs of supportive items and services into the payment for the independent procedure or service with which they are associated encourages hospital efficiencies and also enables hospitals to manage their resources with maximum flexibility. We believe that contrast agents are particularly well suited for packaging because they are always provided in support of an independent diagnostic or therapeutic procedure that involves imaging, and thus payment for contrast agents can be packaged into the payment for the associated separately payable procedures.

Contrast agents are generally considered to be those substances introduced into or around a structure that, because of the differential absorption of x-rays, alteration of magnetic fields, or other effects of the contrast medium in comparison with surrounding tissues, permit visualization of the structure through an imaging modality. The use of certain contrast agents is generally associated with specific imaging modalities, including x-ray, computed tomography (CT), ultrasound, and magnetic resonance imaging (MRI), for purposes of diagnostic testing or treatment. They are most commonly administered through an oral or intravascular route in association with the performance of the independent procedures involving imaging that are the basis for their administration. Even in the absence of this proposal to package payment for all contrast agents, we would propose to package the majority of HCPCS codes for contrast agents recognized under the OPPS in CY 2008. We consider contrast agents to be drugs under the OPPS, and as a result they are packaged if their estimated mean per day cost is equal to or less than $60 for CY 2008. (For more discussion of our drug packaging criteria, we refer readers to section V.B.2 of this proposed rule.) Seventy-five percent of contrast agents HCPCS codes have an estimated mean per day cost equal to or less than $60 based on our CY 2006 claims data.

Contrast agents are described by those Level II HCPCS codes in the range from Q9945 through Q9964. There currently are no HCPCS C-codes or other Level II HCPCS codes outside the range specified above used to report contrast agents under the OPPS. As shown in Table 19, in CY 2007, we packaged 7 out of 20 of these contrast agent HCPCS codes based on the $55 packaging threshold. For CY 2008, we are proposing to package all drugs with a per day mean cost of $60 or less. For CY 2008, the vast majority of contrast agents would be packaged under the traditional OPPS packaging methodology using the $60 packaging threshold, based on the CY 2006 claims data available for this proposed rule. In fact, of the 20 contrast agent HCPCS codes we are including in our proposed packaging approach, 15 would have been proposed to be packaged for CY 2008 under our drug packaging methodology. These 15 codes represent 94 percent of all occurrences of contrast agents billed under the OPPS. We believe that this shift in the packaging status for several of these agents between CYs 2007 and 2008 may be because, in CY 2007, a number of the contrast agents exceeded the $55 threshold by only a small amount and, based on our latest claims data for CY 2008, a number of these products have now fallen below the proposed $60 threshold. Given that the vast majority of contrast agents billed would already be packaged under the OPPS in CY 2008, we believe it would be desirable to package payment for the remaining contrast agents as it promotes efficiency and results in a consistent payment policy across products that may be used in many of the same independent procedures. We also note that the significant costs associated with these 15 contrast agents would already be reflected in the proposed median costs for those independent procedures and, if we were to pay for the 5 remaining agents separately, we would be treating these 5 agents differently than the others. If the 5 agents remained separately payable, there would effectively be two payments for contrast agents when these 5 agents were billed—a separate payment and a payment for packaged contrast agents that was part of the procedure payment. This could potentially provide a payment incentive to administer certain contrast agents that might not be the most clinically appropriate or cost effective. Moreover, as noted previously, contrast agents are always provided with independent procedures and, under a consistent approach to packaging in keeping with our enhanced efforts to encourage hospital efficiency and promote value-based purchasing under the OPPS, their payment would be appropriately packaged for CY 2008.

We have calculated the median costs on which the proposed CY 2008 payment rates are based using the packaging status of each contrast agent HCPCS code as provided in Table 19 below. As we discussed earlier in more detail, this has the effect of both changing the median cost for the independent service (the diagnostic or therapeutic procedure requiring imaging) into which the cost of the dependent service (the contrast agent) is packaged and also of redistributing payment that would otherwise have been made separately for the service we are proposing to newly package for CY 2008.

For example, HCPCS code Q9947 (Low osmolar contrast material, 200–249 mg/ml iodine concentration, per ml) is one of the contrast agents that we are proposing to package that would not otherwise be packaged in CY 2008 under the proposed $60 packaging threshold. HCPCS code Q9947 is sometimes billed with CPT code 71260 (Computed tomography, thorax; with contrast material(s)). HCPCS code Q9947 is assigned to APC 9159 (LOCM 200–249 mg/ml iodine, 1ml) for CY 2007. HCPCS code Q9947 was billed with CPT code 71260 8,172 times in the single bills available for this CY 2008 proposed rule, and 2 percent of the single bills for CPT code 71260 also reported HCPCS code Q9947. Under our proposed policy for CY 2008, we are proposing to package payment for

HCPCS code Q9947 into the payment for separately payable procedures that are provided in conjunction with the contrast agent. Specifically, we would package payment for HCPCS code Q9947 so that, in this example, HCPCS code Q9947 would receive packaged payment through the separate OPPS payment for CPT code 71260. CPT code 71260 is assigned to APC 0283 (Computed Tomography with Contrast) for CY 2007 with a CY 2007 median cost of $249.48. The procedure is assigned to APC 0283, with a proposed APC name change to ''Level I Computed Tomography with Contrast'' for CY 2008 and a proposed CY 2008 median cost of $286.13.

The proposed CY 2008 payment rates associated with this example are outlined in Table 18 below. The table indicates that the CY 2008 payment that we are proposing for CPT code 71260 is higher than the CY 2007 payment amount for that code. The proposed increase in the payment rate for CPT code 71260 in CY 2008 is slightly greater than the estimated CY 2007 payment for the separately payable HCPCS code Q9947. Notably, a number of low osmolar contrast agents other than HCPCS code Q9947 that were separately paid in CY 2007 also are proposed for packaged payment in CY 2008 because their mean per day cost falls below the $60 packaging threshold for drugs, biologicals, and radiopharmaceuticals for CY 2008. Packaging the costs of these contrast media also affects the proposed payment rate for CPT code 71260. For another example of packaging contrast agents, we refer readers to the example included in Table 13 of section II.A.4.c.(4) of this proposed rule on packaging imaging supervision and interpretation services. That example illustrates the effect of packaging both a supervision and interpretation service (CPT code 72265 (Myelography, lumbosacral, radiological supervision and interpretation)) and a contrast agent (HCPCS code Q9947 (low osmolar contrast material, 200–249 mg/ml iodine, per ml)) into the payment for an imaging procedure (CPT code 72132 (Computed tomography, lumbar spine; with contrast material)).

This example cannot demonstrate the overall impact of packaging contrast agents on any given hospital because each individual hospital's case mix and billing pattern differs. The overall impact of packaging contrast agents, as well as all the other proposed packaging changes, can only be assessed in the aggregate for classes of hospitals. Section XXII.B. of this proposed rule displays the overall impact of APC weight recalibration and packaging changes we are proposing by classes of hospitals, and the OPPS Hospital-Specific Impacts—Provider-Specific Data file presents our estimates of CY 2008 hospital payment for those hospitals we include in our ratesetting and payment simulation database. The hospital-specific impact file can be found on the CMS Web site at *http://www.cms.hhs.gov/HospitalOutpatientPPS/* under supporting documentation for this proposed rule.

TABLE 18.—EXAMPLE OF THE EFFECTS OF THE CY 2008 PACKAGING PROPOSAL ON PAYMENT FOR CPT CODE 72160 AND HCPCS CODE Q9947

HCPCS code	Short descriptor	Sum of CY 2007 payment (Q9947 paid separately)	Sum of CY 2008 proposed payment (Q9947 packaged)
Q9947	LOCM 200–249 mg/ml iodine, 1 ml (dependent service)	*$64.24	$0.00
71260	Ct thorax w/dye (independent service)	250.94	289.71
Total Payment		315.18	289.71

*Based on the mean number of units per day from our CY 2008 proposed rule data (48.3) and the April 2007 per unit payment rate for Q9947 ($1.33).

The estimated overall impact of these changes that we are proposing for CY 2008 is based on the assumption that hospital behavior would not change with regard to when the contrast agents are provided by the same hospital that performs the imaging procedure. Under this proposal, in order to provide imaging procedures requiring contrast agents, hospitals would either need to administer the necessary contrast agent themselves or refer patients elsewhere for the administration of the contrast agent. In the latter case, claims data would show such a change in practice in future years and that change would be reflected in future ratesetting. However, with respect to contrast agents, we believe that hospitals are limited in the extent to which they could change their behavior with regard to how they furnish these services because contrast agents are typically provided on the same day immediately prior to an imaging procedure being performed. We would expect that hospitals would always bill the contrast agent on the same claim as the other independent services for which the contrast agent was administered.

As we indicated earlier, in all cases we are proposing that hospitals that furnish the supportive contrast agent in association with independent procedures involving imaging must bill both services on the same claim so that the cost of the contrast agent can be appropriately packaged into payment for the significant independent procedure. We expect to carefully monitor any changes in billing practices on a service-specific and hospital specific basis to determine whether there is reason to request that QIOs review the quality of care furnished or to request that Program Safeguard Contractors review the claims against the medical record.

TABLE 19.—CONTRAST MEDIA HCPCS CODES PROPOSED FOR PACKAGED PAYMENT IN CY 2008

HCPCS code	Short descriptor	CY 2007 SI	CY 2007 APC	Proposed CY 2008 SI
Q9945	LOCM <=149 mg/ml iodine, 1 ml	K	9157	N*
Q9946	LOCM 150–199 mg/ml iodine, 1 ml	K	9158	N*
Q9947	LOCM 200–249 mg/ml iodine, 1 ml	K	9159	N

TABLE 19.—CONTRAST MEDIA HCPCS CODES PROPOSED FOR PACKAGED PAYMENT IN CY 2008—Continued

HCPCS code	Short descriptor	CY 2007 SI	CY 2007 APC	Proposed CY 2008 SI
Q9948	LOCM 250–299 mg/ml iodine, 1 ml	K	9160	N*
Q9949	LOCM 300–349 mg/ml iodine, 1 ml	K	9161	N*
Q9950	LOCM 350–399 mg/ml iodine, 1 ml	K	9162	N*
Q9951	LOCM >= 400 mg/ml iodine, 1 ml	K	9163	N*
Q9952	Inj Gad-base MR contrast, 1 ml	K	9164	N*
Q9953	Inj Fe-based MR contrast, 1 ml	K	1713	N
Q9954	Oral MR contrast, 100 ml	K	9165	N*
Q9955	Inj perflexane lip micros, ml	K	9203	N*
Q9956	Inj octafluoropropane mic, ml	K	9202	N
Q9957	Inj perflutren lip micros, ml	K	9112	N
Q9958	HOCM <=149 mg/ml iodine, 1 ml	N	n/a	N*
Q9959	HOCM 150–199 mg/ml iodine, 1 ml	N	n/a	N
Q9960	HOCM 200–249 mg/ml iodine, 1 ml	N	n/a	N*
Q9961	HOCM 250–299 mg/ml iodine, 1 ml	N	n/a	N*
Q9962	HOCM 300–349 mg/ml iodine, 1 ml	N	n/a	N*
Q9963	HOCM 350–399 mg/ml iodine, 1 ml	N	n/a	N*
Q9964	HOCM>= 400 mg/ml iodine, 1 ml	N	n/a	N*

*Indicates that the contrast agent would have been packaged under the $60 packaging threshold methodology in CY 2008, even in the absence the broader packaging proposal for contrast agents.

(7) Observation Services

We are proposing to package payment for all observation care, reported under HCPCS code G0378 (Hospital observation services, per hour) for CY 2008. Payment for observation would be packaged as part of the payment for the separately payable services with which it is billed. We have defined observation care as a well-defined set of specific, clinically appropriate services that include ongoing short-term treatment, assessment, and reassessment before a decision can be made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital. Observation status is commonly assigned to patients who present to the emergency department and who then require a significant period of treatment or monitoring before a decision is made concerning their next placement or to patients with unexpectedly prolonged recovery after surgery. Throughout this proposed rule, as well as in our manuals and guidance documents, we use both of the terms ''observation services'' and ''observation care'' in reference to the services defined above.

Payment for all observation care under the OPPS was packaged prior to CY 2002. Since CY 2002, separate payment of a single unit of an observation APC for an episode of observation care has been provided in limited circumstances. Effective for services furnished on or after April 1, 2002, separate payment for observation was made if the beneficiary had chest pain, asthma, or congestive heart failure and met additional criteria for diagnostic testing, minimum and maximum limits to observation care time, physician care, and documentation in the medical record (66 FR 59856, 59879). Payment for observation care that did not meet these specified criteria was packaged. Between CY 2003 and CY 2006, several more changes were made to the OPPS policy regarding separate payment for observation services, such as: Clarification that observation is not separately payable when billed with ''T'' status procedures on the day of or day before observation care; development of specific Level II HCPCS codes for hospital observation services and direct admission to observation care; and removal of the initially established diagnostic testing requirements for separately payable observation (67 FR 66794, 69 FR 65828, and 70 FR 68688). Throughout this time period, we maintained separate payment for observation care only for the three specified medical conditions, and OPPS payment for observation for all other clinical conditions remained packaged.

Since January 1, 2006, hospitals have reported observation services based on an hourly unit of care using HCPCS code G0378. This code has a status indicator of ''Q'' under the CY 2007 OPPS, meaning that the OPPS claims processing logic determines whether the observation is packaged or separately payable. The OCE's current logic determines whether observation services billed under HCPCS code G0378 are separately payable through APC 0339 (Observation) or whether payment for observation services will be packaged into the payment for other separately payable services provided by the hospital in the same encounter based on criteria discussed subsequently. (We note that if an HOPD directly admits a patient to observation, Medicare currently pays separately for that direct admission reported under HCPCS code G0379 (Direct admission of patient for hospital observation care) in situations where payment for the actual observation care reported under HCPCS code G0378 is packaged.) For CY 2008, as discussed in more detail later in this proposed rule (section XI.), we are proposing to continue the coding and payment methodology for direct admission to observation status, with the exception of the requirement that HCPCS code G0379 is only eligible for separate payment if observation care reported under HCPCS code G0378 does not qualify for separate payment. This requirement would no longer be applicable under our proposal to package all observation services reported under HCPCS code G0378.

Currently, separate OPPS payment may be made for observation services reported under HCPCS code G0378 provided to a patient when all of the following requirements are met. The hospital would receive a single separate payment for an episode of observation care (APC 0339) when:

1. Diagnosis Requirements

a. The beneficiary must have one of three medical conditions: congestive heart failure, chest pain, or asthma.

b. Qualifying ICD–9–CM diagnosis codes must be reported in Form Locator (FL) 76, Patient Reason for Visit, or FL 67, principal diagnosis, or both in order for the hospital to receive separate payment for APC 0339. If a qualifying ICD–9–CM diagnosis code(s) is reported in the secondary diagnosis field, but is

not reported in either the Patient Reason for Visit field (FL 76) or in the principal diagnosis field (FL 67), separate payment for APC 0339 is not allowed.

2. Observation Time

a. Observation time must be documented in the medical record.

b. A beneficiary's time in observation (and hospital billing) begins with the beneficiary's admission to an observation bed.

c. A beneficiary's time in observation (and hospital billing) ends when all clinical or medical interventions have been completed, including followup care furnished by hospital staff and physicians that may take place after a physician has ordered the patient be released or admitted as an inpatient.

d. The number of units reported with HCPCS code G0378 must equal or exceed 8 hours.

3. Additional Hospital Services

a. The claim for observation services must include one of the following services in addition to the reported observation services. The additional services listed below must have a line-item date of service on the same day or the day before the date reported for observation:

- An emergency department visit (APC 0609, 0613, 0614, 0615, or 0616); or
- A clinic visit (APC 0604, 0605, 0606, 0607, or 0608); or
- Critical care (APC 0617); or
- Direct admission to observation reported with HCPCS code G0379 (APC 0604).

b. No procedure with a ''T'' status indicator can be reported on the same day or day before observation care is provided.

4. Physician Evaluation

a. The beneficiary must be in the care of a physician during the period of observation, as documented in the medical record by admission, discharge, and other appropriate progress notes that are timed, written, and signed by the physician.

b. The medical record must include documentation that the physician explicitly assessed patient risk to determine that the beneficiary would benefit from observation care.

In the context of our proposed CY 2008 packaging approach, for several reasons we believe that it is appropriate to package payment for all observation services reported with HCPCS code G0378 under the CY 2008 OPPS. Primarily, observation services are ideal for packaging because they are always provided as a supportive service in conjunction with other independent separately payable hospital outpatient services such as an emergency department visit, surgical procedure, or another separately payable service, and thus observation costs can logically be packaged into OPPS payment for independent services. As discussed extensively earlier in this section, packaging payment into larger payment bundles creates incentives for providers to furnish services in the most efficient way that meets the needs of the patient, encouraging long-term cost containment.

As we discussed in the general overview of the CY 2008 packaging approach earlier in this section (section II.A.4.b. of this proposed rule), there has been substantial growth in program expenditures for hospital outpatient services under the OPPS in recent years. The primary reason for this upsurge is growth in the intensity and utilization of services rather than the general price of services or enrollment changes. This observed trend is notably reflected in the frequency and costs of separately payable observation care for the last few years. While median costs for an episode of observation care that would meet the criteria for separate payment have remained relatively stable between CY 2003 and CY 2006, the frequency of claims for separately payable observation services has rapidly increased. Comparing claims data for separately payable observation care available for proposed rules spanning from CY 2005 to CY 2008 (that is, claims data reflecting services furnished from CY 2003 to CY 2006), we see substantial growth in separately payable observation care billed under the OPPS over that time. In CY 2003, the full first year when observation care was separately payable, there were approximately 56,000 claims for separately payable observation care. In CY 2004, there were approximately 77,000 claims for separately payable observation care. In CY 2005, that number increased to approximately 124,300 claims, representing about a 61 percent increase in one year. In addition, in the CY 2006 data available for this proposed rule, the frequency of claims for separately payable observation services increased again, to more than 271,200 claims, about a 118-percent increase over CY 2005 and more than triple the number of claims from 2 years earlier. While it is not possible to discern the specific factors responsible for the growth in claims for separately payable observation services, as there have been minor changes in both the process and criteria for separate payment for these services over this time period, the substantial growth by itself is noteworthy.

We are also concerned that the current criteria for separate payment for observation services may provide disincentives for efficiency. In order for observation services to be separately payable, they must last at least 8 hours. While this criterion was put in place to ensure that separate payment is made only for observation services of a substantial duration, it may create a financial disincentive for an HOPD to make a timely determination regarding a patient's safe disposition after observation care ends. By packaging payment for all observation services, regardless of their duration, we would provide incentives for more efficient delivery of services and timely decision-making. The current criterion also prohibits separate payment for observation services when a ''T'' status procedure (generally a surgical procedure) is provided on the same day or the previous day by the HOPD to the same Medicare beneficiary. Again, this may create a financial disincentive for hospitals to provide minor surgical procedures during a patient's observation stay, unless those procedures are essential to the patient's care during that time period, even if the most efficient and effective performance of those procedures could be during the single HOPD encounter.

Currently, the OPPS pays separately for observation care for only the three original medical conditions designated in CY 2002, specifically chest pain, asthma, and congestive heart failure. As discussed in more detail in the observation section (section XI.) of this proposed rule, the APC Panel recommended at its March 2007 meeting that we consider expanding separate payment for observation services to include two additional diagnoses, syncope and dehydration. As mentioned previously, we have defined observation care as a well-defined set of specific, clinically appropriate services, which include ongoing, short-term treatment, assessment, and reassessment, that are furnished while a decision is being made regarding whether a patient will require further treatment as a hospital inpatient or if the individual is able to be discharged from the hospital. Given the definition of observation services, it is clear that, in certain circumstances, observation care could be appropriate for patients with a range of diagnoses. Both the APC Panel and numerous commenters to prior OPPS proposed rules have confirmed their agreement with this perspective. In addition, the June 2006

Institute of Medicine (IOM) Report entitled, ''Hospital-Based Emergency Care: At the Breaking Point,'' encourages hospitals to apply tools to improve the flow of patients through emergency departments, including developing clinical decisions units where observation care is provided. The IOM's Committee on the Future of Emergency Care in the United States Health System recommended that CMS remove the current limitations on the medical conditions that are eligible for separate observation care payment in order to encourage the development of such observation units.

As packaging payment provides desirable incentives for greater efficiency in the delivery of health care and provides hospitals with significant flexibility to manage their resources, we believe it is most appropriate to treat observation care for all diagnoses similarly by packaging its costs into payment for the separately payable independent services with which the observation is associated. This consistent payment methodology would provide hospitals with the flexibility to assess their approaches to patient care and patient flow and provide observation care for patients with a variety of clinical conditions when hospitals conclude that observation services would improve their treatment of those patients. Approximately 70 percent of the occurrences of observation care billed under the OPPS are currently packaged, and this proposal would extend the incentives for efficiency already present for the vast majority of observation services that are already packaged under the OPPS to the remaining 30 percent of observation services for which we currently make separate payment.

We have calculated the median costs on which the proposed CY 2008 payment rates are based according to our proposed packaging approach under which payment for HCPCS code G0378 would always be packaged (status indicator ''N''). As we discussed previously in more detail, in this section, this has the effect of both changing the median costs for the independent services into which the costs of the dependent and supportive observation services are packaged and also of redistributing payment that would otherwise have been made separately for the observation services we are proposing to newly package for CY 2008.

For example, separately payable observation care is frequently billed with CPT code 99285 (Emergency department visit for the evaluation and management of a patient (Level 5)). In the CY 2008 OPPS proposed rule claims data, CPT code 99285 was billed 157,668 times on claims with HCPCS code G0378 that meet our current criteria for separate payment for observation care. In addition, about 57 percent of the claims for HCPCS code G0378 that meet our current criteria for separate payment also reported CPT code 99285. Under our proposed policy for CY 2008, we are proposing to package payment for HCPCS code G0378 into the payment for separately payable procedures that are provided in conjunction with HCPCS code G0378. Specifically, we would package payment for HCPCS code G0378 when it is provided with a separately paid service such as CPT code 99285, so that in this example observation would receive packaged payment through the separate OPPS payment for the Level 5 emergency department visit. CPT code 99285 is assigned to APC 0616 (Level 5 Emergency Visits), with a CY 2007 APC median cost of $323.36 and a proposed CY 2008 median cost of $344.50. The CY 2007 median cost of APC 0339 for separately payable observation is $440.22.

The proposed CY 2008 payment rates associated with this example are outlined in Table 20 below. The table indicates that the proposed CY 2008 payment for a Level 5 emergency department visit is higher than the CY 2007 payment amount for that code. However, the proposed increase in the Level 5 emergency department visit payment rate for CY 2008 is significantly less than the CY 2007 payment for separately payable observation. This is due to the fact that, although observation services are commonly billed with a Level 5 emergency department visit, the proportion of all Level 5 emergency department visits that include observation (12 percent) is relatively small. Thus, when observation care that would have met the CY 2007 criteria for separate payment is packaged into payment for separately payable services such as a Level 5 emergency department visit, it raises the payment rate for that separately payable service for all occurrences of the service, even those occurrences where observation care is not provided. As a result, the payment rate for the separately payable service, the Level 5 emergency department visit, does not increase by the full amount of the former payment rate for separately payable observation care as that amount is spread over many more occurrences of Level 5 emergency department visits. In addition, OPPS' use of medians leads relative weight estimates to be less sensitive to packaging decisions.

TABLE 20.—EXAMPLE OF THE EFFECTS OF THE CY 2008 PACKAGING PROPOSAL ON PAYMENT FOR OBSERVATION CARE (HCPCS CODE G0378) AND CPT CODE 99295

HCPCS code	Short descriptor	Sum of CY 2007 payment (some G0378 paid separately)	Sum of CY 2008 proposed payment (G0378 packaged)
G0378 (under criteria for separately paid observation care).	Hospital observation per hr (dependent service)	$442.81	$0.00
99285	Emergency dept visit (independent service)	325.26	348.81
Total Payment		768.07	348.81

This example cannot demonstrate the overall impact of packaging observation services on any given hospital because each individual hospital's case-mix and billing pattern would be different. The overall impact of packaging HCPCS code G0378, as well as all other packaging changes that we are proposing for CY 2008, can only be assessed in the aggregate for classes of hospitals. Section XXII.B. of this proposed rule displays the overall impact of APC weight recalibration and packaging changes that we are proposing by classes of hospitals, and the OPPS Hospital-Specific Impacts—Provider-Specific Data file presents our estimates of CY 2008 hospital payment

for those hospitals we include in our ratesetting and payment simulation database. The hospital-specific impact file can be found at *http://www.cms.hhs.gov/HospitalOutpatientPPS/* under supporting documentation for this proposed rule.

The estimated overall impact of these changes that we are proposing for CY 2008 presented in section XXII.B. of this proposed rule is based on the assumption that hospital behavior would not change with regard to when the dependent observation care is provided in the same encounter and by the same hospital that performs the independent services. To the extent that hospitals could change their behavior and cease providing observation services, refer patients elsewhere for that care, or increase the frequency of observation services, the data would show such a change in practice in future years and that change would be reflected in future budget neutrality adjustments. However, with respect to observation care, we believe that hospitals are limited in the extent to which they could change their behavior with regard to how they furnish these services because observation care, by definition, is 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 after receiving the independent services. We believe it is unlikely that hospitals would cease providing medically necessary observation care or refer patients elsewhere for that care if they were unable to reach a decision that the patient could be safely discharged from the outpatient department. We would expect that hospitals would always bill the supportive observation care on the same claim as the other independent services provided in the single hospital encounter.

As we indicated earlier, in all cases we are proposing that hospitals that furnish the observation care in association with independent services must bill those services on the same claim so that the costs of the observation care can be appropriately packaged into payment for the independent services. We expect to carefully monitor any changes in billing practices on a service-specific and hospital-specific basis to determine whether there is reason to request that QIOs review the quality of care furnished or to request that Program Safeguard Contractors review the claims against the medical record.

In summary, we are proposing to package payment for all observation services reported with HCPCS code G0378 for CY 2008. Payment for observation services would be made as part of the payment for the separately payable independent services with which they are billed. As part of this proposal, we would change the status indicator for HCPCS code G0378 from ''Q'' to ''N.'' In addition, we would no longer require the current criteria for separate payment related to hospital visits and ''T'' status procedures, minimum number of hours, and qualifying diagnoses. However, we would retain as general reporting requirements those criteria related to physician evaluation, documentation, and observation beginning and ending time as listed in sections II.A.2.a., b., and c., and 4.a. and b. of this proposed rule. Those 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.

d. Proposed Development of Composite APCs

(1) Background

As we discuss above in regard to our reasons for our proposed packaging approach for the CY 2008 OPPS, we believe that it is crucial that the payment approach of the OPPS create incentives for hospitals to seek ways to provide services more efficiently than exist under the current OPPS structure and allow hospitals maximum flexibility to manage their resources. The current OPPS structure usually provides payment for individual services which are generally defined by individual HCPCS codes. We currently package the costs of some items and services (such as drugs and biologicals with an average per day cost of less than $55) into the payment for separately payable individual services. However, because the extent of packaging in the OPPS is currently modest, furnishing many individual separately payable services increases total payment to the hospital. We believe that this aspect of the current OPPS structure is a significant factor in the growth in volume and spending that we discuss in our general overview and provides a primary rationale for our proposed packaging approach for services in the CY 2008 OPPS. While packaging payment for supportive dependent services into the payment for the independent services which they accompany promotes greater efficiency and gives hospitals some flexibility to manage their resources, we believe that payment for larger bundles of major separately paid services that are commonly performed in the same hospital outpatient encounter or as part of a multi-day episode of care would create even more incentives for efficiency, as discussed earlier. Moreover, defining the ''service'' paid under the OPPS by combinations of HCPCS codes for component services that are commonly performed in the same encounter and that result in the provision of a complete service would enable us to use more claims data and to establish payment rates that we believe more appropriately capture the costs of services paid under the OPPS.

Section 1833(t)(1)(B) of the Act permits us to define what constitutes a ''service'' for purposes of payment under the OPPS and is not restricted to defining a ''service'' as a single HCPCS code. For example, the OPPS currently packages payment for certain items and services reported with HCPCS codes into the payment for other separately payable services on the claim. Consistent with our statutory flexibility to define what constitutes a service under the OPPS, we are proposing to view a service, in some cases, as not just the diagnostic or treatment modality identified by one individual HCPCS code but as the totality of care provided in a hospital outpatient encounter that would be reported with two or more HCPCS codes for component services.

In view of this statutory flexibility to define what constitutes a ''service'' for purposes of OPPS payment, our desire to encourage efficiency in HOPD care, our focus on value-based purchasing, and our desire to use as much claims data as possible to set payment rates under the OPPS, we examined our claims data to determine how we could best use the multiple procedure claims (''hardcore'' multiples) that are otherwise not available for ratesetting because they include multiple separately payable procedures furnished on the same date of service. As discussed in more detail in our discussion of single and multiple procedure claims in section II.A.1.b. of this proposed rule, we have focused in recent years on ways to convert multiple procedure claims to single procedure claims to maximize our use of the claims data in setting median costs for separately payable procedures. We have been successful in using the bypass list to generate ''pseudo'' single procedure claims for use in median setting, but this approach generally does not enable us to use the hardcore multiple claims that contain multiple separately payable

procedures, all with associated packaging that cannot be split among them. We believe that we could use the data from many more multiple procedure claims by creating APCs for payment of those services defined as frequently occurring common combinations of HCPCS codes for component services that we see in correctly coded multiple procedure claims.

Our examination of data for multiple procedure claims identified two specific sets of services that we believe are good candidates for payment based on the naturally occurring common combinations of component codes that we see on the multiple procedure claims. These are low dose rate (LDR) prostate brachytherapy and cardiac electrophysiologic evaluation and ablation services.

Specifically, we have been told (and our data support) that claims for LDR prostate brachytherapy, when correctly coded, report at least two major separately payable procedure codes the majority of the time. For reasons discussed below, we are proposing to use these correctly coded claims that would otherwise be unusable hardcore multiples as the basis for an encounter-based composite APC that would make a single payment when both codes are reported with the same date of service. We also are proposing to pay separately for these procedure codes in cases where only one of the two procedures is provided in a hospital encounter, through the APC associated with that component procedure code that is furnished.

Similarly, we have been told (and our data support) that multiple cardiac electrophysiologic evaluation, mapping, and ablation services are typically furnished on the same date of service and that the correctly coded claims are typically the multiple procedure claims that include several component services and that we are unable to use in our current claims process. The CY 2007 CPT book introductory discussion in the section entitled ''Intracardiac Electrophysiological Procedures/Studies'' notes that, in many circumstances, patients with arrhythmias are evaluated and treated at the same encounter. Therefore, as discussed in detail below, we are also proposing to establish an encounter based composite APC for these services that would provide a single payment for certain common combinations of component cardiac electrophysiologic services that are reported on the same date of service.

These composite APCs reflect an evolution in our approach to payment under the OPPS. Where the claims data show that combinations of services are commonly furnished together, in the future we will actively examine whether it would be more appropriate to establish a composite APC under which we would pay a single rate for the service reported with a combination of HCPCS codes on the same date of service (or different dates of service) than to continue to pay for these individual services under service-specific APCs. We are proposing these specific encounter-based composite APCs for CY 2008 because we believe that this approach could move the OPPS toward possible payment based on an encounter or episode-of-care basis, enable us to use more valid and complete claims data, create hospital incentives for efficiency, and provide hospitals with significant flexibility to manage their resources that do not exist when we pay for services on a per service basis. As such, these proposed composite APCs may serve as a prototype for future creation of more composite APCs, through which we could provide OPPS payment for other types of services in the future. We note that while these proposed composite APCs for CY 2008 are based on observed combinations of component HCPCS codes reported on the same date of service for a single encounter, we also will be exploring in the future how we could set payments based on episodes of care involving services that extend beyond the same date but which are all supportive of a single, related course of treatment. While we are not proposing to implement multi-day episode-of-care APCs in CY 2008, we welcome comments on the concept of developing these APCs to provide payment for such episodes in order to inform our future analyses in this area.

While we have never previously used the term ''composite'' APC under the OPPS, we do have one historical payment policy that resembles the CY 2008 proposed composite APC policy. Since the inception of the OPPS, CMS has limited the aggregate payment for specified less intensive mental health services furnished on the same date to the payment for a day of partial hospitalization, which we considered to be the most resource intensive of all outpatient mental health treatment (65 FR 18455). 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 that we should pay more for a day of individual mental health services under the OPPS. Through the OCE, when the 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 would exceed the per diem partial hospitalization payment (listed as APC 0033 (Partial Hospitalization)), those specified mental health services are assigned to APC 0034, which has the same payment rate as APC 0033, and the hospital is paid one unit of APC 0034. This longstanding policy regarding payment of APC 0034 for combinations of independent services provided in a single hospital encounter resembles the payment policy for composite APCs that we are proposing for LDR prostate brachytherapy and cardiac electrophysiologic evaluation and ablation services for CY 2008. Similar to the logic for the proposed composite APCs, the OCE determines whether to pay these specified mental health services individually or to make a single payment at the same rate as the per diem rate for partial hospitalization for all of the specified mental health services furnished on that date of service. However, we note this established policy for payment of APC 0034 differs from the proposed policies for the new CY 2008 composite APCs because APC 0034 is only paid if the sum of the individual payment rates for the specified mental health services provided on one date of service exceeds the APC 0034 payment rate, which equals the per diem rate of APC 0033 for partial hospitalization.

We are not proposing to change this mental health services payment policy for CY 2008. However, we are proposing to change the status indicator from ''S'' to ''Q'' for the HCPCS codes for the specified mental health services to which APC 0034 applies because those codes are conditionally packaged when the sum of the payment rates for the single code APCs to which they are assigned exceeds the per diem payment rate for partial hospitalization. While we have not published APC 0034 in Addendum A in the past, we are including it in Addendum A to this proposed rule entitled ''Mental Health Composite,'' consistent with our naming taxonomy and publication of the two other proposed composite APCs. We are also including the mental health composite APC 0034 and its member HCPCS codes in Addendum M to this proposed rule in the same way that we show the HCPCS codes to which the LDR Prostate Brachytherapy Composite APC and Cardiac Electrophysiologic Evaluation and Ablation Composite APC apply.

In summary, we are not proposing a change to the longstanding payment policy under which the OPPS pays one unit of APC 0034 in cases in which the total payments for specified mental health services provided on the same date of service would otherwise exceed the payment rate for APC 0033. However, we are proposing to change the status indicator to ''Q'' for the HCPCS codes for mental health services to which this policy applies and which comprise this existing composite APC, because payment for these services would be packaged unless the sum of the individual payments assigned to the codes would be less than the payment for APC 0034.

We look forward to public comments on the concept of composite APCs in general and, specifically, the two new proposed encounter-based composite APCs for CY 2008, and we hope to involve the public and the APC Panel in the creation of additional composite APCs. Our goal would be to use the many naturally occurring multiple procedure claims that cannot currently be incorporated under the existing APC structure, regardless of whether the naturally occurring pattern of multiple procedure claims prevents the development of single bills.

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

(a) Background

LDR prostate brachytherapy is a treatment for prostate cancer in which needles or catheters are inserted into the prostate, and then radioactive sources are permanently implanted into the prostate through the hollow needles or catheters. The needles or catheters are then removed from the body, leaving the radioactive sources in the prostate forever, where they slowly give off radiation to destroy the cancer cells until the sources are no longer radioactive. At least two CPT codes are used to report the composite treatment service because there are separate codes that describe placement of the needles or catheters and application of the brachytherapy sources. LDR prostate brachytherapy cannot be furnished without the services described by both of these codes. Generally, the component services represented by both codes occur in the same operative session in the same hospital on the same date of service. However, we have been told of uncommon cases in which they are furnished in different locations, with the patient being transported from one location to another for application of the sources. In addition, other services, commonly CPT code 76965 (Ultrasonic guidance for interstitial radioelement application) and CPT code 77290 (Therapeutic radiology simulation-aided field setting; complex) are often provided in the same hospital encounter.

CPT code 55875 (Transperineal placement of needles or catheters into prostate for interstitial radioelement application, with or without cystoscopy) reports the placement of the needles or catheters for services furnished on or after January 1, 2007. Before this date, including in the claims for services furnished in CY 2006 that were used to develop this proposed rule, CPT code 55859 (Transperineal placement of needles or catheters into prostate for interstitial radioelement application, with or without cystoscopy) reported this service. All of the claims for CPT code 55859 (as reported in the CY 2006 claims data) are for the placement of needles or catheters for prostate brachytherapy, although not all are related to permanent brachytherapy source application.

CPT code 77778 (Interstitial radiation source application; complex) reports the application of brachytherapy sources and, when billed with CPT code 55859 (or CPT code 55875 after January 1, 2007) for the same encounter, reports placement of the sources in the prostate. We have been told that application of brachytherapy sources to the prostate is estimated to be about 85 percent of all occurrences of CPT code 77778 under the OPPS, consistent with our CY 2006 claims data used for CY 2008 ratesetting. CPT code 77778 is also used to report the application of sources of brachytherapy to body sites other than the prostate.

Historical coding, APC assignments, and payment rates for CPT codes 55859 (CPT code 55875 beginning in CY 2007) and 77778 are shown below in Table 21.

TABLE 21.—HISTORICAL PAYMENT RATES FOR COMPLEX INTERSTITIAL APPLICATION OF BRACHYTHERAPY SOURCES

OPPS CY	Combination APC	Payment rate for CPT code 77778	APC for HCPCS code 77778	Payment rate for CPT codes 55859/55875	APC for HCPCS code 55859	Brachytherapy source
2000	N/A	$198.31	APC 0312	$848.04	APC 0162	Pass-through.
2001	N/A	205.49	APC 0312	878.72	APC 0162	Pass-through.
2002	N/A	6,344.67	APC 0312	2,068.23	APC 0163	Pass-through with pro rata reduction.
2003 (prostate brachytherapy with iodine sources).	G0261, APC 648, $5,154.34.	n/a	n/a	n/a	n/a	Packaged.
2003 (prostate brachytherapy with palladium sources).	G0256, APC 649, $5,998.24.	n/a	n/a	n/a	n/a	Packaged.
2003 (not prostate brachytherapy, not including sources).	N/A	2,853.58	APC 0651	1,479.60	APC 0163	Separate payment based on scaled median cost per source.
2004	N/A	558.24	APC 0651	1,848.55	APC 0163	Cost.
2005	N/A	1,248.93	APC 0651	2,055.63	APC 0163	Cost.
2006	N/A	666.21	APC 0651	1,993.35	APC 0163	Cost.
2007	N/A	1,035.50	APC 0651	2,146.84	APC 0163	Cost.

Payment rates for CPT code 77778, in particular, have fluctuated over the years. We have frequently been informed by the public that reliance on single procedure claims to set the median costs for these services results in use of only incorrectly coded claims for LDR prostate brachytherapy because, for application of brachytherapy sources to the prostate, a correctly coded claim is a multiple procedure claim. Specifically, we have been informed that a correctly coded claim for LDR prostate brachytherapy should include, for the same date of service, both CPT

codes 55859 and 77778, brachytherapy sources reported with Level II HCPCS codes, and typically separately coded imaging and radiation therapy planning services, and that we should use correctly coded claims to set the median for APC 0651 (Complex Interstitial Radiation Source Application) in particular (where CPT code 77778 is assigned). In presentations to the APC Panel in its March 2006 meeting, and in response to the CY 2006 and CY 2007 OPPS proposed rules, commenters urged us to set the payment rate for LDR prostate brachytherapy services using only multiple procedure claims. Specifically for CY 2007, they urged us to sum the costs on multiple procedure claims containing CPT codes 77778 and 55859 (and no other separately payable services not on the bypass list) and, excluding the costs of sources, split the resulting aggregate median cost on the multiple procedure claim according to a preestablished attribution ratio between CPT codes 77778 and 55859. They indicated that any claim for a brachytherapy service that did not also report a brachytherapy source should be considered to be incorrectly coded and thus not reflective of the hospital's resources required for the interstitial source application procedure. The presenters to the APC Panel believed that claims that did not contain both brachytherapy source and source application codes should be excluded from use in establishing the median cost for APC 0651. They believed that hospitals that reported the brachytherapy sources on their claims were more likely to report complete charges for the associated brachytherapy source application procedure than hospitals that did not report the separately payable brachytherapy sources.

As a result of those comments, for both CY 2006 and CY 2007, we used multiple procedure claims containing both CPT codes 55859 and 77778 to determine a median cost for the totality of both services (with both packaging and bypassing of the other commonly furnished services). We compared the median calculated from this subset of claims reflecting the most common clinical scenario to the single bill median costs for CPT codes 55859 and 77778 as a method of determining whether the total payment to the hospital for both services furnished to provide LDR prostate brachytherapy would be reasonable. In both years, we found that the sum of the single bill medians was reasonably close to the median cost of both services from multiple claims when they were treated as a single procedure and the supporting services were either packaged or bypassed for purposes of calculating the median for the combined pair of codes. (We refer readers to the CY 2006 final rule with comment period (70 FR 68596) and the CY 2007 final rule with comment period (71 FR 68043) for specific discussion of these findings.) Hence, we concluded that the single bill median costs were reasonable and, for both the CY 2006 OPPS and CY 2007 OPPS, we based payment for CPT codes 55859 and 77778 on single procedure claims.

(b) Proposed Payment for LDR Prostate Brachytherapy

For the CY 2008 OPPS, we are proposing to create a composite APC 8001, titled ''LDR Prostate Brachytherapy Composite,'' that would provide one bundled payment for LDR prostate brachytherapy when the hospital bills both CPT codes 55875 and 77778 as component services provided during the same hospital encounter. It is shown in Addendum A to this proposed rule as APC 8001 (LDR Prostate Brachytherapy Composite). As discussed in detail in section VII. of this proposed rule, we are proposing to continue to pay sources of brachytherapy separately in accordance with the requirements of the statute.

In the CY 2006 claims used to calculate the proposed CY 2008 median costs, CPT code 55859 was reported 14,083 times. The proposed rule median cost for CPT code 55859, calculated from 2,232 single and ''pseudo'' single bills, is $2,328.56. The CY 2008 proposed rule median cost for APC 0163 (Level IV Cystourethroscopy and other Genitourinary Procedures) to which CPT code 55859 was assigned for CY 2006 and to which CPT code 55875 is assigned for CY 2007 is $2,322.30. In the set of claims used to calculate the median cost for APC 0651, to which CPT code 77778 is the only assigned service, CPT code 77778 was reported 11,850 times. The CY 2008 proposed rule median cost for APC 0651 (and, therefore, for CPT code 77778) based on 339 single and ''pseudo'' single procedure bills is $969.73.

In examining the claims data used to calculate the median costs for this proposed rule, we found 9,807 claims on which both CPT code 55859 and CPT code 77778 were billed on the same date of service. These data suggest that LDR prostate brachytherapy constituted at least 70 percent of CY 2006 claims for CPT code 55859, with the remainder of claims representing the insertion of needles or catheters for high dose rate prostate brachytherapy or unusual clinical situations where the LDR sources were not applied in the same operative session as the insertion of the needles or catheters. These data are consistent with our understanding of current clinical practice for prostate brachytherapy, and we believe that those multiple claims are correctly coded claims for this common clinical scenario. Similarly, 83 percent of the claims for complex interstitial brachytherapy source application CPT code 77778 also included the CPT code for inserting needles or catheters into the prostate, consistent with our understanding that the vast majority of cases of complex interstitial brachytherapy source application procedures are specifically for the treatment of prostate cancer, rather than other types of cancer.

Using the proposed packaging approach for imaging supervision and interpretation services and guidance services for CY 2008, we were able to identify 1,343 claims, 14 percent of all OPPS claims that reported these two procedures on the same date, that contain both CPT codes 55859 and 77778 on the same date of service and no other separately paid procedure code. We were not able to use more claims to develop this composite APC median cost because there are several radiation therapy planning codes that are commonly reported with CPT codes 55859 and 77778 and that are both separately paid and not on the bypass list because the amount of their associated packaging exceeds the threshold for inclusion on the bypass list. A complete discussion of the bypass list under our CY 2008 packaging proposal is provided in section II.A. of this proposed rule.

We packaged the costs of packaged revenue codes and packaged HCPCS codes into the sum of the costs for CPT codes 55859 and 77778 to derive a total proposed median cost of $3,127.35 for the composite LDR prostate brachytherapy service based upon the 1,343 claims that contained both CPT codes and no other separately paid procedure codes. This is reasonably comparable to $3,298.29, the sum of the CPT median costs we calculated using the single procedure bills for CPT codes 55859 and 77778 (($2,328.56 plus $969.73). We believe that the difference between the composite APC median cost based upon those claims that contain both codes and the sum of the median costs for the APCs to which the two individual CPT codes map is minimal and may be attributable to efficiencies in furnishing the services together during a single encounter.

We believe that creation of the composite APC for the payment of LDR prostate brachytherapy is consistent with the statute and with our desire to use more claims data for ratesetting, particularly data from correctly coded claims that reflect typical clinical practice, and to make payment for larger packages and bundles of services to provide enhanced incentives for efficiency and cost containment under the OPPS and to maximize hospital flexibility in managing resources.

Under our proposal, hospitals that furnish LDR prostate brachytherapy would report CPT codes 55875 and 77778 and the codes for the applicable brachytherapy sources in the same manner that they currently report these items and services (in addition to reporting any other services provided), using the same HCPCS codes and reporting the same charges. We would require that hospitals report both CPT codes resulting in the composite APC payment on the same claim when they are furnished to a single Medicare beneficiary in the same facility on the same date of service, and we would make any necessary conforming changes to the billing instructions to ensure that they do not present an obstacle to correct reporting. We may implement edits to ensure that hospitals do not submit two separate claims for these two procedures when furnished on the same date in the same facility. When this combination of codes is reported, the OCE would assign the composite APC 8001 and the Pricer would pay based on the payment rate for the composite APC. The OCE would assign APC 0163 or APC 0651 only when both codes are not reported on the same claim with the same date of service, and we would expect this to be the atypical case. The composite APC would have a status indicator of ''T'' so that payment for other procedures also assigned to status indicator ''T'' with lower payment rates would be reduced by 50 percent when furnished on the same date of service as the composite service, in order to reflect the efficiency that occurs when multiple procedures are furnished to a Medicare beneficiary in a single operative session. We would not expect that the composite APC payment would be commonly reduced because we believe that it is unlikely that a higher paid procedure would be performed on the same date.

We are proposing to continue to establish separate payment rates for APC 0651 (to which only CPT code 77778 is assigned) and for APC 0163 (to which we are proposing to continue to assign CPT code 55875). In some cases, CPT 55875 may be reported for the insertion of needles or catheters for high dose rate prostate brachytherapy, and the low dose rate brachytherapy source application procedure (CPT code 77778) would not be reported. In high dose rate prostate brachytherapy, the sources are applied temporarily several times over a few days while the needles or catheters remain in the prostate, and the needles or catheters are removed only after all the treatment fractions have been completed. We have also been told by hospitals that, even when LDR prostate brachytherapy is planned, there are occasions in which the needles or catheters are inserted in one facility and the patient is moved to another facility for the application of the sources. In those cases, we would need to be able to appropriately pay the hospital that inserted the needles or catheters before the patient was discharged prior to source application. Moreover, there are cases in which the needles or catheters are inserted but it is not possible to proceed to the application of the sources and, therefore, the hospital would correctly report only CPT code 55875. Similarly, more than 10 brachytherapy sources can be applied interstitially (as described by CPT code 77778) to sites other than the prostate and it is, therefore, necessary to have a separate payment rate for CPT code 77778. Hence, for CY 2008 we are proposing to continue to pay for CPT code 55875 (the successor to CPT code 55859) through APC 0163 and to pay for CPT code 77778 through APC 0651 when the services are individually furnished other than on the same date of service in the same facility.

In summary, we are proposing to establish a composite APC, shown in Addendum A as APC 8001, to provide payment for LDR prostate brachytherapy when the composite service, billed as CPT codes 55875 and 77778, is furnished in a single hospital encounter and to base the payment for the composite APC on the median cost derived from claims that contain both codes. These two CPT codes are assigned to status indicator ''Q'' in Addendum B to this proposed rule to signify their conditionally packaged status, and their composite APC assignments are noted in Addendum M. This proposal would permit us to base payment on claims for the most common clinical scenario for interstitial radiation source application to the prostate. We note that this payment bundle would also include payment for the commonly associated imaging guidance services, which would be newly packaged under our proposed CY 2008 packaging approach. Most importantly, this composite APC payment methodology that we are proposing would contribute to our goal of providing payment under the OPPS for a larger bundle of component services provided in a single hospital outpatient encounter, creating additional hospital incentives for efficiency and cost containment, while providing hospitals with the most flexibility to manage their resources.

(3) Proposed Cardiac Electrophysiologic Evaluation and Ablation Composite APC

(a) Background

During its March 2007 meeting, members of the APC Panel indicated that the reason we found so few single bills for procedures assigned to APC 0087 (Cardiac Electrophysiologic Recording/Mapping), specifically 72 of 11,834 or 0.61 percent of all proposed rule CY 2006 claims, is that most of the services assigned to APCs 0085 (Level II Electrophysiologic Evaluation), 0086 (Ablate Heart Dysrhythm Focus), and 0087 are performed in varying combinations with one another. Therefore, correctly coded claims would most often include multiple codes for component services that are reported with different CPT codes and that are now paid separately through different APCs. There would never be many single bills and those that are reported as single bills would likely represent atypical cases or incorrectly coded claims.

We examined the combinations of services observed in our claims data across these three APCs to see whether there was the potential for handling the data differently so that we could use more claims data to set the payment rates for these procedures, particularly those services assigned to APC 0087 where we have had a persistent concern regarding the limited and reportedly unrepresentative single bills available for use in calculating the median cost according to our standard OPPS methodology. We initially developed and examined frequency distributions of unique combinations of codes on claims which contained at least one unit of any code assigned to APC 0085, 0086, or 0087 and then broadened these analysis to any combination of an electrophysiologic evaluation and ablation code.

Our initial frequency distributions supported the APC Panel members' description of their experiences. We identified and enumerated the most commonly appearing unique occurrences (either single procedures or combinations) of codes for services

assigned to status indicator ''S,'' ''T,'' ''V,'' or ''X'' that contained at least one code assigned to APC 0085, 0086, or 0087. There were 7,379 claims in the top 100 occurrence types. Table 22 shows the 10 most common unique occurrences from CY 2006 claims available for this proposed rule.

TABLE 22.—TEN MOST FREQUENTLY OCCURRING UNIQUE OCCURRENCES OF CARDIAC ELECTROPHYSIOLOGIC EVALUATION, MAPPING, AND ABLATION PROCEDURES AND OTHER SEPARATELY PAYABLE SERVICES

Combination number	Frequency	HCPCS code	Short descriptor	CY 2007 APC	CY 2007 SI
1	763	93620	Electrophysiology evaluation	0085	T
2	509	93609	Map tachycardia, add-on	0087	T
		93620	Electrophysiology evaluation	0085	T
		93621	Electrophysiology evaluation	0085	T
		93623	Stimulation, pacing heart	0087	T
		93651	Ablate heart dysrhythm focus	0086	T
3	398	93609	Map tachycardia, add-on	0087	T
		93620	Electrophysiology evaluation	0085	T
		93621	Electrophysiology evaluation	0085	T
		93651	Ablate heart dysrhythm focus	0086	T
4	381	93650	Ablate heart dysrhythm focus	0086	T
5	376	93620	Electrophysiology evaluation	0085	T
		93623	Stimulation, pacing heart	0087	T
6	248	93005	Electrocardiogram, tracing	0099	S
		93609	Map tachycardia, add-on	0087	T
		93620	Electrophysiology evaluation	0085	T
		93621	Electrophysiology evaluation	0085	T
		93623	Stimulation, pacing heart	0087	T
		93651	Ablate heart dysrhythm focus	0086	T
7	225	93005	Electrocardiogram, tracing	0099	S
		93609	Map tachycardia, add-on	0087	T
		93620	Electrophysiology evaluation	0085	T
		93621	Electrophysiology evaluation	0085	T
		93651	Ablate heart dysrhythm focus	0086	T
8	225	93613	Electrophys map 3d, add-on	0087	T
		93620	Electrophysiology evaluation	0085	T
		93621	Electrophysiology evaluation	0085	T
		93651	Ablate heart dysrhythm focus	0086	T
9	217	93005	Electrocardiogram, tracing	0099	S
		93620	Electrophysiology evaluation	0085	T
10	185	93613	Electrophys map 3d, add-on	0087	T
		93620	Electrophysiology evaluation	0085	T
		93621	Electrophysiology evaluation	0085	T
		93623	Stimulation, pacing heart	0087	T
		93651	Ablate heart dysrhythm focus	0086	T

Although the number of claims for each unique occurrence was modest, we were able to determine that there were certain combinations of codes that occurred most often together. Based on our review of the most frequently occurring combinations of codes on claims that also contained at least one code assigned to APC 0085, 0086 or 0087 and our clinical review of the codes, we proceeded to study combination claims that contained at least one code from group A for evaluation services and at least one code from group B for ablation services reported on the same date of service on an individual claim, as specified in Table 23 below.

TABLE 23.—GROUPS OF CARDIAC ELECTROPHYSIOLOGIC EVALUATION AND ABLATION PROCEDURES FOR FURTHER ANALYSIS

Codes used in combinations: at least one in Group A and one in Group B	HCPCS code	CY 2007 APC	CY 2007 SI
Group A:			
Electrophysiology evaluation	93619	0085	T
Electrophysiology evaluation	93620	0085	T
Group B:			
Ablate heart dysrhythm focus	93650	0086	T
Ablate heart dysrhythm focus	93651	0086	T
Ablate heart dysrhythm focus	93652	0086	T

When we studied claims that contained a code in group A and also a code in group B, we found that there were 5,118 claims that met these criteria, and that of these 5,118 claims, 4,552 (89 percent) contained both CPT code 93620 (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) from APC 0085 and CPT code 93651 (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) from APC 0086 with the same date of service. Given that CPT code 93651 had a total frequency of 8,091, this means that more than 55 percent of the claims for CPT code 93651 also contained CPT code 93620. CPT code 93620 had a total frequency of 12,624, approximately 50 percent higher than the total frequency for CPT code 93651, which is consistent with our expectations because CPT code 93620 describes a diagnostic service and CPT code 93651 is a treatment service that may be provided based upon the findings of the evaluation described by CPT code 93620. In addition to the codes for group A and group B services, the combination claims also contained costs for packaged services that were reported under revenue codes without HCPCS codes and under packaged HCPCS codes. As we discuss in considerable detail above, we lack a methodology that could be used to allocate these packaged costs to major separately paid procedures in a manner which gives us confidence that the costs would be attributed correctly. We have explored and will continue to explore an alternative strategy that would enable us to use these correctly coded multiple procedure claims for ratesetting.

In our review of these claims, not only did we find a high number of claims on which there was one code from group A and one code from group B, but we also found that claims for procedures assigned to APC 0087 for CY 2007 usually appeared on claims that contained a code from APC 0085 or APC 0086, or both. The most frequently appearing CPT codes that were assigned to APC 0087 for CY 2007 were, as shown above, 93609 (Intraventricular and/or intra-atrial mapping of tachycardia site(s), with catheter manipulation to record from multiple sites to identify origin of tachycardia (List separately in addition to code for primary procedure)), 93613 (Intracardiac electrophysiologic 3-dimensional mapping (List separately in addition to code for primary procedure)), 93621 (Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of arrhythmia; with left atrial pacing and recording from coronary sinus or left atrium (List separately in addition to code for primary procedure)), 93622 (Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of arrhythmia; with left ventricular pacing and recording (List separately in addition to code for primary procedure)), and 93623 (Programmed simulation and pacing after intravenous drug infusion (List separately in addition to code for primary procedure)). These codes are all CPT add-on codes that CPT indicates are to be reported in addition to the code for the primary procedure. Our clinical review of the services described by these five CPT codes determined that they are supportive dependent services that are provided most often as supplemental to procedures assigned to APCs 0085 and 0086. The procedures in APCs 0085 and 0086 can be performed without these supportive add-on procedures, but these dependent services cannot be done except as a supplement to another electrophysiologic procedure. Therefore, we are proposing to unconditionally package all of these five CPT codes under the grouping of intraoperative services for the CY 2008 OPPS. We discuss the packaging of intraoperative services in general, including these services, above.

However, packaging these supportive ancillary services that are so often reported with the cardiac electrophysiologic evaluation and ablation services does not enable us to use many more claims because, as we noted previously, the claims on which these codes most commonly appeared typically also contained at least one separately paid code from APC 0085 and one code from APC 0086. Although the most common combination of codes from APCs 0085 and 0086 is the pair of CPT codes 93620 and 93651, there are numerous other combinations of services from APCs 0085 and 0086 that are performed and, while not as frequent, these combinations are also reflected in the multiple claims.

In order to use more claims and adequately reflect the varied, common combinations of electrophysiologic evaluation and ablation CPT codes, we calculated a composite median cost from all claims containing at least one code from group A and at least one code from group B as if they were a single service. We selected multiple procedure claims that contained at least one code in group A and one code in group B on the same date of service and calculated a median cost from the total costs on these claims. Some claims had more than one code from each group. Although the claim was required to contain at least one code from each group to be included, the claim could also contain any number of codes from either group and any number of units of those codes. In addition, the costs of the five supportive intraoperative services previously assigned to APC 0087 that we identify above were packaged, as well as the costs of the other items and services proposed to be packaged for the CY 2008 OPPS. This selection process yielded 5,118 claims to use for the calculation. The proposed composite median cost for these claims using the CY 2008 proposed rule data is $8,528.83. We believe that this cost is attributable largely to the 4,552 claims that contain one unit each of CPT code 93620 and CPT code 93651 (and some unknown numbers and combinations of packaged services). In comparison, the sum of the CY 2008 proposed rule CPT code median costs for CPT code 93620 (which is $3,111.76) and CPT code 93651 (which is $5,643.95) is $8,755.71. If the 50 percent multiple procedure discount is applied to the CPT code median cost for the lower cost procedure based on its assignment to an APC with a ''T'' status, the adjusted sum of the median costs is $7,199.83 ($5,643.95 + $1,555.88). These medians were calculated using only claims that contain correct devices and do not contain token charges or the ''FB'' modifier. We believe the significant positive difference between the composite and discounted costs still reflects efficiencies, as the sum of the discounted median costs does not take into account the cost of other procedures also provided that are assigned to APCs 0085 and 0086, while the composite median cost of $8,528.83 does, to some extent, reflect the cost of other multiple procedures in APCs 0085 and 0086 that were also reported on the claims used to develop the composite median cost. In addition, these two calculations are based upon two different sets of claims, single procedure claims in one case (which do not represent the way the service is typically furnished) and the specified subset of clinically common combination claims in the second case. Moreover, while the 50 percent multiple procedure reduction is our best aggregate estimate of the overall degree of efficiency applicable to multiple surgeries, it may or may not be specifically appropriate to this particular combination of procedures.

By selecting the multiple procedure claims that contained at least one code in each group, we were able to use many more claims than were available to establish the individual APC medians. The percents by CPT code for the composite configuration below in Table 24 represent the sum of the frequency of single bills used to set the medians for APCs 0085 and 0086 with packaging of the five intraoperative services and the frequency of multiple bills used to set the medians for the composite claims containing at least one code from each group and with packaging of the costs of the five intraoperative services, divided by the total frequency of each CPT code.

TABLE 24.—PERCENTAGE OF CLAIMS USED TO CALCULATE MEDIAN COSTS FOR CARDIAC ELECTROPHYSIOLOGIC EVALUATION AND ABLATION PROCEDURES

Codes used in combinations: at least one in group A and one in Group B	HCPCS code	Proposed CY 2008 APC	SI	Standard configuration (with packaging of intraoperative services)		Composite configuration (with packaging of intraoperative services)
				CPT percentage of single claims	Overall APC percentage of single claims	CPT percentage of single and combination claims
Group A:						
Electrophysiology evaluation	93619	0085	T	38.99	25.47	63.96
Electrophysiology evaluation	93620	0085	T	22.30	25.47	61.77
Group B:						
Ablate heart dysrhythm focus	93650	0085	T	39.58	25.47	52.50
Ablate heart dysrhythm focus	93651	0086	T	4.59	4.68	63.30
Ablate heart dysrhythm focus	93652	0086	T	7.53	4.68	58.78

Moreover, by packaging CPT codes 93609, 93613, 93621, 93622, and 93623, we use many more of the claims for these codes from the most common clinical scenarios than would otherwise be possible if the supportive intraoperative services were separately paid. Wherever any of these codes appears on a claim that can be used for median setting, the cost data for these codes are packaged in the calculation of the median cost for the separately paid services on the claim.

(b) Proposed Payment for Cardiac Electrophysiologic Evaluation and Ablation

In view of our findings with regard to how often the codes in groups A and B appear together on the same claim, we are proposing to establish one composite APC, shown in Addendum A as APC 8000 (Cardiac Electrophysiologic Evaluation and Ablation Composite), for CY 2008 that would pay for a composite service made up of any number of services in groups A and B when at least one code from group A and at least one code from group B appear on the same claim with the same date of service. The five CPT codes involved in this composite APC are assigned to status indicator ''Q'' in Addendum B to this proposed rule to identify their conditionally packaged status, and their composite APC assignments are identified in Addendum M. We are proposing to use the composite median cost of $8,528.83 as the basis for establishing the relative weight for this newly created APC for the composite electrophysiologic evaluation and ablation service. Under this composite APC, unlike most other APCs, we would make a single payment for all services reported in groups A and B. We are proposing that hospitals would continue to code using CPT codes to report these services and that the OCE would recognize when the criteria for payment of the composite APC are met and would assign the composite APC instead of the single procedure APCs as currently occurs. The Pricer would make a single payment for the composite APC that would encompass the program payment for the code in group A, the code in group B, and any other codes reported in groups A or B, as well as the packaged services furnished on the same date of service. The proposed composite APC would have a status indicator of ''T'' so that payment for other procedures also assigned to status indicator ''T'' with lower payment rates would be reduced by 50 percent when furnished on the same date of service as the composite service, in order to reflect the efficiency that occurs when multiple procedures are furnished to a Medicare beneficiary in a single operative session. We would not expect that the proposed composite APC payment would be commonly reduced because we believe that it is unlikely that a higher paid procedure would be performed on the same date. We are proposing to continue to pay separately for other separately paid services that are not reported under the codes in groups A and B (such as chest x-rays and electrocardiograms).

Moreover, 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, we are proposing that payments would be made under the single procedure APCs and the composite APC would not apply. Given our CY 2008 proposal to unconditionally package payment for five cardiac electrophysiologic CPT codes as members of the category of intraoperative services that were previously assigned to APCs 0085 and 0087, we are also proposing to reconfigure APCs 0084 through 0087, where many of the cardiac electrophysiologic procedures that will be separately paid when they are not paid according to the composite APC are assigned. Specifically, we are proposing to discontinue APC 0087, and reconfigure APCs 0084, 0085, and 0086, with proposed titles and median costs of Level I Electrophysiologic Procedures (APC 0084) at $647.41; Level II Electrophysiologic Procedures (APC 0085) at $3,059.46; and Level III Electrophysiologic Procedures (APC 0086) at $5,709.52, respectively. We refer readers to section IV.A.2. of this proposed rule for a discussion of

calculation of median costs for device-dependent APCs. We believe this reconfiguration improves the clinical and resource homogeneity of these APCs which would provide payment for cardiac electrophysiologic procedures that would be individually paid when they do not meet the criteria for payment of the composite APC.

We believe that creation of the proposed composite APC 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. We believe that this proposed ratesetting methodology results in an appropriate median cost for the composite service when at least one evaluation service in group A is furnished on the same date as at least one ablation service in group B. 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. We expect to develop additional composite APCs in the future as we learn more about major currently separately paid services that are commonly furnished together during the same hospital outpatient encounter.

e. Service-Specific Packaging Issues

As a result of requests from the public, a Packaging Subcommittee to the APC Panel was established to review all the procedural CPT codes with a status indicator of ''N.'' Commenters to past rules have suggested that certain packaged services could be provided alone, without any other separately payable services on the claim, and requested that these codes not be assigned status indicator ''N.'' In deciding whether to package a service or pay for a code separately, we 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 above regarding our proposed packaging approach for CY 2008, we have modified the historical considerations outlined above in developing our proposal for the CY 2008 OPPS. The Packaging Subcommittee discussed many HCPCS codes during the March 2007 APC Panel meeting, prior to development of the proposed packaging approach discussed above, and we have summarized and responded to the APC Panel's packaging-related recommendations below. Three of the codes reviewed by the Packaging Subcommittee at the March 2007 APC Panel meeting are included in the seven categories of services identified for packaging under the CY 2008 OPPS. For those three codes, we specifically applied the proposed CY 2008 criteria for determining whether a code should be proposed as packaged or separately payable for CY 2008. Specifically, we determined whether the service is a dependent service falling into one of the seven specified categories that is always or almost always provided integral to an independent service. For those four codes that were reviewed during the March 2007 APC Panel meeting but that do not fit into any of the seven categories of codes that are part of our CY 2008 proposed packaging approach, we applied the packaging criteria described above that were historically used under the OPPS. Moreover, we took into consideration our interest in expanding the size of payment groups for component services to provide encounter-based and episode-of-care-based payment in the future in order to encourage hospital efficiency and provide hospitals with maximal flexibility to manage their resources.

In accordance with a recommendation of the APC Panel, for the CY 2007 OPPS, we implemented a new policy that designates certain codes as ''special'' packaged codes, assigned to status indicator ''Q'' under the OPPS, where separate payment is provided if the code is reported without any other services that are separately payable under the OPPS on the same date of service. Otherwise, payment for the ''special'' packaged code is packaged into payment for the separately payable services provided by the hospital on the same date. We note that these ''special'' packaged codes are a subset of those HCPCS codes that are assigned to status indicator ''Q,'' which means that their payment is conditionally packaged under the OPPS. We are proposing to update our criteria to determine packaged versus separate payment for ''special'' packaged HCPCS codes assigned to status indicator ''Q'' for CY 2008. For CY 2008, payment for ''special'' packaged codes would be packaged when these HCPCS codes are billed on the same date of service as a code assigned to status indicator ''S,'' ''T,'' ''V,'' or ''X.'' When one of the ''special'' packaged codes assigned to status indicator ''Q'' is billed on a date of service without a code that is assigned to any of the four status indicators noted above, the ''special'' packaged code assigned to status indicator ''Q'' would be separately payable.

The Packaging Subcommittee identified areas for change for some currently packaged CPT codes that it believed could frequently be provided to patients as the sole service on a given date and that required significant hospital resources as determined from hospital claims data. Based on the comments received, additional issues, and new data that we shared with the Packaging Subcommittee concerning the packaging status of codes for CY 2008, the Packaging Subcommittee reviewed the packaging status of numerous HCPCS codes and reported its findings to the APC Panel at its March 2007 meeting. The APC Panel accepted the report of the Packaging Subcommittee, heard several presentations on certain packaged services, discussed the deliberations of the Packaging Subcommittee, and recommended that—

1. CMS place CPT code 76937 (Ultrasound guidance for vascular access requiring ultrasound evaluation of potential access sites, documentation of selected vessel patency, concurrent realtime ultrasound visualization of vascular needle entry, with permanent recording and reporting (list separately in addition to code for primary procedure)) on the list of ''special'' packaged codes (status indicator ''Q''). (Recommendation 1)

2. CMS evaluate providing separate payment for trauma activation when it is reported on a claim for an ED visit, regardless of the level of the emergency department visit. (Recommendation 2)

3. CMS place CPT code 0175T (Computer aided detection (CAD) (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation and report, with or without digitization of film radiographic images, chest radiograph(s), performed remote from primary interpretation) on the list of ''special'' packaged codes (status indicator ''Q''). (Recommendation 3)

4. CMS place CPT code 0126T (Common carotid intima-media thickness (IMT) study for evaluation of atherosclerotic burden or coronary heart disease risk factor assessment) on the list of ''special'' packaged codes (status indicator ''Q'') and that CMS consider mapping the code to APC 340 (Minor Ancillary Procedures). (Recommendation 4)

5. CMS place CPT code 0069T (Acoustic heart sound recording and computer analysis only) on the list of ''special'' packaged codes (status indicator ''Q'') and that CMS exclude APC 0096 (Non-Invasive Vascular Studies) as a potential placement for this CPT code. (Recommendation 5)

6. CMS maintain the packaged status of HCPCS code A4306 (Disposable drug delivery system, flow rate of less than 50 ml per hour) and that CMS present additional data on this system to the APC Panel when available. (Recommendation 6)

7. CMS reevaluate the packaged OPPS payment for CPT code 99186 (Hypothermia; total body) based on current research and availability of new therapeutic modalities. (Recommendation 7)

8. The Packaging Subcommittee remains active until the next APC Panel meeting. (Recommendation 8)

We address each of these recommendations in turn in the discussion that follows.

Recommendation 1

For CY 2008, we are proposing to maintain CPT code 76937 as a packaged service. We are not adopting the APC Panel's recommendation to pay separately for this code in some circumstances as a ''special'' packaged code. In the CY 2006 OPPS final rule with comment period (70 FR 68544 through 68545), in response to several public comments, we reviewed in detail the claims data related to CPT code 76937. During its March 2006 APC Panel meeting, after reviewing data pertinent to CPT code 76937, the APC Panel recommended that CMS maintain the packaged status of this code for CY 2007, and we accepted that recommendation. During the March 2007 APC Panel meeting, after reviewing current data and listening to a public presentation, the Panel recommended that we treat this code as a ''special'' packaged code for CY 2008, noting that certain uncommon clinical scenarios could occur where it would be possible to bill this service alone on a claim, without any other separately payable OPPS services.

We are proposing to maintain CPT code 76937 as an unconditionally packaged service for CY 2008, fully consistent with the proposed packaging approach for the CY 2008 OPPS, as discussed above. Because CPT code 76937 is a guidance procedure and we are proposing to package payment for all guidance procedures for CY 2008, we believe it is appropriate to maintain the unconditionally packaged status of this code, which is a CPT designated add-on procedure that we would expect to be generally provided only in association with other independent services. We applied the updated criteria for determining whether this service should receive packaged or separately payment under the CY 2008 OPPS. Specifically, we determined that this service is a supportive ancillary service that is integral to an independent service, resulting in our CY 2008 proposal to packaged payment for the service.

We discussed this code extensively in both the CY 2006 and CY 2007 final rules with comment period (70 FR 68544 through 68545; 71 FR 67996 through 67997). Our hospital claims data demonstrate that guidance services are used frequently for the insertion of vascular access devices, and we have no evidence that patients lack appropriate access to guidance services necessary for the safe insertion of vascular access devices in the hospital outpatient setting. Because we believe that ultrasound guidance would almost always be provided with one or more separately payable independent procedures, its costs would be appropriately bundled with the handful of vascular access device insertion procedures with which it is most commonly performed. We further believe that hospital staff chooses whether to use no guidance or fluoroscopic guidance or ultrasound guidance on an individual basis, depending on the clinical circumstances of the vascular access device insertion procedure.

Therefore, we do not believe that CPT code 76937 is an appropriate candidate for designation as a ''special'' packaged code. The CY 2007 CPT book indicates that this code is an add-on code and should be reported in addition to the code reported for the primary procedure. According to our CY 2006 claims data available for this proposed rule, this code was billed over 60,000 times, yet less than one-tenth of 1 percent of all claims for the procedure were billed without any separately payable OPPS service on the claim. Because this code is provided alone only extremely rarely, we believe this code would not be appropriately treated as a ''special'' packaged code. Therefore, we are proposing to continue to unconditionally package CPT code 76937 for CY 2008.

Recommendation 2

For CY 2008, we are proposing to maintain the packaged status of revenue code 068x, trauma response, when the trauma response is provided without critical care services. During the August 2006 APC Panel meeting, the APC Panel encouraged CMS to pay differentially for critical care services provided with and without trauma activation. For CY 2007, as a result of the APC Panel's August 2006 discussion and our own data analysis, we finalized a policy to pay differentially for critical care provided with and without trauma activation. The CY 2007 payment rate for critical care unassociated with trauma activation is $405.04 (APC 0617, Critical Care), while the payment rate for critical care associated with trauma activation is $899.58 (APC 0617 and APC 0618 (Trauma Response with Critical Care)). During the March 2007 APC Panel meeting, a presenter requested that CMS also pay differentially for emergency department visits provided with and without trauma activation. Two organizations that submitted comment letters for the APC Panel's review specifically requested separate payment for revenue code 068x every time it appears on a claim, regardless of the other services that were billed on that claim. The APC Panel recommended that CMS evaluate providing separate payment for trauma activation when it is reported on a claim for an emergency department visit, regardless of the level of the emergency department visit.

After accepting the APC Panel's recommendation and evaluating this issue, we continue to believe that, while it is currently appropriate to pay separately for trauma activation when billed in association with critical care services, it is also currently appropriate to maintain the packaged payment status of revenue code 068x when trauma response services are provided in association with both clinic and emergency department visits under the CY 2008 OPPS. As mentioned above, it is our general objective to expand the size of the payment groups under the OPPS to move toward encounter-based and episode-of-care-based payments in order to encourage maximum hospital efficiency with a focus on value-based purchasing. Because trauma activation in association with emergency department or clinic visits would always be provided in the same hospital outpatient encounter as the visit for care of the injured Medicare beneficiary, packaging payment for trauma activation when billed in association with both clinic and emergency department visits is most consistent with our proposed packaging approach. We are also concerned that unpackaging payment for trauma activation in those circumstances where the trauma response would be less likely to be essential to appropriately treating a

Medicare beneficiary would reduce the incentive for hospitals to provide the most efficient and cost-effective care. We note that, while we are proposing for CY 2008 to continue to provide separate payment for trauma activation in association with critical care services, we may reconsider this payment policy for future OPPS updates as we further develop encounter-based and episode-of-care-based payment approaches.

Furthermore, continued packaged payment for trauma activation when unassociated with critical care is consistent with the principles of a prospective payment system, where hospitals receive payment based on the median cost related to all of the hospital resources associated with the main service provided. In various situations, each hospital's costs may be higher or lower than the median cost used to set payment rates. In light of our proposed packaging approach for the CY 2008 OPPS, we believe it is particularly important not to make any changes in our payment policies for other services that are not fully aligned with promoting efficient, judicious, and deliberate care decisions by hospitals that allow them maximum flexibility to manage their resources through encouraging the most cost-effective use of hospital resources in providing the care necessary for the treatment of Medicare beneficiaries. Packaging payment encourages hospitals to establish protocols that ensure that services are furnished only when they are medically necessary and to carefully scrutinize the services ordered by practitioners to minimize unnecessary use of hospital resources.

Therefore, we are adopting the APC Panel's recommendation that we evaluate providing separate payment for revenue code 068x when provided in association with emergency department visits. For CY 2008, after our thorough assessment, we are proposing to maintain the packaged status of revenue code 068x, except when revenue code 068x is billed in association with critical care services.

Recommendation 3

For CY 2008, we are proposing to maintain the unconditionally packaged status of CPT codes 0174T (Computer aided detection (CAD) (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation and report, with or without digitization of film radiographic images, chest radiograph(s), performed concurrent with primary interpretation) and 0175T. These services involve the application of computer algorithms and classification technologies to chest x-ray images to acquire and display information regarding chest x-ray regions that may contain indications of cancer. CPT code 0152T (Computer aided detection (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation, with or without digitization of film radiographic images; chest radiograph(s) (List separately in addition to code for primary procedure)), the predecessor code to CPT codes 0174T and 0175T, was indicated as an add-on code to chest x-ray CPT codes for CY 2006, according to the AMA's CY 2006 CPT book. However, on July 1, 2006, the AMA released to the public an update that deleted CPT codes 0152T and replaced it with the two new Category III CPT codes 0174T and 0175T.

In its March 2006 presentation to the APC Panel, before the AMA had released the CY 2007 changes to CPT code 0152T, a presenter requested that we pay separately for this service and assign it to a New Technology APC with a payment rate of $15, based on its estimated cost, clinical considerations, and similarity to other image post processing services that are paid separately. We proposed to accept the APC Panel's recommendation to package CPT code 0152T for CY 2007.

In its August 2006 presentation to the APC Panel, after the AMA had released the CY 2007 code changes, the same presenter requested that we assign both of the two new codes to a New Technology APC with a payment rate of $15. The APC Panel members discussed these codes extensively. They considered the possibility of treating CPT code 0175T as a ''special'' packaged code, thereby assigning payment to the code only when it was performed by a hospital without any other separately payable OPPS service also provided on the same day. They questioned the meaning of the word ''remote'' in the code descriptor for CPT code 0175T, noting that was unclear as to whether remote referred to time, geography, or a specific provider. They believed it was likely that a hospital without a CAD system that performed a chest x-ray and sent the x-ray to another hospital for performance of the CAD would be providing the CAD service under arrangement and, therefore, would be providing at least one other service (chest x-ray) that would be separately paid. Thus, even in these cases, payment for the CAD service could be appropriately packaged. After significant and lengthy deliberation, the APC Panel recommended that we package payment for both of the new CPT codes, 0174T and 0175T, for CY 2007.

In its March 2007 presentation to the APC Panel, the same presenter requested that we pay separately for CPT codes 0174T and 0175T, mapping them to New Technology APC 1492, with a payment rate of $15. The presenter indicated that chest x-ray CAD is not a screening tool and should only be billed to Medicare when applied to chest x-rays suspicious for lung cancer. The presenter also explained that additional and distinct hospital resources are required for chest x-ray CAD that are not required for a standard chest x-ray. In addition, remote chest x-ray CAD described by CPT code 0175T can be performed at a different time or location or by a different provider than the chest x-ray service. The presenter expressed concern that if hospitals were not paid separately for this technology, hospitals would not be able to provide it, thereby limiting beneficiary access to chest x-ray CAD. The APC Panel recommended conditional packaging as a ''special'' packaged code for CPT code 0175T, but did not recommend a change to the unconditionally packaged status of CPT code 0174T. We are not adopting the APC Panel's recommendation for designation of CPT code 0175T as a ''special'' packaged code under the CY 2008 OPPS.

We believe that packaged payment for diagnostic chest x-ray CAD under a prospective payment methodology for outpatient hospital services is most appropriate. We are proposing to maintain CPT codes 0174T and 0175T as unconditionally packaged services for CY 2008, fully consistent with the proposed packaging approach for the CY 2008 OPPS, as discussed above. Because CPT codes 0174T and 0175T are supportive ancillary services that fit into the ''image processing'' category, and we are proposing to package payment for all image processing services for CY 2008, we believe it is appropriate to maintain the packaged status of these codes. We applied the updated criteria for determining whether these two CAD services should receive packaged or separate payment. Specifically, we determined that this service is a dependent service that is integral to an independent service, in this case, the chest x-ray or other OPPS service that we would expect to be provided in addition to the CAD service.

After hearing many public presentations and discussions regarding the use of chest x-ray CAD, we continue to believe that even the remote service would almost always be provided by a hospital either in conjunction with other separately payable services or

under arrangement. For example, if a physician orders a chest x-ray and CAD service to be performed at hospital A, and hospital A, which does not have the CAD technology, sends the chest-ray to hospital B for the performance of chest x-ray CAD, hospital B could only provide the CAD service if it were provided under arrangement, to avoid the OPPS unbundling prohibition. Assuming that the CAD service was provided under arrangement, hospital A would bill for the chest x-ray CAD that was performed by hospital B and would pay hospital B for the service provided. In that case, hospital A would also bill the chest x-ray service that it provided. In another scenario that has been described to us, if a physician were to send a patient to a hospital clinic with the patient's chest x-ray for consultation, we believe that the patient would likely receive a visit service, in addition to the chest x-ray CAD. Therefore, in both of these circumstances, payment for the chest x-ray CAD would be appropriately packaged into payment for the separately payable services with which it was provided.

We also do not believe that CPT code 0175T should be treated as a ''special'' packaged code. As discussed earlier in this section with regard to our packaging proposal for image processing services for CY 2008, we are concerned with establishing payment policies that could encourage certain inefficient and more costly service patterns, particularly for those services that do not need to be provided as a face-to-face encounter with the patient. If we were to assign CPT code 0175T to ''special'' packaged status, we would likely create an incentive for hospitals to perform chest x-ray CAD remotely, for example, several days after performance of the initial chest x-ray, rather than immediately following the chest x-ray on the same day, to enable the hospital to receive separate payment for the service. In CY 2005, there were approximately 7.3 million claims for all chest x-ray services in the HOPD, so a payment policy that could induce such changes in service delivery would be problematic in light of our commitment to encouraging the most efficient and cost-effective care for Medicare beneficiaries. Creating such perverse payment incentives through conditional packaging is a particular problem for those services that do not need a face-to-face encounter with the patient. In fact, as part of our proposed CY 2008 packaging approach, we are also proposing to unconditionally package payment in CY 2008 for several other image processing services that are not always performed face-to-face, including HCPCS code G0288 (Reconstruction, computer tomographic angiography of aorta for surgical planning for vascular surgery) and CPT code 76377 (3D rendering with interpretation and reporting of computed tomography, magnetic resource imaging, ultrasound, or other tomographic modality; requiring image postprocessing on an independent workstation).

The proposed unconditionally packaged treatment of the two CPT codes for chest x-ray CAD is fully consistent with the proposed packaging approach for the CY 2008 OPPS, as discussed above, and the principles and incentives for efficiency inherent in a prospective payment system based on groups of services. Packaging these services creates incentives for providers to furnish services in the most cost-effective way and provides them with the most flexibility to manage their resources. As stated above, packaging encourages hospitals to establish protocols that ensure that services are furnished only when they are medically necessary and to carefully scrutinize the services ordered by practitioners to minimize unnecessary use of hospital resources. Therefore, we are proposing to continue to unconditionally package payment for CPT codes 0174T and 0175T for CY 2008.

Recommendation 4

For CY 2008, we are adopting the APC Panel's recommendation and proposing to add CPT code 0126T to the list of ''special'' packaged codes and assign this code to APC 0340 (Minor Ancillary Procedures).

This service describes an ultrasound procedure that measures common carotid intima-media thickness to evaluate a patient's degree of atherosclerosis. This code became effective January 1, 2006. We received a comment to the CY 2007 proposed rule requesting that this code become separately payable for CY 2007. At that point, we had no cost data for the service and, as discussed in the CY 2007 OPPS/ASC final rule with comment period (71 FR 67998), we reviewed this code with the Packaging Subcommittee, as is our standard procedure for codes that we are asked to review during the comment period. The APC Panel noted that this service could sometimes be provided to a patient without any other separately payable services. Therefore, the APC Panel recommended that we add this code to the list of ''special'' packaged codes and pay for it separately when it is provided without any other separately payable services on the same day. For circumstances when this code is paid separately, the APC Panel recommended that we consider assigning this code to APC 0340.

While we continue to believe that this procedure would not commonly be provided alone, we are adopting the APC Panel recommendation and are proposing to treat this code as a ''special'' packaged code subject to conditional packaging, mapping to APC 0340 for CY 2008 when it would be separately paid. This is fully consistent with the proposed packaging approach for the CY 2008 OPPS, as discussed above. Because CPT code 0126T is almost always performed during another procedure, and we are proposing to package payment for all intraoperative procedures for CY 2008, we believe it is appropriate to designate this CPT code as a ''special'' packaged code. We applied the updated criteria for determining whether this service should receive packaged or separate payment. Specifically, we determined that this service is usually a dependent service that is integral to an independent service, but that it could sometimes be provided without an independent service.

As with all ''special'' packaged codes, we will closely monitor cost data and frequency of separate payment for this procedure as soon as we have more claims data available.

Recommendation 5

For CY 2008, we are proposing to maintain the packaged status of CPT code 0069T, and we are not adopting the APC Panel's recommendation to designate this service as a ''special'' packaged code. This service uses signal processing technology to detect, interpret, and document acoustical activities of the heart through special sensors applied to a patient's chest. This code was a new Category III CPT code implemented in the CY 2005 OPPS. CPT code 0069T was an add-on code to an electrocardiography (EKG) service for CYs 2005 and 2006. However, effective January 1, 2007, the AMA changed the code descriptor to remove the add-on code designation for CPT code 0069T. This code has been packaged under the OPPS since CY 2005.

During the August 2005 APC Panel meeting, the APC Panel recommended packaging CPT code 0069T for CY 2005. In its March 2006 presentation to the APC Panel, a presenter requested that we pay separately for CPT code 0069T and assign it to APC 0099 (Electrocardiograms) based on its estimated cost and clinical characteristics. The presenter stated that

the acoustic heart sound recording and analysis service may be provided with or without a separately reportable electrocardiogram. Members of the APC Panel engaged in extensive discussion of clinical scenarios as they considered whether CPT code 0069T could or could not be appropriately reported alone or in conjunction with several different procedure codes. Ultimately, the APC Panel recommended assigning this service to a separately payable status indicator. However, during the August 2006 meeting, the APC Panel further discussed CMS' proposal to package payment for CPT code 0069T for CY 2007 and considered the CY 2007 code descriptor change, finally recommending that CMS continue to package this code for CY 2007.

During the March 2007 APC Panel meeting, the same presenter requested that we pay separately for this service and assign it to APC 0096 (Non-Invasive Vascular Studies) or to APC 0097 (Cardiac and Ambulatory Blood Pressure Monitoring), with CY 2007 payment rates of $94.06 and $62.85, respectively. The presenter stated that the estimated true cost of this service lies between $62 and $94. The presenter clarified that this service is usually provided with an EKG, but noted that the test is sometimes provided without an EKG, according to its revised code descriptor for CY 2007. The presenter agreed that it would be rare for the acoustic heart sound procedure to be performed alone without any other separately payable OPPS services. The APC Panel recommended that we place CPT code on the list of ''special'' packaged codes and that we exclude APC 0096 as a potential placement for this CPT code.

Because this service does not fit into one of the seven identified categories of packaged codes proposed for the CY 2008 OPPS, we followed our historical packaging guidelines to determine whether to maintain the packaged status of this code or to pay for it separately. Based on the clinical uses that were described during the March 2007 and earlier APC Panel meetings, APC Panel discussions, and our claims data review, we continue to believe that it is highly unlikely that CPT code 0069T would be performed in the HOPD as a sole service without other separately payable OPPS services. In addition, our data indicate that this service is estimated to require only minimal hospital resources. Based on CY 2006 claims, we had only 8 single claims for CPT code 0069T, with a median line-item cost of $5.21, consistent with its low expected cost. Therefore, we believe that payment for CPT code 0069T is appropriately packaged because it would usually be closely linked to the performance of an EKG or other separately payable cardiac service, would rarely, if ever, be the only OPPS service provided to a patient in an encounter, and has a low estimated resource cost. The proposed packaged treatment of this code is consistent with the principles and incentives for efficiency inherent in a prospective payment system based on groups of services. Therefore, we are proposing to continue to package payment for CPT code 0069T for CY 2008.

Recommendation 6

For CY 2008, we are proposing to adopt the APC Panel's recommendation and maintain the packaged status of HCPCS code A4306. As requested by the APC Panel, we will also present to the APC Panel additional data on this system when available.

HCPCS code A4306 describes a disposable drug delivery system with a flow rate of less than 50 ml per hour. As discussed in a presentation at the March 2007 APC Panel meeting, there is a particular disposable drug delivery system that is specifically used to treat postoperative pain. Since the implementation of the OPPS, this code was assigned to status indicator ''A,'' indicating that it was payable according to another fee schedule, in this case, the Durable Medical Equipment (DME) fee schedule. There were discussions during CYs 2005 and 2006 between CMS and a manufacturer, and it was determined that this code should be removed from the DME fee schedule as this code does not describe DME. For CY 2007, HCPCS code A4306 is payable under the OPPS, with status indicator ''N'' indicating that its payment is unconditionally packaged.

One presenter to the APC Panel requested that we pay separately for this supply under the OPPS. For CY 2007, we packaged payment for this code because it is considered to be a supply, and since the inception of the OPPS the established payment policy packages payment for supplies because they are directly related and integral to an independent service furnished under the OPPS.

Our CY 2006 claims data indicate that HCPCS code A4306 was billed on OPPS claims 1,773 times, yielding a line-item median cost of approximately $3. The APC Panel and a presenter believe that this code may not always be appropriately billed by hospitals as the data also show that this code was billed together with computed tomography (CT) scans of the thorax, abdomen, and pelvis approximately 40 percent of the time that this supply was reported. The APC Panel speculated that this code may be currently reported when other types of drug delivery devices are utilized for nonsurgical procedures or for purposes other than the treatment of postoperative pain. Therefore, the APC Panel requested that we share additional data when available.

In summary, because HCPCS code A4306 represents a supply and payment of supplies is packaged under the OPPS according to longstanding policy, we are proposing to maintain the packaged status of HCPCS code A4306 for CY 2008.

Recommendation 7

For CY 2008, we are proposing to maintain the packaged status of CPT code 99186, consistent with the APC Panel's recommendation that we reevaluate the packaged OPPS payment for CPT code 99186 based on current research and the availability of new therapeutic modalities.

This service describes induced total body hypothermia that is performed on some post-cardiac arrest patients to avoid or lessen brain damage. The service has been packaged since the implementation of the OPPS. One presenter to the APC Panel at the March 2007 meeting requested that this code be assigned a separately payable status indicator under the OPPS. The presenter expressed concern that hospitals that provide this service and subsequently transfer the patient to another hospital prior to admission are not adequately paid for their services.

Because this service does not fit into one of the seven identified categories of packaged codes proposed for the CY 2008 OPPS, we followed our historical packaging guidelines to determine whether to maintain the packaged status of this code or to pay for it separately. Claims data indicate that this code was billed 39 times under the OPPS in CY 2006 and was never billed without another separately payable service on the same date. The proposed CY 2008 median cost for this code is $35, with individual costs ranging from $17 to $69, likely reflecting the costs associated with traditional methods of inducing total body hypothermia, such as ice packs applied to the body. In fact, the presenter noted that a technologically advanced total body hypothermia system costs $30,000, with an additional cost of $1,600 per disposable body suit. As expected, our claims data show that this service was provided most frequently with high level emergency department visits and critical care services.

We believe that the circumstances in which total body hypothermia would be provided to a Medicare beneficiary and billed under the OPPS are extremely rare, as patients requiring this therapy would almost always be admitted as inpatients if they survive. We believe that, in the uncommon situation where a patient presents to one hospital and then is cooled and transported to another hospital without admission to the first hospital, payment for the hypothermia service would be most appropriately packaged into payment for the many other separately payable services that it most likely accompanied and that would be paid to the first hospital under the OPPS.

In addition, consistent with the principles and incentives for efficiency inherent in a prospective payment system based on groups of services, packaging payment for this procedure that is highly integrated with other services provided in the hospital outpatient encounter creates incentives for providers to furnish services in the most cost-effective way. In situations 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 most cost-effective item that meets the patient's needs.

Recommendation 8

In response to the APC Panel's recommendation for the Packaging Subcommittee to remain active until the next APC meeting, we note that the APC Panel Packaging Subcommittee remains active, and additional issues and new data concerning the packaging status of codes will be shared for its consideration as information becomes available. We continue to encourage submission of common clinical scenarios involving currently packaged HCPCS codes to the Packaging Subcommittee for its ongoing review, and we also encourage recommendations of specific services or procedures whose payment would be most appropriately packaged under the OPPS. Additional detailed suggestions for the Packaging Subcommittee should be submitted to *APCPanel@cms.hhs.gov*, with ''Packaging Subcommittee'' in the subject line.

B. Proposed Payment for Partial Hospitalization

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

1. Background

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

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

For CY 2005, the PHP per diem amount was based on 12 months of hospital and CMHC PHP claims data (for services furnished from January 1, 2003, through December 31, 2003). We used data from all hospital bills reporting condition code 41, which identifies the claim as partial hospitalization, and all bills from CMHCs because CMHCs are Medicare providers only for the purpose of providing partial hospitalization services. We used CCRs from the most recently available hospital and CMHC cost reports to convert each provider's line-item charges as reported on bills to estimate the provider's cost for a day of PHP services. Per diem costs were then computed by summing the line-item costs on each bill and dividing by the number of days on the bill.

In the CY 2005 OPPS update, the CMHC median per diem cost was $310, the hospital-based PHP median per diem cost was $215, and the combined CMHC and hospital-based median per diem cost was $289. We believed that the reduction in the CY 2005 CMHC median per diem cost compared to prior years indicated that the use of updated CCRs had accounted for the previous increase in CMHC charges and represented a more accurate estimate of CMHC per diem costs for PHP.

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

Following the methodology used for the CY 2005 OPPS update, the CY 2006 OPPS updated combined hospital-based and CMHC median per diem cost was $161, a decrease of 44 percent compared to the CY 2005 combined median per diem amount.

As we were concerned that this amount may not cover the cost for PHPs, as stated in the CY 2006 OPPS final rule with comment period (70 FR 68548 and 68549), we applied a 15-percent reduction to the combined hospital-based and CMHC median per diem cost to establish the CY 2005 PHP APC. (We refer readers to the CY 2006 OPPS final rule with comment period for a full discussion of how we established the CY 2006 PHP rate (70 FR 68548).) We stated our belief that a reduction in the CY 2005 median per diem cost would strike an appropriate balance between using the best available data and providing adequate payment for a program that often spans 5–6 hours a

day. We stated that 15 percent was an appropriate reduction because it recognized decreases in median per diem costs in both the hospital data and the CMHC data, and also reduced the risk of any adverse impact on access to these services that might result from a large single-year rate reduction. However, we adopted this policy as a transitional measure, and stated in the CY 2006 OPPS final rule with comment period that we would continue to monitor CMHC costs and charges for these services and work with CMHCs to improve their reporting so that payments can be calculated based on better empirical data, consistent with the approach we have used to calculate payments in other areas of the OPPS (70 FR 68548).

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

For the CY 2007 final rule with comment period, we analyzed 12 months of more current data for hospital and CMHC PHP claims for services furnished between January 1, 2005, and December 31, 2005. We also used the most currently available CCRs to estimate costs. Using these updated data, we recreated the analysis performed for the CY 2007 proposed rule to determine if the significant factors we used in determining the proposed PHP rate had changed. The median per diem cost for CMHCs increased $8 to $173, while the median per diem cost for hospital-based PHPs decreased $19 to $190. The CY 2005 average charge per day for CMHCs was $675, similar to the figure noted in the CY 2007 proposed rule ($673) but still significantly lower than what was noted as the average charge for CY 2003 ($1,184).

The combined hospital-based and CMHC median per diem cost would have been $175 for CY 2007. Rather than allowing the PHP median per diem cost to drop to this level, we proposed to reduce the PHP median cost by 15 percent, similar to the methodology used for the CY 2006 update. However, after considering all public comments received concerning the proposed CY 2007 PHP per diem rate and results obtained using the more current data, we modified our proposal to continue using the 15 percent reduction methodology as the basis for calculating the combined hospital based and CMHC median per diem cost for CY 2007. Instead, we made a 5 percent reduction to the CY 2006 median per diem rate to provide a transitional path to the per diem cost indicated by the data. We believed that this approach accounted for the downward direction of the data and addressed concerns raised by commenters about the magnitude of another 15 percent reduction in 1 year. Thus, to calculate the CY 2007 APC PHP per diem cost, we reduced $245.65 (the CY 2005 combined hospital-based and CMHC median per diem cost of $289 reduced by 15 percent) by 5 percent, which resulted in a combined per diem cost of $233.37.

2. Proposed PHP APC Update

For the past 2 years, we were concerned that we did not have sufficient evidence to support using the median per diem cost produced by the most current year's PHP data. After extensive analysis, we now believe we have determined the appropriate level of cost for the type of day services that is being provided. This analysis included an examination of revenue-to-cost center mapping, refinements to the per diem methodology, and an in-depth analysis of the number of units of service per day.

In the CY 2006 and CY 2007 OPPS updates, the data have produced median costs that we believe were too low to cover the cost of a program that typically spans 5 to 6 hours per day. However, we continued to observe a clear downward trend in the data. We stated that if the data continue to reflect a low PHP per diem cost in CY 2008, we expect to continue the transition of decreasing the PHP median per diem cost to an amount that is more reflective of the data.

We received a comment on the CY 2007 proposed rates that CMS understated the PHP median cost by not using a hospital-specific CCR for partial hospitalization. In our response to this comment in the CY 2007 OPPS/ASC final rule with comment period (71 FR 68000), we noted that, although most hospitals do not have a cost center for partial hospitalization, we used the CCR as specific to PHP as possible. The following CMS Web site contains the revenue-code-to-cost-center crosswalk: *http://www.cms.hhs.gov/HospitalOutpatientPPS/03_crosswalk.asp#TopOfPage*.

This crosswalk indicates how charges on a claim are mapped to a cost center for the purpose of converting charges to cost. One or more cost centers are listed for most revenue codes that are used in the OPPS median calculations, starting with the most specific, and ending with the most general. Typically, we map the revenue code to the most specific cost center with a provider-specific CCR. However, if the hospital does not have a CCR for any of the listed cost centers, we consider the overall hospital CCR as the default. For partial hospitalization, the revenue center codes billed by PHPs are mapped to Primary Cost Center 3550 ''Psychiatric/Psychological Services''. If that cost center is not available, they are mapped to the Secondary Cost Center 6000 ''Clinic.'' We use the overall facility CCR for CMHCs because PHPs are CMHCs' only Medicare cost, and CMHCs do not have the same cost structure as hospitals. Therefore, for CMHCs, we use the CCR from the outpatient provider-specific file.

Closer examination of the revenue-code-to-cost-center crosswalk revealed that 10 of the revenue center codes (shown in the table below) that are common among hospital based PHP claims did not map to a Primary Cost Center 3550 ''Psychiatric/Psychological Services'' or a Secondary Cost Center of 6000 ''Clinic.''

Revenue center code	Revenue center description
0430	Occupational Therapy.
0431	Occupational Therapy: Visit charge.
0432	Occupational Therapy: Hourly charge.
0433	Occupational Therapy: Group rate.
0434	Occupational Therapy: Evaluation/re-evaluation.
0439	Occupational Therapy: Other occupational therapy.
0904	Psychiatric/Psychological Treatment: Activity therapy.
0940	Other Therapeutic Services.
0941	Other Therapeutic Services: Recreation Rx.
0942	Other Therapeutic Services: Education/training.

We believe these 10 revenue center codes did not map to either a Primary Cost Center 3550 ''Psychiatric/Psychological Services'' or a Secondary Cost Center 6000 ''Clinic'' because these codes may be used for services that are not PHP or psychiatric related. For example, many Occupational Therapy claims are not furnished to PHP patients and, therefore, should be appropriately mapped to a Primary Cost Center 5100 ''Occupation Therapy'' (the general Occupational Therapy Cost Center). Another example would be claims for Diabetes Education, which is also not furnished to PHP patients.

In order to more accurately estimate costs for PHP claims, for purposes of our analysis, we remapped these 10 revenue center codes to a Primary Cost Center 3550 ''Psychiatric/Psychological Services'' or a Secondary Cost Center 6000 ''Clinic''. Once we remapped the

codes, we computed an alternate cost for each line item of the CY 2006 hospital-based PHP claims. There are a total of 638,652 line items in the CY 2006 hospital-based PHP claims. Prior to remapping, there were 282,871 line items where a default CCR was used to estimate costs. After the remapping, there were 141,682 line items left defaulting to the hospitals' overall CCR. While this remapping creates a more accurate estimate of PHP per diem costs for a significant number of claims, there was not a large change in the resulting median per diem cost. The median per diem costs for hospital-based PHPs increased by $5.20 (from $191.80 to $197).

As part of our effort to produce the most accurate per diem cost estimate, we have reexamined our methodology for computing the PHP per diem cost. Section 1833(t)(2)(C) of the Act requires that we establish relative payment weights based on median (or mean, at the election of the Secretary) hospital costs determined by 1996 claims data and data from the most recent available cost reports. As explained in section II.B.1 of this proposed rule, payment to providers under OPPS for PHP services represents the provider's overhead costs associated with the program. Because a day of care is the unit that defines the structure and scheduling of partial hospitalization services, we established a per diem payment methodology for the PHP APC. Other than being a per diem payment, we use the general OPPS ratesetting methodology for determining median cost.

As we have described in prior **Federal Register** notices, our current method for computing per diem costs is as follows: we use data from all hospital bills reporting condition code 41, which identifies the claim as partial hospitalization, and all bills from CMHCs. We use CCRs from the most recently available hospital and CMHC cost reports to convert each provider's line-item charges as reported on bills to estimate the provider's cost for a day of PHP services. Per diem costs are then computed by summing the line-item costs on each bill and dividing by the number of days of PHP care provided on the bill. These computed per diem costs are arrayed from lowest to highest and the middle value of the array is the median per diem cost.

We have developed an alternate way to 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. 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 believe this alternative method of computing a per diem median cost produces a more accurate estimate because each day gets an equal weight towards computing the median. We have considered this alternative method for several years, but in light of the volatility of the data, we have not believed it would provide a reasonable and appropriate median per diem cost. In light of the stabilizing trend in the data, and in light of the robustness of recent data analysis, we now believe it is appropriate to propose the adoption of this method. We believe this method for computing a PHP per diem median cost more accurately reflects the costs of a PHP and uses all available PHP data. Therefore, for CY 2008, we are proposing to adopt this alternate method for computing PHP median per diem costs.

As noted previously, for the past 2 years, the data have produced median costs that we believe were too low to cover the cost of a program that typically spans 5 to 6 hours per day. This length of day would include 5 or 6 services with a break for lunch. We looked at the number of units of service being provided in a day of care, as a possible explanation for the low per diem cost for PHP. Our analysis revealed that both hospital-based and CMHC PHPs have a significant number of days where less than 4 units of service were provided.

Specifically, 64 percent of the days that CMHCs were paid were for days where 3 or less units of services were provided, and 34 percent of the days that hospital-based PHPs were paid were for days where 3 or less units of service were provided. We believe these findings are significant because they may explain a lower per diem cost. Therefore, based on these findings, we computed median per diem costs in two categories:

(a) All days.

(b) Days with 4 units of service or more (removing days with 3 services or less).

These median per diem costs were computed separately for CMHCs and hospital based PHPs and are shown in the table below:

	CMHCs	Hospital-based PHPs
All Days	$178	$186
Days with 4 units or more	$191	$218

As expected, excluding the low unit days resulted in a higher median per diem cost estimate. However, if the programs have many ''low unit days,'' their cost and Medicare payment should reflect this level of service. It would not be appropriate to set the PHP rate to exclude the ''low unit days'' because these days are covered PHP days. We believe the analysis of the number of units of service per day supports a lower per diem cost. Therefore, including all days supports the data trend towards a lower per diem cost and we believe more accurately reflects the costs of providing these PHP services.

Although the minimum number of PHP services required in a PHP day is three, it was never our intention that this represented the typical number of services to be provided in a typical PHP day. Our intention was to cover days that consisted of only three services, generally because a patient was transitioning towards discharge. Rather than set separate rates for half-days and full-days, we believed it was appropriate to set one rate that would be paid for all PHP days, including those for patients transitioning towards discharge. We intend that the PHP benefit is for a full day, with shorter days only occurring while a patient transitions out of the PHP.

However, as indicated in the data, many programs have these ''low unit days,'' and we believe their cost and Medicare payment should reflect this level of service. It would not be appropriate to set the PHP rate excluding the low unit days because these days are covered. Again, we believe the data support the estimated per diem cost under $200 that we have observed in the data.

At this time, we believe the most appropriate payment rate for PHPs is computed using both hospital-based and CMHC PHP data, including the remapped data for all days, resulting in a median per diem cost of $178. Therefore, we are proposing a CY 2008 APC PHP per diem cost of $178.

3. Proposed Separate Threshold for Outlier Payments to CMHCs

In the November 7, 2003 final rule with comment period (68 FR 63469), we indicated that, given the difference in PHP charges between hospitals and CMHCs, we did not believe it was appropriate to make outlier payments to CMHCs using the outlier percentage target amount and threshold established for hospitals. There was a significant difference in the amount of outlier payments made to hospitals and CMHCs for PHP. In addition, further analysis indicated that using the same OPPS

outlier threshold for both hospitals and CMHCs did not limit outlier payments to high cost cases and resulted in excessive outlier payments to CMHCs. Therefore, beginning in CY 2004, we established a separate outlier threshold for CMHCs. For CYs 2004 and 2005, we designated a portion of the estimated 2.0 percent outlier target amount specifically for CMHCs, consistent with the percentage of projected payments to CMHCs under the OPPS in each of those years, excluding outlier payments. For CY 2006, we set the estimated outlier target at 1.0 percent and allocated a portion of that 1.0 percent, 0.6 percent (or 0.006 percent of total OPPS payments), to CMHCs for PHP services. For CY 2007, we set the estimated outlier target at 1.0 percent and allocated a portion of that 1.0 percent, an amount equal to 0.15 percent of outlier payments and 0.0015 percent of total OPPS payments to CMHCS for PHP service outliers. The CY 2007 CMHC outlier threshold is met when the cost of furnishing services by a CMHC exceeds 3.40 times the PHP APC payment amount. The CY 2007 OPPS outlier payment percentage is 50 percent of the amount of costs in excess of the threshold.

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

As noted in section II.G. of this proposed rule, for CY 2008, we are proposing to continue our policy of setting aside 1.0 percent of the aggregate total payments under the OPPS for outlier payments. We are proposing that a portion of that 1.0 percent, an amount equal to 0.03 percent of outlier payments and 0.0003 percent of total OPPS payments, would be allocated to CMHCs for PHP service outliers. As discussed in section II.G. of this proposed rule, we again are proposing to set a dollar threshold in addition to an APC multiplier threshold for OPPS outlier payments. However, because the PHP is the only APC for which CMHCs may receive payment under the OPPS, we would not expect to redirect outlier payments by imposing a dollar threshold. Therefore, we are not proposing to set a dollar threshold for CMHC outliers. As noted above, we are proposing to set the outlier threshold for CMHCs for CY 2008 at 3.40 times the APC payment amount and the CY 2008 outlier payment percentage applicable to costs in excess of the threshold at 50 percent.

C. Proposed Conversion Factor Update

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

Section 1833(t)(3)(C)(ii) of the Act requires us to update the conversion factor used to determine payment rates under the OPPS on an annual basis. Section 1833(t)(3)(C)(iv) of the Act provides that, for CY 2008, the update is equal to the hospital inpatient market basket percentage increase applicable to hospital discharges under section 1886(b)(3)(B)(iii) of the Act.

The proposed hospital market basket increase for FY 2008 published in the IPPS proposed rule on May 3, 2007, is 3.3 percent (72 FR 24835). To set the OPPS proposed conversion factor for CY 2008, we increased the CY 2007 conversion factor of $61.468, as specified in the CY 2007 OPPS/ASC final rule with comment period (71 FR 68003), by 3.3 percent.

In accordance with section 1833(t)(9)(B) of the Act, we further adjusted the conversion factor for CY 2007 to ensure that the revisions that we are proposing to make to our updates for a revised wage index and rural adjustment are made on a budget neutral basis. We calculated an overall budget neutrality factor of 1.0025 for wage index changes by comparing total payments from our simulation model using the FY 2008 IPPS proposed wage index values to those payments using the current (FY 2007) IPPS wage index values. This adjustment reflects an adjustment of 1.0009 for changes to the wage index and an additional 1.0016 to accommodate the IPPS budget neutrality adjustment for inclusion of the rural floor. As discussed further in section II.D. of this proposed rule, for the first time, the proposed FY 2008 IPPS wage indices include a blanket budget neutrality adjustment for including the rural floor provision, which previously had been applied to the IPPS standardized amount. For further discussion of this proposed policy in its entirety, we refer readers to the FY 2008 IPPS proposed rule (72 FR 24787 through 24792). This proposed adjustment is specific to the IPPS. For the OPPS, we have increased the conversion factor by the proportional amount of the rural floor budget neutrality adjustment to accommodate this proposed change.

We estimated the rural adjustment for CY 2008 to reflect the proposed extension of the adjustment to payment for brachytherapy sources as discussed in section II.F.2. of this proposed rule, but as the impact of the proposed extension was negligible, we did not change the proposed rural adjustment. Therefore, we calculated a budget neutrality factor of 1.000 for the rural adjustment. For CY 2008, we estimate that allowed pass through spending for both drugs and devices would equal approximately $54 million, which represents 0.15 percent of total OPPS projected spending for CY 2008. The proposed conversion factor also is adjusted by the difference between the 0.21 percent pass through dollars set aside in CY 2007 and the 0.15 percent estimate for CY 2008 pass through spending. Finally, proposed payments for outliers remain at 1.0 percent of total payments for CY 2008.

The proposed market basket increase update factor of 3.3 percent for CY 2008, the required wage index and rural budget neutrality adjustment of approximately 1.0025, and the proposed adjustment of 0.06 percent for the difference in the pass-through set aside result in a proposed standard OPPS conversion factor for CY 2008 of $63.693.

D. Proposed Wage Index Changes

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

Section 1833(t)(2)(D) of the Act requires the Secretary to determine a wage adjustment factor to adjust, for geographic wage differences, the portion of the OPPS payment rate and the copayment standardized amount attributable to labor and labor related cost. Since the inception of the OPPS, CMS policy has been to wage adjust 60 percent of the OPPS payment, based on a regression analysis that determined that 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). We are not proposing to revise this policy for the CY 2008 OPPS. We refer readers to section II.H. of this proposed rule for a description and example of how the wage index for a

particular hospital is used to determine the payment for the hospital. This adjustment must be made in a budget neutral manner. (As we have done in prior years, we are proposing to adopt the final IPPS wage indices for the OPPS and to extend these wage indices to hospitals that participate in the OPPS but not the IPPS (referred to in this section as ''non IPPS'' hospitals).)

As discussed in section II.A. of this proposed rule, we standardize 60 percent of estimated costs (labor-related costs) for geographic area wage variation using the IPPS pre-reclassified wage indices in order to remove the effects of differences in area wage levels in determining the 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), OPPS has consistently adopted the final IPPS wage indices as the wage indices for adjusting the OPPS standard payment amounts for labor market differences. Thus, the wage index that applies to a particular hospital under the IPPS will also apply to that hospital under the OPPS. As initially explained in the September 8, 1998 OPPS proposed rule, we believed and continue to believe that using the IPPS wage index as the source of an adjustment factor for OPPS is reasonable and logical, given the inseparable, subordinate status of the hospital outpatient within the hospital overall. In accordance with section 1886(d)(3)(E) of the Act, the IPPS wage index is updated annually. In accordance with our established policy, we are proposing to use the final FY 2008 final version of these wage indices to determine the wage adjustments for the OPPS payment rate and copayment standardized amount that would be published in our final rule with comment period for CY 2008.

We note that the proposed FY 2008 IPPS wage indices continue to reflect a number of changes implemented over the past few years as a result of the revised Office of Management and Budget (OMB) standards for defining geographic statistical areas, the implementation of an occupational mix adjustment as part of the wage index, wage adjustments provided for under Pub. L. 105–33 and Pub. L. 108–173, and clarification of our policy for multicampus hospitals. The following is a brief summary of the components of the proposed FY 2008 IPPS wage indices and any adjustments that we are proposing to apply to the OPPS for CY 2008. We refer the reader to the FY 2008 IPPS proposed rule (72 FR 24776 through 24802) for a detailed discussion of the changes to the wage indices and to the correction notice to the FY 2008 IPPS proposed rule published in the **Federal Register** on June 7, 2007 (72 FR 31507). In this proposed rule, we are not reprinting the proposed FY 2008 IPPS wage indices referenced in the discussion below, with the exception of the out-migration wage adjustment table (Addendum L to this proposed rule). We also refer readers to the CMS Web site for the OPPS at *http://www.cms.hhs.gov/providers/hopps*. At this Web site, the reader will find a link to the proposed FY 2008 IPPS wage indices tables and to those tables as corrected in the correction notice to the FY 2008 IPPS proposed rule published in the **Federal Register** on June 7, 2007.

1. *The proposed continued use of the Core Based Statistical Areas (CBSAs) issued by the OMB as revised standards for designating geographical statistical areas based on the 2000 Census data, to define labor market areas for hospitals for purposes of the IPPS wage index.* The OMB revised standards were published in the **Federal Register** on December 27, 2000 (65 FR 82235), and OMB announced the new CBSAs on June 6, 2003, through an OMB bulletin. In the FY 2005 IPPS final rule, CMS adopted the new OMB definitions for wage index purposes. In the FY 2008 IPPS proposed rule, we again stated that hospitals located in Metropolitan Statistical Areas (MSAs) will be urban and hospitals that are located in Micropolitan Areas or outside CBSAs will be rural. We also reiterated our policy that when an MSA is divided into one or more Metropolitan Divisions, we use the Metropolitan Division for purposes of defining the boundaries of a particular labor market area. To help alleviate the decreased payments for previously urban hospitals that became rural under the new geographical definitions, we allowed these hospitals to maintain for the 3-year period from FY 2005 through FY 2007, the wage index of the MSA where they previously had been located. This hold harmless provision expires after FY 2007. We adopted the same policy for OPPS, but because the OPPS operates on a calendar year, wage index policies are in effect through December 31, 2007. To be consistent with the IPPS, as proposed in the FY 2008 IPPS proposed rule, beginning in CY 2008 (January 1, 2008) under the OPPS, these hospitals will receive their statewide rural wage index. Hospitals paid under the IPPS are eligible to apply for reclassification in FY 2008.

As noted above, for purposes of estimating an adjustment for the OPPS payment rates to accommodate geographic differences in labor costs in this proposed rule, we have used the wage indices identified in the FY 2008 IPPS proposed rule and as corrected in the June 7, 2007 correction notice to the FY 2008 IPPS proposed rule, that are fully adjusted for differences in occupational mix using the entire 6-month survey data collected in 2006.

2. *The reclassifications of hospitals to geographic areas for purposes of the wage index.* For purposes of the OPPS wage index, we are proposing to adopt all of the IPPS reclassifications for FY 2008, including reclassifications that the Medicare Geographic Classification Review Board (MGCRB) approved. We note that reclassifications under section 508 of Pub. L. 108–173 were set to terminate March 31, 2007. However, section 106(a) of the MIEA-TRHCA extended any geographic reclassifications of hospitals that were made under section 508 and that would expire on March 31, 2007 until September 30, 2007. On March 23, 2007, we published a notice in the **Federal Register** (72 FR 13799) that indicated how we are implementing section 106 of the MIEA-TRHCA through September 30, 2007. Because the section 508 provision will expire on September 30, 2007, the OPPS wage index will not include any reclassifications under section 508 for CY 2008.

3. *The out-migration wage adjustment to the wage index.* In the FY 2008 IPPS proposed rule (72 FR 24798 through 24799), we discussed the out-migration adjustment under section 505 of Pub. L. 108–173 for counties under this adjustment. Hospitals paid under the IPPS located in the qualifying section 505 ''out-migration'' counties receive a wage index increase unless they have already been otherwise reclassified. We note that in the FY 2008 IPPS proposed rule, we propose using the post-reclassified, rather than the pre-reclassified wage indices, in calculating the out-migration adjustment. (See the FY 2008 IPPS proposed rule for further information on the out-migration adjustment.) For OPPS purposes, we are proposing to continue our policy in CY 2008 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. Because non-IPPS hospitals cannot reclassify, they are eligible for the out migration wage adjustment. Table 4J published in the addendum to the FY 2008 IPPS proposed rule and as corrected in the June 7, 2007 correction notice to the FY 2008 IPPS proposed rule identifies counties eligible for the out-migration adjustment. As stated earlier, we are reprinting the corrected

version of Table 4J in this proposed rule as Addendum L.

4. *Wage Index for Multicampus Hospitals.* We also wish to clarify that the IPPS policy for multicampus wage index payments also applies to OPPS. As a result of the new labor market areas introduced in FY 2005, there are hospitals with multiple campuses previously located in a single MSA that are now in more than one CBSA. A multicampus hospital is an integrated institution. For this reason, the multicampus hospital has one provider number and submits a single cost report that combines the total wages and hours of each of its campuses in the manner described in the FY 2008 IPPS proposed rule (72 FR 24783).

In the FY 2008 IPPS proposed rule, we proposed to apportion wages and hours across multiple campuses using full-time equivalent (FTE) staff data in order to include wage data for the individual campuses of a multicampus hospital in its local wage index calculation. To the extent that a multicampus hospital system has associated outpatient facilities, we would expect the FTEs for those outpatient facilities to be included in the FTE estimate for the closest inpatient facility. As part of this policy, we would fully expect that an OPD that is part of a multicampus hospital system would receive a wage index based on the geographic location of the inpatient campus with which it is associated. This would include cases where one inpatient campus reclassified. Affiliated outpatient facilities would receive the reclassified wage index of the inpatient campus. For further discussion of the FY 2008 IPPS proposed multicampus hospital policy in its entirety, we refer readers to the FY 2008 IPPS proposed rule (72 FR 24783 through 24784).

5. *Rural Floor Provision.* Section 4410 of Pub. L. 105–33 provides that the area wage index applicable to any hospital that is located in an urban area of a State may not be less than the area wage index applicable to hospitals located in rural areas of the State (''the rural floor''). Table 4A in the FY 2008 IPPS proposed rule (72 FR 24924), as corrected in the June 7, 2007 correction notice (72 FR 31507), identifies urban areas where hospitals located in those areas are assigned the rural floor (noted by a superscript ''2''). For CY 2008 under the OPPS, we are proposing to continue our policy to allow non-IPPS hospitals paid under the OPPS to receive the rural floor wage index when applicable under the IPPS for FY 2008. For the first time, the proposed FY 2008 IPPS wage indices include a blanket budget neutrality adjustment for including the rural floor provision, which previously had been applied to the IPPS standardized amount. For further discussion of this proposed policy in its entirety, we refer readers to the FY 2008 IPPS proposed rule (72 FR 24787 through 24792).

We note that all changes to the wage index resulting from geographic labor market area reclassifications or other adjustments must be incorporated in a budget neutral manner. Accordingly, in calculating the OPPS budget neutrality estimates for CY 2008, in this proposed rule, we have included the wage index changes that would result from the MGCRB reclassifications, implementation of sections 4410 of Pub. L. 105–33 and 505 of Pub. L. 108–173, and other refinements proposed in the FY 2008 IPPS proposed rule. For the CY 2008 OPPS final rule, we are proposing to use the final FY 2008 IPPS wage indices, including the budget neutrality adjustment for the rural floor for calculating OPPS payment in CY 2008. We discuss how the proposed OPPS conversion factor compensates for the inclusion of this budget neutrality adjustment in the wage indices in the budget neutrality section (II.C.) of this proposed rule.

E. Proposed Statewide Average Default CCRs

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

CMS uses CCRs to determine outlier payments, payments for pass-through devices, and monthly interim transitional corridor payments under the OPPS. Some hospitals do not have a valid CCR. These hospitals include, but are not limited to, hospitals that are new and have not yet submitted a cost report, hospitals that have a CCR that falls outside predetermined floor and ceiling thresholds for a valid CCR, or hospitals that have recently given up their all-inclusive rate status. Last year, we updated the default urban and rural CCRs for CY 2007 in our final rule with comment period (71 FR 68006 through 68009). In this proposed rule, we are proposing to update the default ratios for CY 2008 using the most recent cost report data.

We calculated the statewide default CCRs using the same overall CCRs that we use to adjust charges to costs on claims data. Table 25 lists the proposed CY 2008 default urban and rural CCRs by State and compares them to last year's default CCRs. These CCRs are the ratio of total costs to total charges from each provider's most recently submitted cost report, for those cost centers relevant to outpatient services weighted by Medicare Part B charges. We also adjusted these ratios to reflect final settled status by applying the differential between settled to submitted costs and charges from the most recent pair of settled to submitted cost reports.

For this proposed rule, 78.17 percent of the submitted cost reports represented data for CY 2005. We only used valid CCRs to calculate these default ratios. That is, we removed the CCRs for all-inclusive hospitals, CAHs, and hospitals in Guam, and the U.S. Virgin Islands, American Samoa, and the Northern Mariana Islands because these entities are not paid under the OPPS, or in the case of all-inclusive hospitals, because their CCRs are suspect. We further identified and removed any obvious error CCRs and trimmed any outliers. We limited the hospitals used in the calculation of the default CCRs to those hospitals that billed for services under the OPPS during CY 2006.

Finally, we calculated an overall average CCR, weighted by a measure of volume for CY 2006, for each state except Maryland. This measure of volume is the total lines on claims and is the same one that we use in our impact tables. For Maryland, we used an overall weighted average CCR for all hospitals in the nation as a substitute for Maryland CCRs. Few providers in Maryland are eligible to receive payment under the OPPS, which limits the data available to calculate an accurate and representative CCR. The observed differences between last year's and this year's default statewide CCRs largely reflect a general decline in the ratio between costs and charges widely observed in the cost report data. However, observed increases in some areas suggest that the decline in CCRs is moderating. Further, the addition of weighting by Part B charges to the overall CCR in CY 2007 slightly increases the variability of the overall CCR calculation.

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

For CY 2008, we are proposing to continue to apply this treatment of using the default statewide CCR, to include an entity that has not accepted assignment of an existing hospital's provider agreement in accordance with § 489.18, and that has not yet submitted its first Medicare cost report. This policy is effective for hospitals experiencing a change of ownership on or after January 1, 2007. As stated in the CY 2007 OPPS/ASC final rule with comment period (71 FR 68006), we believe that a hospital that has not accepted assignment of an existing hospital's provider agreement is similar to a new hospital that will establish its own costs and charges. We also believe that the hospital that has chosen not to accept assignment may have different costs and charges than the existing hospital. Furthermore, we believe that the hospital should be provided time to establish its own costs and charges. Therefore, we are proposing to use the default statewide CCR to determine cost-based payments until the hospital has submitted its first Medicare cost report.

TABLE 25.—PROPOSED CY 2008 STATEWIDE AVERAGE CCRS

State	Rural/urban	Proposed CY 2008 default CCR	Previous default CCR (CY 2007 OPPS final rule)
ALASKA	RURAL	0.5389	0.5337
ALASKA	URBAN	0.3851	0.3830
ALABAMA	RURAL	0.2317	0.2321
ALABAMA	URBAN	0.2198	0.2228
ARKANSAS	RURAL	0.2660	0.2645
ARKANSAS	URBAN	0.2776	0.2749
ARIZONA	RURAL	0.2770	0.2823
ARIZONA	URBAN	0.2360	0.2323
CALIFORNIA	RURAL	0.2305	0.2463
CALIFORNIA	URBAN	0.2260	0.2324
COLORADO	RURAL	0.3677	0.3704
COLORADO	URBAN	0.2578	0.2672
CONNECTICUT	RURAL	0.3888	0.3886
CONNECTICUT	URBAN	0.3481	0.3491
DISTRICT OF COLUMBIA	URBAN	0.3364	0.3392
DELAWARE	RURAL	0.3192	0.3230
DELAWARE	URBAN	0.3952	0.3953
FLORIDA	RURAL	0.2175	0.2191
FLORIDA	URBAN	0.1985	0.1990
GEORGIA	RURAL	0.2842	0.2846
GEORGIA	URBAN	0.2786	0.2888
HAWAII	RURAL	0.3781	0.3574
HAWAII	URBAN	0.3171	0.3199
IOWA	RURAL	0.3499	0.3489
IOWA	URBAN	0.3379	0.3428
IDAHO	RURAL	0.4369	0.4360
IDAHO	URBAN	0.4097	0.4159
ILLINOIS	RURAL	0.2910	0.3082
ILLINOIS	URBAN	0.2812	0.2878
INDIANA	RURAL	0.3207	0.3160
INDIANA	URBAN	0.3155	0.3204
KANSAS	RURAL	0.3201	0.3200
KANSAS	URBAN	0.2466	0.2523
KENTUCKY	RURAL	0.2480	0.2508
KENTUCKY	URBAN	0.2666	0.2698
LOUISIANA	RURAL	0.2727	0.2808
LOUISIANA	URBAN	0.2842	0.2730
MARYLAND	RURAL	0.2924	0.3181
MARYLAND	URBAN	0.3140	0.2978
MASSACHUSETTS	URBAN	0.3466	0.3487
MAINE	RURAL	0.4580	0.4568
MAINE	URBAN	0.4261	0.4294
MICHIGAN	RURAL	0.3354	0.3461
MICHIGAN	URBAN	0.3272	0.3286
MINNESOTA	RURAL	0.5094	0.5085
MINNESOTA	URBAN	0.3452	0.3383
MISSOURI	RURAL	0.2916	0.2944
MISSOURI	URBAN	0.2977	0.3034
MISSISSIPPI	RURAL	0.2820	0.2841
MISSISSIPPI	URBAN	0.2300	0.2312
MONTANA	RURAL	0.4664	0.4392
MONTANA	URBAN	0.4646	0.4628
NORTH CAROLINA	RURAL	0.3007	0.3048
NORTH CAROLINA	URBAN	0.3580	0.3700
NORTH DAKOTA	RURAL	0.3831	0.3668
NORTH DAKOTA	URBAN	0.3842	0.3945
NEBRASKA	RURAL	0.3561	0.3756

TABLE 25.—PROPOSED CY 2008 STATEWIDE AVERAGE CCRS—Continued

State	Rural/urban	Proposed CY 2008 default CCR	Previous default CCR (CY 2007 OPPS final rule)
NEBRASKA	URBAN	0.2832	0.2899
NEW HAMPSHIRE	RURAL	0.3646	0.3700
NEW HAMPSHIRE	URBAN	0.3217	0.3249
NEW JERSEY	URBAN	0.2908	0.2972
NEW MEXICO	RURAL	0.2759	0.2741
NEW MEXICO	URBAN	0.3691	0.3978
NEVADA	RURAL	0.3370	0.3348
NEVADA	URBAN	0.1949	0.2141
NEW YORK	RURAL	0.4210	0.4446
NEW YORK	URBAN	0.4177	0.4275
OHIO	RURAL	0.3629	0.3689
OHIO	URBAN	0.2760	0.2834
OKLAHOMA	RURAL	0.2874	0.2949
OKLAHOMA	URBAN	0.2517	0.2608
OREGON	RURAL	0.3344	0.3438
OREGON	URBAN	0.3899	0.4054
PENNSYLVANIA	RURAL	0.2980	0.3052
PENNSYLVANIA	URBAN	0.2448	0.2524
PUERTO RICO	URBAN	0.4718	0.4689
RHODE ISLAND	URBAN	0.3085	0.3087
SOUTH CAROLINA	RURAL	0.2589	0.2546
SOUTH CAROLINA	URBAN	0.2563	0.2479
SOUTH DAKOTA	RURAL	0.3517	0.3479
SOUTH DAKOTA	URBAN	0.2918	0.3035
TENNESSEE	RURAL	0.2607	0.2648
TENNESSEE	URBAN	0.2514	0.2491
TEXAS	RURAL	0.2823	0.2891
TEXAS	URBAN	0.2495	0.2580
UTAH	RURAL	0.4320	0.4410
UTAH	URBAN	0.4218	0.4161
VIRGINIA	RURAL	0.2788	0.2821
VIRGINIA	URBAN	0.2789	0.2805
VERMONT	RURAL	0.4329	0.4325
VERMONT	URBAN	0.3401	0.3376
WASHINGTON	RURAL	0.3796	0.3742
WASHINGTON	URBAN	0.3574	0.3717
WISCONSIN	RURAL	0.3633	0.3670
WISCONSIN	URBAN	0.3648	0.3638
WEST VIRGINIA	RURAL	0.3134	0.3162
WEST VIRGINIA	URBAN	0.3677	0.3691
WYOMING	RURAL	0.4655	0.4714
WYOMING	URBAN	0.3592	0.3520

F. Proposed OPPS Payments to Certain Rural Hospitals

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

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

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

Section 5105 of Pub. L. 109–171 reinstituted the hold harmless transitional outpatient payments (TOPs) for covered OPD services furnished on or after January 1, 2006, and before January 1, 2009, for rural hospitals having 100 or fewer beds that are not SCHs. When the OPPS payment is less than the payment the provider would have received under the previous

reasonable cost-based system, the amount of payment is increased by 95 percent of the amount of the difference between those two payment systems for CY 2006, by 90 percent of the amount of that difference for CY 2007, and by 85 percent of the amount of that difference for CY 2008.

For CY 2006, we implemented section 5105 of Pub. L. 109–171 through Transmittal 877, issued on February 24, 2006. We did not specifically address whether TOPs payments 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. Therefore, we believe that EACHs are not currently eligible for TOPs payment under Pub. L. 109–171. In the CY 2007 OPPS/ASC final rule with comment period, we updated § 419.70(d) to reflect the requirements of Pub. L. 109 171 (71 FR 68010 and 68228).

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

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

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

Last year, 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. Currently, fewer than 10 hospitals are classified as EACHs. As of CY 1998, under section 4201(c) of Pub. L. 105–33, a hospital can no longer become newly classified as an EACH. Therefore, in the CY 2007 OPPS/ASC final rule with comment period 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 (71 FR 68010 and 68227).

This adjustment is budget neutral and applied before calculating outliers and coinsurance. 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 might review the adjustment in the future and, if appropriate, would revise the adjustment.

For CY 2008, we are proposing to continue our current policy of a budget neutral 7.1 percent payment increase for rural SCHs, including EACHs, for all services and procedures paid under the OPPS, excluding drugs, biologicals, and services paid under the pass-through payment policy in accordance with section 1833(t)(13)(B) of the Act. For CY 2008, we are proposing to include brachytherapy sources in the group of services eligible for the 7.1 percent payment increase because we are proposing to pay them at prospective rates based on their median costs as calculated from historical claims data. Consequently, we are proposing to revise § 419.43 to reflect our proposal to make brachytherapy sources eligible for the 7.1 percent payment increase for rural SCHs. We plan to reassess the 7.1 percent adjustment in the near future by examining differences between urban and rural costs using updated claims, cost, and provider information. In that process, we will include brachytherapy sources in each hospital's mix of services.

G. Proposed Hospital Outpatient Outlier Payments

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

Currently, the OPPS pays outlier payments on a service-by-service basis. For CY 2007, the outlier threshold is met when the cost of furnishing a service or procedure by a hospital exceeds 1.75 times the APC payment amount and exceeds the APC payment rate plus a $1,825 fixed-dollar threshold. We introduced a fixed-dollar threshold in CY 2005 in addition to the traditional multiple threshold in order to better target outliers to those high cost and complex procedures where a very costly service could present a hospital with significant financial loss. If a provider meets both of these conditions, the multiple threshold and the fixed-dollar threshold, the outlier payment is calculated as 50 percent of the amount by which the cost of furnishing the service exceeds 1.75 times the APC payment rate.

As explained in the CY 2007 OPPS/ASC final rule with comment period (71 FR 68011 through 68012), we set our projected target for aggregate outlier payments at 1.0 percent of aggregate total payments under the OPPS for CY 2007. The outlier thresholds were set so that estimated CY 2007 aggregate outlier payments would equal 1.0 percent of aggregate total payments under the OPPS. In that final rule with comment period (71 FR 68010), we also published total outlier payments as a percent of total expenditures for CY 2005. In the past, we have received comments asking us to publish estimated outlier payments to provide a context for the proposed outlier thresholds for the update year. Our current estimate, using available CY 2006 claims, is that outlier payments for CY 2006 would be approximately 1.1 percent of total CY 2006 OPPS payment. Using the same set of claims and CY 2007 payment rates, we currently estimate that outlier payments for CY 2007 would be approximately 1.0 percent of total CY 2007 OPPS payments. We note that we provide estimated CY 2008 outlier payments by hospital for hospitals with claims included in the claims data that we used to model impacts on the CMS Web site in the Hospital Specific Impacts—Provider-Specific Data file on the CMS Web site at: *http://www.cms.hhs.gov/HospitalOutpatientPPS/*.

For CY 2008, we are proposing to continue our policy of setting aside 1.0 percent of aggregate total payments under the OPPS for outlier payments. We are proposing that a portion of that 1.0 percent, 0.03 percent, would be allocated to CMHCs for partial hospitalization program service outliers. This amount is the amount of estimated outlier payments resulting from the proposed CMHC outlier threshold of 3.4 times the APC payment rate, as a proportion of all payments dedicated to outlier payments. For further discussion of CMHC outliers, we refer readers to section II.B.3. of this proposed rule.

In order to ensure that estimated CY 2008 aggregate outlier payments would equal 1.0 percent of estimated aggregate total payments under the OPPS, we are proposing that the outlier threshold be set so that outlier payments 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 $2,000 fixed-dollar threshold. This proposed threshold reflects minor changes to the

methodology discussed below as well as APC recalibration, including changes due in part to the CY 2008 packaging proposal discussed in section II.A.4. of this proposed rule.

We calculated the fixed-dollar threshold for this CY 2008 proposed rule using largely the same methodology as we did in CY 2007, except that we are proposing to adjust the overall CCRs to reflect the anticipated annual decline in overall CCRs, discussed below, and to use CCRs from the most recent update to the Outpatient Provider-Specific File (OPSF), rather than CCRs we calculate internally for ratesetting. In November 2006, we issued Transmittal 1030, ''Policy Changes to the Fiscal Intermediary (FI) Calculation of Hospital Outpatient Payment System (OPPS) and Community Mental Health Center (CMHC) Cost-to-Charge Ratios (CCRs),'' instructing fiscal intermediaries (or, if applicable, the MAC) to update the overall CCR calculation for outlier and other cost-based payments using the CCR calculation methodology that we finalized for CY 2007. As discussed in the CY 2007 proposed and final rules, this methodology aligned the fiscal intermediary's CCR calculation and the CCR calculation we previously used to model outlier thresholds by removing allied and nursing health costs for those hospitals with paramedical education programs from the fiscal intermediary's CCR calculation and weighting our ''traditional'' CCR calculation by total Medicare Part B charges. We believe that the OPSF best estimates the CCRs that fiscal intermediaries (or, if applicable, MAC) would use to determine outlier payments in CY 2008. For this proposed rule, we used the April update to the OPSF. We supplemented a CCR calculated internally for the handful of providers with claims in our claims dataset that were not listed in the April update to the OPSF.

The claims that we use to model each OPPS update lag by 2 years. For this proposed rule, we used CY 2006 claims to model the CY 2008 OPPS. In order to estimate CY 2008 outlier payments for this proposed rule, we inflated the charges on the CY 2006 claims using the same inflation factor of 1.1504 that we used to estimate the IPPS fixed dollar outlier threshold for the FY 2008 IPPS proposed rule. For 1 year, the inflation factor is 1.0726. The methodology for determining this charge inflation factor was discussed in the FY 2008 IPPS proposed rule (72 FR 24837). As we stated in the CY 2005 OPPS final rule with comment period, we believe that the use of this charge inflation factor is appropriate for the 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).

In comments on the CY 2007 OPPS/ASC proposed rule, a commenter asked that CMS modify the charge methodology used to set the OPPS outlier threshold to account for the change in CCRs over time in a manner similar to that used for the FY 2007 IPPS. The commenter indicated that it would be appropriate to apply an inflation adjustment factor so that the CCRs that CMS uses to simulate OPPS outlier payments would more closely reflect the CCRs that would be used in CY 2007 to determine actual outlier payment. In the CY 2007 OPPS/ASC final rule with comment period, we expressed concern that cost increases between inpatient and outpatient departments could be different and indicated that we would study the issue and address any changes to the outlier methodology through future rulemaking (71 FR 68012).

In assessing the possibility of utilizing a cost inflation adjustment for the OPPS, we determined that we could not calculate an OPPS-specific reliable cost per unit, comparable to the cost per discharge component of the IPPS calculation, because of variability in definition of an OPPS unit of service across calendar years. However, we also believe that the costs and charges reported under the applicable cost centers largely are commingled inpatient and outpatient costs and charges. Notwithstanding fairly accurate estimates of outlier payments as a percent of total payments over the past few years, as discussed above, we do not want to systematically overestimate the OPPS outlier threshold as could occur if we did not apply a CCR inflation adjustment factor. Therefore, we are proposing to apply the CCR inflation adjustment factor that is proposed to be applied for IPPS outlier calculation to the CCRs used to simulate the CY 2008 OPPS outlier payments that determine the fixed dollar threshold. Specifically, for CY 2008, we are proposing to apply an adjustment of 0.9912 to the CCRs that are currently on the OPSF to trend them forward from CY 2007 to CY 2008. The methodology for calculating this adjustment is discussed in the FY 2008 IPPS proposed rule (72 FR 24837).

Therefore, for this CY 2008 proposed rule, we applied the overall CCRs from the April 2007 OPSF file after adjustment to approximate CY 2008 CCRs (using the proposed CCR inflation adjustment factor of 0.9912) to charges on CY 2006 claims that were adjusted to approximate CY 2008 charges (using the proposed charge inflation factor of 1.1504). We simulated aggregated CY 2008 outlier payments using these costs for several different fixed-dollar thresholds, holding the 1.75 multiple 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 2008 OPPS payments. We estimate that a proposed fixed dollar threshold of $2,000, 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 are proposing 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 fixed dollar $2,000 threshold are met. For CMHCs, if a CMHC provider's cost for partial hospitalization exceeds 3.4 times the payment rate for APC 0033, the outlier payment is calculated as 50 percent of the amount by which the cost exceeds 3.4 times the APC payment rate.

H. Calculation of the Proposed National Unadjusted Medicare Payment

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

The basic methodology for determining prospective payment rates for OPD services under the OPPS is set forth in existing regulations at § 419.31 and § 419.32. The payment rate for services and procedures for which payment is made under the OPPS is the product of the conversion factor calculated in accordance with section II.C. of this proposed rule and the relative weight determined under section II.A. of this proposed rule. Therefore, the national unadjusted payment rate for each APC contained in Addendum A to this proposed rule and for HCPCS codes to which payment under the OPPS has been assigned in Addendum B to this proposed rule (Addendum B is provided as a convenience for readers) was calculated by multiplying the proposed CY 2008 scaled weight for the APC by the proposed CY 2008 conversion factor.

However, to determine the payment that will be made in a calendar year under the OPPS to a specific hospital for

an APC for a service that has a status indicator of ''S,'' ''T,'' ''V,'' or ''X'' in a circumstance in which the multiple procedure discount does not apply, we take the following steps:

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

Step 2. Determine the wage index area in which the hospital is located and identify the wage index level that applies to the specific hospital. The wage index values assigned to each area reflect the new geographic statistical areas as a result of revised OMB standards (urban and rural) to which hospitals are assigned for FY 2008 under the IPPS, reclassifications through the MCGRB, section 1886(d)(8)(B) ''Lugar'' hospitals, and section 401 of Pub. L. 108–173. We note that the reclassifications of hospitals under the one-time appeals process under section 508 of Pub. L. 108–173 expires on September 30, 2007, and is no longer applicable in this determination of appropriate wage values for CY 2008 OPPS. The wage index values include the occupational mix adjustment described in section II.D. of this proposed rule that was developed for the proposed FY 2008 IPPS payment rates published in the **Federal Register** on May 3, 2007 (72 FR 24777 through 27782).

Step 3. Adjust the wage index of hospitals located in certain qualifying counties that have a relatively high percentage of hospital employees who reside in the county, but who work in a different county with a higher wage index, in accordance with section 505 of Pub. L. 108–173. Addendum L to this proposed rule contains the qualifying counties and the proposed wage index increase developed for the FY 2008 IPPS as corrected in the June 7, 2007 correction notice to the FY 2008 IPPS proposed rule (72 FR 31507). This step is to be followed only if the hospital has chosen not to accept reclassification under Step 2 above.

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

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

Step 6. If a provider is a SCH, as defined in § 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 § 412.63(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.

I. Proposed Beneficiary Copayments

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

1. Background

Section 1833(t)(3)(B) of the Act requires the Secretary to set rules for determining copayment amounts to be paid by beneficiaries for covered OPD services. Section 1833(t)(8)(C)(ii) of the Act specifies that the Secretary must reduce the national unadjusted copayment amount for a covered OPD service (or group of such services) furnished in a year in a manner so that the effective copayment rate (determined on a national unadjusted basis) for that service in the year does not exceed specified percentages. For all services paid under the OPPS in CY 2008, and in calendar years thereafter, the specified percentage is 40 percent of the APC payment rate (section 1833(t)(8)(C)(ii)(V) of the Act). Section 1833(t)(3)(B)(ii) of the Act provides that, for a covered OPD service (or group of such services) furnished in a year, the national unadjusted coinsurance amount cannot be less than 20 percent of the OPD fee schedule amount. Sections 1834(d)(2)(C)(ii) and (d)(3)(C)(ii) of the Act further requires that the coinsurance for screening flexible sigmoidoscopies and screening colonoscopies be equal to 25 percent of the payment amount. We have applied the 25-percent coinsurance to screening flexible sigmoidoscopies and screening colonoscopies since the beginning of the OPPS.

2. Proposed Copayment

For CY 2008, we are proposing to determine copayment amounts for new and revised APCs using the same methodology that we implemented for CY 2004. (We refer readers to the November 7, 2003 OPPS final rule with comment period (68 FR 63458).) The proposed unadjusted copayment amounts for services payable under the OPPS that would be effective January 1, 2008, are shown in Addendum A and Addendum B to this proposed rule.

We note that we have historically used standard rounding principles to establish a 20 percent copayment for those few circumstances where the copayment rate was between 19.5 and 20 percent using our established copayment rules. For example, the CY 2008 proposed payment and copayment amounts for APC 9228 (Tigecycline injection) are $0.91 and $0.18, respectively. Twenty percent of $0.91 is $0.182. Because it would be impossible to set a copayment rate at exactly 20 percent in this case, that is, $0.182, we rounded the amount, using standard rounding principles, to $0.18. Also using standard rounding principles, 19.78 percent ($0.18 as a percentage of $0.91) rounds to 20 percent and meets the statutory requirement of a copayment amount of at least 20 percent. For CY 2008, APC 9046 (Iron Sucrose Injection) has a proposed payment amount and copayment amount of $0.37 and $0.08, respectively. Using our established copayment rules, 20 percent of $0.37 is $0.074. Normally, we would apply standard rounding principles to achieve an amount that is payable, here $0.07 rather than $0.074. However, if we were to set a copayment amount of $0.07, which is 18.9 percent of $0.37, we would not be setting a copayment rate that is at least 20 percent of the OPPS payment rate. We believe that section 1833(t)(3)(B) of the Act requires us to set a copayment amount that is at least 20 percent of the OPPS payment amount, not less than 20 percent. Therefore, we are proposing to set the copayment rate for APC 9046 at $0.08. Eight cents represents the lowest amount that we could set that would bring the copayment rate to 20 percent or, in this case, just above 20 percent. We are proposing to apply this same methodology in the future to instances where the application of our standard copayment methodology would result in a copayment amount that is under 20 percent and cannot be rounded, under standard rounding principles, to 20 percent.

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

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

Step 1. Calculate the beneficiary payment percentage for the APC by

dividing the APC's national unadjusted copayment by its payment rate. For example, using APC 0001, $7.00 is 21 percent of $33.15.

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

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 proposed unadjusted copayments for services payable under the OPPS that would be effective January 1, 2008, are shown in Addendum A and Addendum B to this proposed rule.

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

A. Proposed Treatment of New HCPCS and CPT Codes

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

1. Proposed Treatment of New HCPCS Codes Included in the April and July Quarterly OPPS Updates for CY 2007

For the July quarter of CY 2007, we created a total of 16 new Level II HCPCS codes, specifically C2638, C2639, C2640, C2641, C2642, C2643, C2698, C2699, C9728, Q4087, Q4088, Q4089, Q4090, Q4091, Q4092, and Q4095 that were not addressed in the CY 2007 OPPS/ASC final rule with comment period that updated the CY 2007 OPPS. We designated the payment status of these codes and added them through the July 2007 update (Change Request 5623, Transmittal 1259, dated June 1, 2007). There were no new Level II HCPCS codes for the April 2007 update. In this CY 2008 OPPS/ASC proposed rule, we are soliciting public comment on the status indicators, APC assignments, and payment rates of these codes, which are listed in Table 26A and Table 26B of this proposed rule. Because of the timing of this proposed rule, the codes implemented through the July 2007 OPPS update are not included in Addendum B to this proposed rule. We are proposing to assign the new HCPCS codes for CY 2008 to the appropriate APCs with the proposed rates as displayed in the tables and incorporate them into our final rule with comment period for CY 2008, which is consistent with our annual APC updating policy.

TABLE 26A.—NEW NON-DRUG HCPCS CODES IMPLEMENTED IN JULY 2007

HCPCS code	Long descriptor	Proposed CY 2008 status indicator	Proposed CY 2008 APC	Proposed CY 2008 payment rate	Implementation date
C2638	Brachytherapy source, stranded, iodine-125, per source	K	2638	$ 42.86	July 1, 2007.
C2639	Brachytherapy source, non-stranded, iodine-125, per source	K	2639	31.91	July 1, 2007.
C2640	Brachytherapy source, stranded, palladium-103, per source	K	2640	62.24	July 1, 2007.
C2641	Brachytherapy source, non-stranded, palladium-103, per source	K	2641	45.29	July 1, 2007.
C2642	Brachytherapy source, stranded, cesium-131, per source	K	2642	97.72	July 1, 2007.
C2643	Brachytherapy source, non stranded, cesium-131, per source	K	2643	51.35	July 1, 2007.
C2698	Brachytherapy source, stranded, not otherwise specified, per source	K	2698	42.86	July 1, 2007.
C2699	Brachytherapy source, non-stranded, not otherwise specified, per source.	K	2699	29.93	July 1, 2007.
C9728	Placement of interstitial device(s) for radiation therapy/surgery guidance (eg, fiducial markers, dosimeter), other than prostate (any approach) single or multiple.	T	0156	194.91	July 1, 2007.

TABLE 26B.—NEW DRUG HCPCS CODES IMPLEMENTED IN JULY 2007

HCPCS code	Long descriptor	Proposed CY 2008 status indicator	Proposed CY 2008 APC	Proposed CY 2008 payment rate	Implementation date
Q4087	Injection, immune globulin, (Octogam), intravenous, non-lyophilized, (e.g. liquid), 500 mg.	K	0943	$ 33.48	July 1, 2007.
Q4088	Injection, immune globulin, (Gammagard), intravenous, non-lyophilized, (e.g. liquid), 500 mg.	K	0944	31.20	July 1, 2007.
Q4089	Injection, rho(d) immune globulin (human), (Rhophylac), intravenous, 100 iu.	K	0945	80.00	July 1, 2007.
Q4090	Injection, hepatitis b immune globulin (Hepagam B), intramuscular, 0.5 ml.	K	0946	64.74	July 1, 2007.
Q4091	Injection, immune globulin, (Flebogamma), intravenous, non-lyophilized, (e.g. liquid), 500 mg.	K	0947	32.61	July 1, 2007.
Q4092	Injection, immune globulin, (Gamunex), intravenous, non-lyophilized, (e.g. liquid), 500 mg.	K	0948	31.86	July 1, 2007.
Q4095	Injection, zoledronic acid (Reclast), 1 mg	K	0951	220.81	July 1, 2007.

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

As has been our practice in the past, we implement new Category I and III CPT codes and new Level II HCPCS codes, which are released in the summer through the fall of each year for annual updating, effective January 1, in the final rule updating the OPPS for the following calendar year. These codes are flagged with comment indicator ''NI'' in Addendum B 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 following publication of the final rule that implements the annual OPPS update. (We refer readers to the discussion immediately below concerning our policy for implementing new Category I and III mid-year CPT codes.) We are proposing to continue this recognition and process for CY 2008. New Category I and III CPT codes and new Level II HCPCS codes, effective January 1, 2008, will be listed in Addendum B to the CY 2008 OPPS/ASC final rule with comment period and designated using comment indicator ''NI.'' The status indicator, the APC assignment, or both, for all such codes flagged with comment indicator ''NI'' will be open to public comment. We will respond to all comments received concerning these codes in a subsequent final rule.

In addition, we are proposing to continue our policy of the last 2 years of recognizing new mid-year CPT codes, generally Category III CPT codes, that the AMA releases in January for implementation the following July through the OPPS quarterly update process. Therefore, for CY 2008, we are proposing to include in Addendum B to the CY 2008 OPPS/ASC final rule with comment period the new Category III CPT codes released in January 2007 for implementation on July 1, 2007 (through the OPPS quarterly update process) and the new Category III codes released in July 2007 for implementation on January 1, 2008. However, only those new Category III CPT codes implemented effective January 1, 2008, will be flagged with comment indicator ''NI'' in Addendum B to the CY 2008 OPPS/ASC final rule with comment period, to indicate that we have assigned them an interim payment status which is subject to public comment. Category III CPT codes implemented in July 2007, which appear in Table 27 below, are subject to comment through this proposed rule, and their status will be finalized in the CY 2008 OPPS/ASC final rule with comment period.

TABLE 27.—CATEGORY III CPT CODES IMPLEMENTED IN JULY 2007

HCPCS code	Long descriptor	Proposed CY 2008 status indicator	Proposed CY 2008 APC
0178T	Electrocardiogram, 64 leads or greater, with graphic presentation and analysis; with interpretation and report.	B	Not applicable.
0179T	Electrocardiogram, 64 leads or greater, with graphic presentation and analysis; tracing and graphics only, without interpretation and report.	X	0100.
0180T	Electrocardiogram, 64 leads or greater, with graphic presentation and analysis; interpretation and report only.	B	Not applicable.
0181T	Corneal hysteresis determination, by air impulse stimulation, bilateral, with interpretation and report.	S	0230.
0182T	High dose rate electronic brachytherapy, per fraction	S	1519.

B. Proposed Changes—Variations Within APCs

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

1. Background

Section 1833(t)(2)(A) of the Act requires the Secretary to develop a classification system for covered hospital outpatient services. Section 1833(t)(2)(B) of the Act provides that this classification system may be composed of groups of services, so that services within each group are comparable clinically and with respect to the use of resources. In accordance with these provisions, we developed a grouping classification system, referred to as 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, 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 procedures or furnishing services. Therefore, we do not make separate payment for packaged items or services. For example, packaged items and services include: (1) Use of an operating, treatment, or procedure room; (2) use of a recovery room; (3) most observation services; (4) anesthesia; (5) medical/surgical supplies; (6) pharmaceuticals (other than those for which separate payment may be allowed under the provisions discussed in section V. of this proposed rule); and (7) incidental services such as venipuncture. Our proposed packaging approach for CY 2008 is discussed in section II.A.4. of this proposed rule.

Under the OPPS, we pay for hospital outpatient services on a rate-per-service or, as proposed for CY 2008, on a rate-per-encounter basis that 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. The APC weights are scaled to APC 0606 because it is the middle level clinic visit APC (that is, where the Level 3 Clinic Visit HCPCS code of five levels of clinic visits is assigned), and because middle level 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 the components of the OPPS not less than annually and to revise the groups and relative payment weights and make other adjustments to take into account changes in medical practice, changes in technology, and the addition of new services, new cost data, and other relevant information and factors. Section 1833(t)(9)(A) of the Act, as amended by section 201(h) of the BBRA of 1999, also requires the Secretary, beginning in CY 2001, to consult with an outside panel of experts to review the APC groups and the relative payment weights (the APC Panel recommendations for specific services for the CY 2008 OPPS and our responses to them are discussed in the relevant specific sections throughout this proposed rule).

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

2. Application of the 2 Times Rule

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

During the APC Panel's March 2007 meeting, we presented median cost and utilization data for services furnished during the period of January 1, 2006, through September 30, 2006, 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 2008 are contained principally in sections III.C. and III.D. of this proposed rule.

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 are proposing changes to their HCPCS codes' APC assignments in Addendum B to this proposed rule. In these cases, to eliminate a 2 times violation or to improve clinical and resource homogeneity, we are proposing to reassign the codes to APCs that contained services that were similar with regard to both their clinical and resource characteristics. We also are proposing to rename existing APCs, discontinue 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 2008 included in this proposed rule are related to changes in median costs of services and APCs resulting from our proposed packaging approach for CY 2008, as discussed in section II.A.4. of this proposed rule. We also are proposing changes to the status indicators for some codes that are not specifically and separately discussed in this proposed rule. In these cases, we are proposing to change the status indicators for some codes because we believe that another status indicator more accurately describes their payment status from an OPPS perspective based on the policies that we are proposing for CY 2008.

Addendum B to this proposed rule identifies with a comment indicator ''CH'' those HCPCS codes for which we are proposing a change to the APC assignment or status indicator as assigned in the April 2007 Addendum B update.

3. Proposed Exceptions to the 2 Times Rule

As discussed earlier, we may make exceptions to the 2 times limit on the variation of costs within each APC group in unusual cases such as low volume items and services. Taking into account the APC changes that we are proposing for CY 2008 based on the APC Panel recommendations discussed mainly in sections III.C. and III.D. of this proposed rule, the proposed changes to status indicators and APC assignments as identified in Addendum B to this proposed rule, and the use of CY 2006 claims data to calculate the median costs of procedures classified in the APCs, we reviewed all the APCs to determine which APCs would not satisfy the 2 times rule. We used the following criteria to decide whether to propose exceptions to the 2 times rule for affected APCs:

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

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

Table 28 lists the APCs that we are proposing to exempt from the 2 times rule for CY 2008 based on the criteria cited above. For cases in which a recommendation by the APC Panel appeared to result in or allow a violation of the 2 times rule, we generally accepted the APC Panel's recommendation because those recommendations were based on explicit consideration of resource use, clinical homogeneity, hospital specialization, and the quality of the data used to determine the APC payment rates that we are proposing for CY 2008. The median costs for hospital outpatient services for these and all other APCs that were used in the development of this proposed rule can be found on the CMS Web site at: *http://www.cms.hhs.gov*.

TABLE 28.—PROPOSED APC EXCEPTIONS TO THE 2 TIMES RULE FOR CY 2008

APC	APC title
0033	Partial Hospitalization.
0043	Closed Treatment Fracture Finger/Toe/Trunk.
0060	Manipulation Therapy.
0080	Diagnostic Cardiac Catheterization.
0093	Vascular Reconstruction/Fistula Repair without Device.
0105	Repair/Revision/Removal of Pacemakers, AICDs, or Vascular Devices.
0106	Insertion/Replacement of Pacemaker Leads and/or Electrodes.
0109	Removal/Repair of Implanted Devices.
0235	Level I Posterior Segment Eye Procedures.
0251	Level I ENT Procedures.
0260	Level I Plain Film Except Teeth.
0278	Diagnostic Urography.
0282	Miscellaneous Computed Axial Tomography.
0303	Treatment Device Construction.
0323	Extended Individual Psychotherapy.
0330	Dental Procedures.
0340	Minor Ancillary Procedures.
0368	Level II Pulmonary Tests.
0381	Single Allergy Tests.
0409	Red Blood Cell Tests.
0432	Health and Behavior Services.
0438	Level III Drug Administration.
0604	Level 1 Hospital Clinic Visits.
0664	Level I Proton Beam Radiation Therapy.
0688	Revision/Removal of Neurostimulator Pulse Generator Receiver.

C. New Technology APCs

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

1. Introduction

In the November 30, 2001 final rule (66 FR 59903), we finalized changes to the time period a service was eligible for payment under a New Technology APC. Beginning in CY 2002, we retain services within New Technology APC groups until we gather sufficient claims data to enable us to assign the service

to a clinically appropriate APC. This policy allows us to move a service from a New Technology APC in less than 2 years if sufficient data are available. It also allows us to retain a service in a New Technology APC for more than 3 years if sufficient data upon which to base a decision for reassignment have not been collected.

We note that the cost bands for New Technology APCs range from $0 to $50 in increments of $10, from $50 to $100 in increments of $50, from $100 through $2,000 in increments of $100, and from $2,000 through $10,000 in increments of $500. These increments, which are in two parallel sets of New Technology APCs, one with status indicator ''S'' and the other with status indicator ''T,'' allow us to price new technology services more appropriately and consistently.

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

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

At its March 2007 meeting, the APC Panel recommended that CMS keep services in New Technology APCs until sufficient data are available to assign them to clinical APCs, but for no longer than 2 years. We note that because of the potential for quarterly assignment of new services to New Technology APCs and the 2 year time lag in claims data for an OPPS update (that is, CY 2006 data are utilized for this CY 2008 OPPS rulemaking cycle), if we were to accept the APC Panel's recommendation, we would always reassign services from New Technology to clinical APCs based on 1 year or less of claims data. For example, if a new service was first assigned to a New Technology APC in July 2006, we would have 6 months of data for purposes of CY 2008 rulemaking but, in order to ensure that the service was in a New Technology APC for no longer than 2 years, we would need to move the service to a clinical APC for CY 2008. While we might have sufficient claims data from 6 months of CY 2006 to support a proposal for such a reassignment for CY 2008, we are not confident that this would always be the case for all new services, given our understanding of the dissemination of new technology procedures into medical practice and the diverse characteristics of new technology services that treat different clinical conditions. Therefore, we are not accepting the APC Panel's recommendation because we believe that accepting the recommendation would limit our ability to individually assess the OPPS treatment of each new technology service in the context of available hospital claims data. We are particularly concerned about continuing to provide appropriate payment for low volume new technology services that may be expected to continue to be low volume under the OPPS due to the prevalence of the target conditions in the Medicare population. We appreciate the APC Panel's thoughtful discussion of new technology services, and we agree with the APC Panel that it should be our priority to regularly reassign services from New Technology APCs to clinical APCs under the OPPS, so that they are treated like most other OPPS services for purposes of ratesetting once hospitals have had sufficient experience with providing and reporting the new services. Rather, consistent with our current policy, for CY 2008 we are proposing to 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. 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 hospital claims data upon which to base a decision for reassignment have not been collected.

The procedures presented below represent services assigned to New Technology APCs for CY 2007 for which we believe we have sufficient data to reassign them to clinically appropriate APCs for CY 2008. Therefore, we are proposing to reassign them to clinically appropriate APCs as indicated specifically in our discussion and in Table 29 of this proposed rule.

a. Positron Emission Tomography (PET)/Computed Tomography (CT) Scans (New Technology APC 1511)

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

From August 2000 through April 2005, we paid separately for PET and CT scans. In CY 2004, the payment rate for nonmyocardial PET scans was $1,450, while it was $193 for typical diagnostic CT scans. Prior to CY 2005, nonmyocardial PET and the PET portion of PET/CT scans were described by G-codes for billing to Medicare. Several commenters to the November 15, 2004 final rule with comment period (69 FR 65682) urged that we replace the G-codes for nonmyocardial PET and PET/CT scan procedures with the established CPT codes. These commenters stated that movement to the established CPT codes would greatly reduce the burden on hospitals of tracking and billing the G-codes which are not recognized by other payers and would allow for more uniform hospital billing of these scans. We agreed with the commenters that movement from the G-codes to the established CPT codes for nonmyocardial PET and PET/CT scans would allow for more uniform billing of these scans. As a result of a Medicare national coverage determination (Publication 100–3, Medicare Claims Processing Manual section 220.6) that was made effective January 28, 2005, we discontinued numerous G-codes that described myocardial PET and nonmyocardial PET procedures and replaced them with the established CPT codes. The CY 2005 payment rate for concurrent PET/CT scans using the CPT codes 78814 (Tumor imaging, positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization; limited area (eg, chest, head/neck); 78815 (Tumor imaging, positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization; skull base to mid-thigh); and 78816 Tumor imaging, positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization; whole body) was $1,250, which was $100 higher than the payment rate for PET scans alone. These PET/CT CPT codes were placed in New Technology APC 1514 (New Technology—Level XIV, $1,200–$1,300) for CY 2005.

We continued with these coding and payment methodologies in CY 2006. For CY 2007, while we proposed to reassign both PET and PET/CT Scans to the same new clinical APC, we finalized a policy that reassigned conventional PET procedures to APC 0308 (Non-

Myocardial Positron Emission Tomography (PET) Imaging) with a final median cost of about $850. We also reassigned PET/CT services to a different New Technology APC for CY 2007, specifically New Technology APC 1511 (New Technology—Level XI, $900–$1000), thereby maintaining the historical payment differential of about $100 between PET and PET/CT procedures. Furthermore, we stated in the CY 2007 OPPS/ASC final rule with comment period (71 FR 68022) that we would wait for a full year of CPT coded claims data prior to assigning the PET/CT services to a clinical APC and that maintaining a modest payment differential between PET and PET/CT procedures was warranted for CY 2007.

For CY 2008, we are proposing the reassignment of concurrent PET/CT scans, specifically CPT codes 78814, 78815, and 78816, to a clinical APC because we believe we have adequate claims data from CY 2006 upon which to determine the median cost of performing these procedures. Based on our analysis of approximately 117,000 CY 2006 single claims, the median cost of PET/CT scans is $1,093.52. In comparison, the median cost of the nonmyocardial PET scans, as described by CPT codes 78608, 78811, 78812, and 78813, is $1,093.51 based on our analysis of approximately 34,000 single claims from CY 2006. We note that a comparison of the median cost of PET/CT scans with the median cost of nonmyocardial PET scans, as derived from CY 2006 claims data, demonstrates that these costs are almost the same, thereby reflecting significant hospital resource equivalency between the two types of services. This result is not unexpected because many newer PET scanners also have the capability of rapidly acquiring CT images for attenuation correction and anatomical localization, sometimes with simultaneous image acquisition. The median costs for both PET and PET/CT scans are significantly higher for CY 2008 than for CY 2007 due to our CY 2008 proposal to package payment for all diagnostic radiopharmaceuticals as described in section II.A.4. of this proposed rule that would package payment for the costs of the radiopharmaceuticals utilized similarly into the payment for both PET and PET/CT scans. We believe that our claims data accurately reflect the comparable hospital resources required to provide nonmyocardial PET and PET/CT procedures, and the scans have obvious clinical similarity as well. Therefore, for CY 2008 we are proposing to reassign the CPT codes for PET/CT scans to the clinical APC where nonmyocardial PET scans are also assigned, specifically APC 0308, with a proposed median cost of $1,093.52.

We note that we have been paying separately for fluorodeoxyglucose (FDG), the radiopharmaceutical described by HCPCS code A9552 (F18 fdg), that is commonly administered during nonmyocardial PET and PET/CT procedures. For CY 2008, consistent with our proposed packaging approach as discussed in section II.A.4. of this proposed rule, we are proposing to package payment for the diagnostic radiopharmaceutical FDG into payment for the associated PET and PET/CT procedures. Because FDG is the most commonly used radiopharmaceutical for both PET and PET/CT scans and our single claims for these procedures include FDG more than 80 percent of the time, the packaging of this radiopharmaceutical fully maintains the clinical and resource homogeneity of the reconfigured APC 0308 that we are proposing.

b. IVIG Preadministration-Related Services (New Technology APC 1502)

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

In CY 2006, we created the temporary HCPCS G-code G0332 (Services for intravenous infusion of immunoglobulin prior to administration (this service is to be billed in conjunction with administration of immunoglobulin)). Based on our estimate of the costs of this service in comparison with other services, HCPCS code G0332 was assigned to New Technology APC 1502 (New Technology—Level II, $50–$100), with a payment rate of $75 effective January 1, 2006. In the CY 2007 OPPS/APC final rule with comment period, we indicated our belief that it was appropriate to continue the temporary IVIG preadministration-related services payment through HCPCS code G0332 and its continued assignment to New Technology APC 1502 for CY 2007, in order to help ensure continued patient access to IVIG (71 FR 68092).

For CY 2008, we are proposing to continue to provide separate payment for IVIG preadministration-related services through the assignment of HCPCS code G0332 to a clinical APC. This service has been assigned to a New Technology APC under the OPPS for 2 full years. As noted previously, under the OPPS, we retain services within New Technology APC groups where they are assigned according to our estimates of their costs until we gather sufficient claims data to enable us to assign the services to clinically appropriate APCs based on hospital resource costs as calculated from claims. According to our analysis of the hospital outpatient claims data, we believe we have adequate claims data from CY 2006 upon which to determine the median cost of performing IVIG preadministration related services and to reassign HCPCS code G0332 to an appropriate clinical APC for CY 2008. Our claims data for this high volume service show a total of over 49,000 services performed, with about 48,000 single claims available for ratesetting. The median cost of this service according to our claims data is $38.52. Therefore, we are proposing to reassign HCPCS code G0332 to new clinical APC 0430 (Drug Preadministration-Related Services) with a median cost of $38.52 for CY 2008, where it would be the only service assigned to the APC at this time.

We note that IVIG preadministration-related services are always provided in conjunction with other separately payable services such as drug administration services, and thus are well suited for packaging into the payment for the separately payable services. While at this time we have not made a determination about the appropriateness of continuing separate OPPS payment for HCPCS code G0332 after CY 2008, we would consider packaging payment for HCPCS code G0332 in future years if we determine separate payment is no longer warranted. We intend to reevaluate the appropriateness of separate payment for preadministration-related services for the CY 2009 OPPS rulemaking cycle, especially as we explore the potential for greater packaging and possible encounter-based or episode-based OPPS payment approaches.

c. Other Services in New Technology APCs

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

Other than the concurrent PET/CT and IVIG preadministration-related new technology services discussed in sections III.C.2.a. and III.C.2.b. of this proposed rule, there are five procedures currently assigned to New Technology APCs for CY 2007 for which we believe we also have data that are adequate to support their reassignment to clinical APCs. For CY 2008, we are proposing to reassign these procedures to clinically appropriate APCs, applying their CY 2006 claims data to develop their

clinical APC median costs upon which payments would be based. These procedures and their proposed APC assignments are displayed in Table 29 below.

TABLE 29.—PROPOSED CY 2008 APC REASSIGNMENTS OF OTHER NEW TECHNOLOGY PROCEDURES TO CLINICAL APCS

HCPCS code	Short descriptor	CY 2007 SI	CY 2007 APC	CY 2007 APC payment rate	Proposed CY 2008 SI	Proposed CY 2008 APC	Proposed CY 2008 APC median cost
19298	Place breast rad tube/caths	S	1524	$3,250	T	0648	$3,416.66
G0302	Pre-op service LVRS complete	S	1509	750	S	0209	727.48
G0303	Pre-op service LVRS 10–15dos	S	1507	550	S	0209	727.48
G0304	Pre-op service LVRS 1–9 dos	S	1504	250	S	0213	147.68
G0305	Post op service LVRS min 6	S	1504	250	S	0213	147.68

D. Proposed APC-Specific Policies

1. Hyperbaric Oxygen Therapy (APC 0659)

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

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

In the CY 2005 final rule with comment period (69 FR 65758 through 65759), we finalized a ''per unit'' median cost calculation for 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 cost center. Comments on the CY 2005 proposed rule effectively demonstrated that hospitals report the costs and charges for HBOT in a wide variety of cost centers. We used this methodology to estimate payment for HBOT in CYs 2005, 2006, and 2007. For CY 2008, we are proposing to continue using the same methodology to estimate a ''per unit'' median cost for HCPCS code C1300 of $98.63 using 60,774 claims with multiple units or multiple occurrences.

CY 2008 is the fourth year in which we would have a special methodology to develop the median cost for HBOT services that removed obviously erroneous claims and deviated from our standard methodology of using departmental CCRs, when available, to convert hospitals' charges to costs. Prior to CY 2005, our inclusion of significant numbers of miscoded claims in the median calculation for HBOT and our exclusion of the claims for multiple units of treatment, the typical scenario, resulted in payment rates that were artificially elevated. As explained earlier, beginning in CY 2005 and continuing through the present, we have adjusted the CCR used in the conversion of charges to costs for these services so that claims data would more accurately reflect the relative costs of the services. The median costs of HBOT calculated using this methodology have been reasonably stable for the last 4 years. We believe that this adjustment through use of the hospitals' overall CCRs is all that is necessary to yield a valid median cost for establishing a scaled weight for HBOT services. Therefore, for CY 2008, we are proposing to continue to use the same methodology that we have used since CY 2005 to estimate payment for HBOT.

2. Skin Repair Procedures (APCs 0024, 0025, 0027, and 0686)

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

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

In considering the final CY 2007 APC assignments of these 37 ''Skin

Replacement Surgery and Skin Repair'' codes, we reviewed the recommendations made by the APC Panel at its March 2006 meeting; presentations made to the APC Panel; comments received on the CY 2007 proposed rule; the CPT code descriptors, introductory explanations, cross-references, and parenthetical notes; the clinical characteristics of the procedures; and the code-specific median costs for all related CPT codes available from our CY 2005 claims data. A discussion of the final CY 2007 APC assignments of these procedures can be found in the CY 2007 OPPS/ASC final rule with comment period (71 FR 68054 through 68057).

We now have CY 2006 data for the surgical procedures assigned to the 4 CY 2007 skin repair APCs, including the 37 codes considered last year that were new for CY 2006. These APCs are: APC 0024 (Level I Skin Repair); APC 0025 (Level II Skin Repair); APC 0686 (Level III Skin Repair); and APC 0027 (Level IV Skin Repair). Based on CY 2006 data available for this proposed rule, the median costs for the APCs as configured for CY 2007 are approximately: $93 for APC 0024; $251 for APC 0025; $1,027 for APC 0686; and $1,340 for APC 0027. Both APCs 0024 and 0025 have 2 times violations based on CY 2006 claims data. The HCPCS median costs of significant procedures in APC 0024 range from approximately $83 to $255. We note that a number of the procedures currently assigned to APC 0024 are very low volume, with few single claims available for ratesetting. Similarly, the median costs of the significant procedures in APC 0025 range from a low of $119 to a high of about $399. This APC also contains a number of low volume procedures, as well as some new CY 2007 CPT codes without CY 2006 claims data. There is also some variation in the median costs of the HCPCS codes assigned to APCs 0686 and 0027, but no 2 times violations in these two APCs.

At the March 2007 APC Panel meeting, we discussed with the APC Panel one possible reconfiguration of the skin repair APCs in order to address the 2 times violations in APCs 0024 and 0025 for CY 2008 by improving the resource homogeneity of the APCs, as well as ensuring their clinical homogeneity. We reviewed with the APC Panel the potential results associated with adding an additional level in this APC series and reallocating all of the procedures in the original four APCs among five new APCs, taking into account the frequency, resource utilization, and clinical characteristics of each procedure. We also gave particular attention to CPT code families in considering the clinical and resource homogeneity of each APC in the reconfigured series. The new configuration of APCs eliminates the 2 times violations that would otherwise exist in APCs 0024 and 0025. It also more accurately attributes higher cost procedures to the Levels IV and V APCs, which contain the surgical procedures of the greatest intensity and resource requirements, leading to a more balanced distribution of APC median costs across the five new APC levels.

The APC Panel made a recommendation at its March 2007 meeting supporting CMS' reorganization of the skin repair APCs into five levels. This recommendation also asked CMS to give special consideration to the APC assignments of ''add-on'' codes; in the context of skin procedures, these are generally those CPT codes that report treatment of an additional body area and that are reported along with a primary procedure for treatment of the first body area. We are accepting the APC Panel's recommendation through this CY 2008 proposal to reconfigure the skin APCs into five levels, and we have reexamined the placement of each of the add-on codes within the framework of the five APCs. We agree with the APC Panel that, because these skin repair APCs are assigned to status indicator ''T'' so that add-on codes would typically be paid at 50 percent of their APC payment rate, these add-on codes bear special examination with respect to their median costs and their appropriate APC assignments. As a result, several CPT code placements from the draft configuration discussed with the Panel were changed for this proposal.

In summary, for CY 2008 we are proposing to eliminate the four current skin repair APCs and replace them with five new APCs titled: APC 0133 (Level I Skin Repair); APC 0134 (Level II Skin Repair); APC 0135 (Level III Skin Repair); APC 0136 (Level IV Skin Repair); and APC 0137 (Level V Skin Repair). We are proposing to redistribute each of the procedures assigned to the current four levels of skin repair APCs into the five proposed APCs, with one exception. Specifically, we are proposing to reassign CPT code 15835 (Excision, excessive skin and subcutaneous tissue (including lipectomy); buttock) to APC 0022 (Level IV, Excision/Biopsy), where other CPT codes in its code family reside. The median costs of the five proposed APCs are $83.91 (APC 0133), $132.82 (APC 0134), $294.50 (APC 0135), $971.25 (APC 0136), and $1,316.85 (APC 0137). The proposed configurations of these new APCs are listed in Table 30 below.

TABLE 30—PROPOSED CY 2008 SKIN REPAIR APC CONFIGURATIONS

HCPCS code	Short descriptor	Proposed CY 2008 APC	Proposed CY 2008 APC median cost
11950	Therapy for contour defects	0133	$83.91
11951	Therapy for contour defects.		
11952	Therapy for contour defects.		
11954	Therapy for contour defects.		
12001	Repair superficial wound(s).		
12002	Repair superficial wound(s).		
12004	Repair superficial wound(s).		
12005	Repair superficial wound(s).		
12006	Repair superficial wound(s).		
12007	Repair superficial wound(s).		
12011	Repair superficial wound(s).		
12013	Repair superficial wound(s).		
12014	Repair superficial wound(s).		
12015	Repair superficial wound(s).		
12016	Repair superficial wound(s).		
12017	Repair superficial wound(s).		
12018	Repair superficial wound(s).		

TABLE 30—PROPOSED CY 2008 SKIN REPAIR APC CONFIGURATIONS—Continued

HCPCS code	Short descriptor	Proposed CY 2008 APC	Proposed CY 2008 APC median cost
12031	Layer closure of wound(s).		
12041	Layer closure of wound(s).		
12051	Layer closure of wound(s).		
12052	Layer closure of wound(s).		
12053	Layer closure of wound(s).		
15775	Hair transplant punch grafts.		
15776	Hair transplant punch grafts.		
11760	Repair of nail bed	0134	$132.82
11920	Correct skin color defects.		
11921	Correct skin color defects.		
11922	Correct skin color defects.		
12032	Layer closure of wound(s).		
12034	Layer closure of wound(s).		
12035	Layer closure of wound(s).		
12036	Layer closure of wound(s).		
12037	Layer closure of wound(s).		
12042	Layer closure of wound(s).		
12044	Layer closure of wound(s).		
12045	Layer closure of wound(s).		
12046	Layer closure of wound(s).		
12047	Layer closure of wound(s).		
12054	Layer closure of wound(s).		
12055	Layer closure of wound(s).		
12056	Layer closure of wound(s).		
12057	Layer closure of wound(s).		
13120	Repair of wound or lesion.		
13122	Repair wound/lesion add-on.		
13153	Repair wound/lesion add-on.		
15040	Harvest cultured skin graft.		
15170	Acell graft trunk/arms/legs.		
15171	Acell graft t/arm/leg add-on.		
15340	Apply cult skin substitute.		
15341	Apply cult skin sub add-on.		
15360	Apply cult derm sub, t/a/l.		
15361	Aply cult derm sub t/a/l add.		
15365	Apply cult derm sub f/n/hf/g.		
15366	Apply cult derm f/hf/g add.		
15819	Plastic surgery, neck.		
12020	Closure of split wound	0135	$294.50
12021	Closure of split wound.		
13100	Repair of wound or lesion.		
13101	Repair of wound or lesion.		
13102	Repair wound/lesion add-on.		
13121	Repair of wound or lesion.		
13131	Repair of wound or lesion.		
13132	Repair of wound or lesion.		
13133	Repair wound/lesion add-on.		
13150	Repair of wound or lesion.		
13151	Repair of wound or lesion.		
13152	Repair of wound or lesion.		
15000	Wound prep, 1st 100 sq cm.		
15001	Wound prep, addl 100 sq cm.		
15002	Wnd prep, ch/inf, trk/arm/lg.		
15003	Wnd prep, ch/inf addl 100 cm.		
15004	Wnd prep ch/inf, f/n/hf/g.		
15005	Wnd prep, f/n/hf/g, addl cm.		
15050	Skin pinch graft.		
15110	Epidrm autogrft trnk/arm/leg.		
15111	Epidrm autogrft t/a/l add-on.		
15115	Epidrm a-grft face/nck/hf/g.		
15116	Epidrm a-grft f/n/hf/g addl.		
15150	Cult epiderm grft t/arm/leg.		
15151	Cult epiderm grft t/a/l addl.		
15152	Cult epiderm graft t/a/l +%.		
15155	Cult epiderm graft, f/n/hf/g.		
15156	Cult epidrm grft f/n/hfg add.		
15157	Cult epiderm grft f/n/hfg +%.		
15175	Acellular graft, f/n/hf/g.		
15176	Acell graft, f/n/hf/g add-on.		

TABLE 30—PROPOSED CY 2008 SKIN REPAIR APC CONFIGURATIONS—Continued

HCPCS code	Short descriptor	Proposed CY 2008 APC	Proposed CY 2008 APC median cost
15221	Skin full graft add-on.		
15241	Skin full graft add-on.		
15300	Apply skinallogrft, t/arm/lg.		
15301	Apply sknallogrft t/a/l addl.		
15320	Apply skin allogrft f/n/hf/g.		
15321	Apply sknallogrft f/n/hfg add.		
15330	Aply acell alogrft t/arm/leg.		
15331	Aply acell grft t/a/l add-on.		
15335	Apply acell graft, f/n/hf/g.		
15336	Apply acell grft f/n/hf/g add.		
15350	Skin homograft.		
15351	Skin homograft add-on.		
15400	Apply skin xenograft, t/a/l.		
15401	Apply skn xenogrft t/a/l add.		
15420	Apply skin xgraft, f/n/hf/g.		
15421	Apply skn xgrft f/n/hf/g add.		
15430	Apply acellular xenograft.		
15431	Apply acellular xgraft add.		
20926	Removal of tissue for graft.		
43887	Remove gastric port, open.		
11762	Reconstruction of nail bed	0136	$971.25
14000	Skin tissue rearrangement.		
14001	Skin tissue rearrangement.		
14020	Skin tissue rearrangement.		
14021	Skin tissue rearrangement.		
14040	Skin tissue rearrangement.		
14041	Skin tissue rearrangement.		
14060	Skin tissue rearrangement.		
14061	Skin tissue rearrangement.		
15130	Derm autograft, trnk/arm/leg.		
15131	Derm autograft t/a/l add-on.		
15135	Derm autograft face/nck/hf/g.		
15136	Derm autograft, f/n/hf/g add.		
15200	Skin full graft, trunk.		
15201	Skin full graft trunk add-on.		
15220	Skin full graft sclp/arm/leg.		
15240	Skin full grft face/genit/hf.		
15260	Skin full graft een & lips.		
15261	Skin full graft add-on.		
15740	Island pedicle flap graft.		
15936	Remove sacrum pressure sore.		
15952	Remove thigh pressure sore.		
15953	Remove thigh pressure sore.		
15956	Remove thigh pressure sore.		
15958	Remove thigh pressure sore.		
20920	Removal of fascia for graft.		
20922	Removal of fascia for graft.		
23921	Amputation follow-up surgery.		
25929	Amputation follow-up surgery.		
33222	Revise pocket, pacemaker.		
33223	Revise pocket, pacing-defib.		
11960	Insert tissue expander(s)	0137	$1,316.85
13160	Late closure of wound.		
14300	Skin tissue rearrangement.		
14350	Skin tissue rearrangement.		
15100	Skin splt grft, trnk/arm/leg.		
15101	Skin splt grft t/a/l, add-on.		
15120	Skn splt a-grft fac/nck/hf/g.		
15121	Skn splt a-grft f/n/hf/g add.		
15570	Form skin pedicle flap.		
15572	Form skin pedicle flap.		
15574	Form skin pedicle flap.		
15576	Form skin pedicle flap.		
15600	Skin graft.		
15610	Skin graft.		
15620	Skin graft.		
15630	Skin graft.		
15650	Transfer skin pedicle flap.		
15731	Forehead flap w/vasc pedicle.		

TABLE 30—PROPOSED CY 2008 SKIN REPAIR APC CONFIGURATIONS—Continued

HCPCS code	Short descriptor	Proposed CY 2008 APC	Proposed CY 2008 APC median cost
15732	Muscle-skin graft, head/neck.		
15734	Muscle-skin graft, trunk.		
15736	Muscle-skin graft, arm.		
15738	Muscle-skin graft, leg .		
15750	Neurovascular pedicle graft.		
15760	Composite skin graft.		
15770	Derma-fat-fascia graft.		
15820	Revision of lower eyelid.		
15821	Revision of lower eyelid.		
15822	Revision of upper eyelid.		
15823	Revision of upper eyelid.		
15824	Removal of forehead wrinkles.		
15825	Removal of neck wrinkles.		
15826	Removal of brow wrinkles.		
15828	Removal of face wrinkles.		
15829	Removal of skin wrinkles.		
15840	Graft for face nerve palsy.		
15841	Graft for face nerve palsy.		
15842	Flap for face nerve palsy.		
15845	Skin and muscle repair, face.		
15876	Suction assisted lipectomy.		
15877	Suction assisted lipectomy.		
15878	Suction assisted lipectomy.		
15879	Suction assisted lipectomy.		
15922	Removal of tail bone ulcer.		
15934	Remove sacrum pressure sore.		
15935	Remove sacrum pressure sore.		
15937	Remove sacrum pressure sore.		
15944	Remove hip pressure sore.		
15945	Remove hip pressure sore.		
15946	Remove hip pressure sore.		
20101	Explore wound, chest.		
20102	Explore wound, abdomen.		
20910	Remove cartilage for graft.		
20912	Remove cartilage for graft.		
43886	Revise gastric port, open.		
43888	Change gastric port, open.		
44312	Revision of ileostomy.		
44340	Revision of colostomy		

3. Cardiac Computed Tomography and Computed Tomographic Angiography (APCs 0282, 0376, 0377, and 0398)

(If you choose to comment on issues in this section, please include the caption ''Cardiac Computed Tomography and Computed Tomographic Angiography'' at the beginning of your comment.)

Cardiac computed tomography (CCT) and cardiac computed tomography angiography (CCTA) are noninvasive diagnostic procedures that assist physicians in obtaining detailed images of coronary blood vessels. The data obtained from these procedures can be used for further diagnostic evaluations and/or appropriate therapy for coronary patients.

Currently, there are eight Category III CPT codes that describe CCT and CCTA procedures. The CPT codes, which are shown in Table 31, are 0144T through 0151T. These codes were new for CY 2006. In the CY 2006 OPPS final rule with comment period, we assigned the CCT and CCTA procedure codes to interim APCs, which were subject to public comment. We received no comments on the interim APC assignments. Since January 2006, the CCT and CCTA procedure codes have been assigned to four APCs, specifically, APC 0282 (Miscellaneous Computerized Axial Tomography), APC 0376 (Level II Cardiac Imaging), APC 0377 (Level III Cardiac Imaging), and APC 0398 (Level I Cardiac Imaging).

In the CY 2007 OPPS/ASC proposed rule, we proposed to retain the existing APC assignments for the CCT and CCTA procedure codes. We received several comments on the proposed APCs assignments, which we addressed in the CY 2007 OPPS/ASC final rule with comment period (71 FR 68038 and 68039). Several of the commenters requested that we either not assign the CCT and CCTA procedures to any APCs or assign them to appropriate New Technology APCs. In addition, some commenters were also concerned that CCT and CCTA procedures were not clinically homogeneous with other procedures assigned to APCs 0282, 0376, 0377, and 0398, noting that the last three APCs previously contained only nuclear medicine cardiac imaging procedures.

In the CY 2007 OPPS/ASC final rule with comment period (71 FR 68038), we indicated our belief that the clinical characteristics and expected resource use associated with the CCT and CCTA procedures were sufficiently similar to the other procedures assigned to APCs 0282, 0376, 0377, and 0398 that we believed those APC assignments were appropriate. While several of those APCs also contained nuclear medicine imaging procedures, we had never designated those APCs as specific to

nuclear medicine procedures. Therefore, for CY 2007, we continued with the CY 2006 APC assignments for CPT codes 0144T through 0151T. We did not agree with the commenters that use of CT and CTA for cardiac studies was a new technology for which we had no relevant OPPS cost information that could be used to estimate hospital resources for these procedures. We also believed these services could be potentially covered hospital outpatient services, so that it would not be appropriate for us to depart from our standard OPPS policy and not assign them to APCs. As we indicated in our CY 2007 OPPS/ASC proposed rule (71 FR 49549), some Category III CPT codes describe services that we have determined to be similar in clinical characteristics and resource use to HCPCS codes assigned to existing clinical APCs. In these instances, we may assign the Category III CPT code to the appropriate clinical APC. Other Category III CPT codes describe services that we have determined are not compatible with an existing clinical APC, yet are appropriately provided in the hospital outpatient setting. In these cases, we may assign the Category III CPT code to what we estimate is an appropriately priced New Technology APC. In other cases, we may assign a Category III CPT code to one of several nonseparately payable status indicators, including ''N,'' ''C,'' ''B,''' or ''E,''' which we believe is appropriate for the specific code. As we noted in the CY 2007 OPPS/ASC final rule with comment period, we believed that CCT and CCTA procedures were appropriate for separate payment under the OPPS should local contractors provide coverage for these procedures, and, therefore, they warranted status indicator and APC assignments that would provide separate payment under the OPPS (71 FR 68038).

At its March 2007 meeting, the APC Panel recommended that CMS work with stakeholders to determine more appropriate APC placements for CCT and CCTA procedures. The APC Panel made no specific recommendations regarding the appropriate APC assignments for these services, although several different clinical APC configurations were discussed, along with the alternative of assigning these procedures to New Technology APCs.

We note that we generally meet with interested organizations concerning their views about OPPS payment policy issues with respect to specific technologies or services. Following the publication of the CY 2007 OPPS/ASC final rule with comment period, we received such information from interested individuals and organizations regarding the clinical and facility resource characteristics of CCT and CCTA procedures. We will consider the input of any individual or organization to the extent allowed by Federal law, including the Administrative Procedure Act (APA) and the FACA. We establish the OPPS payment rates for services through regulations, during our annual rulemaking cycle. We are required to consider the timely comments of interested organizations, establish the payment policies for the forthcoming year, and respond to the timely comments of all public commenters in the final rule in which we establish the payments for the forthcoming year.

Analysis of our hospital data for claims submitted for CY 2006 indicate that CCT and CCTA procedures are performed relatively frequently on Medicare patients. Our claims data show a total of over 16,000 procedures performed, with about 11,000 single claims available for ratesetting. Based on our analysis of the robust hospital outpatient claims data, we believe we have adequate claims data from CY 2006 upon which to determine the median costs of performing these procedures and to assign them to appropriate clinical APCs. We see no rationale for reassigning these procedures to New Technology APCs in CY 2008, when we have claims-based cost information regarding these procedures, and they are clinically similar to other procedures paid under the OPPS.

We acknowledge the concerns that have been expressed to us regarding the clinical homogeneity of APCs 0376, 0377, and 0398, where some of the CCT and CCTA are assigned for CY 2007 along with nuclear medicine cardiac imaging procedures. Because we are proposing to package payment for diagnostic radiopharmaceuticals into payment for diagnostic nuclear medicine procedures in CY 2008 as discussed in detail in section II.A.4. of this proposed rule, we believe that to ensure the clinical and resource homogeneity of APCs 0376, 0377, and 0398 in CY 2008, it would be most appropriate to reassign the CCT and CCTA services currently residing in those APCs to other clinical APCs for CY 2008.

Therefore, for CY 2008, we are proposing to assign the CCT and CCTA procedures to two clinical APCs, specifically new clinical APC 0383 (Cardiac Computed Tomographic Imaging) and APC 0282, as shown in Table 31. The proposed median cost of $313.81 for APC 0383 is based entirely on claims data for CPT codes 0145T, 0146T, 0147T, 0148T, 0149T, and 0150T that describe CCT and CCTA services, a clinically homogeneous grouping of services. In addition, the individual median costs of these services range from a low of $276.50 to a high of $436.79, reflecting their hospital resource similarity as well. We are proposing to reassign the two other CCT CPT codes, specifically CPT codes 0144T and 0151T, to APC 0282. The inclusion of these two codes in APC 0282 results in a CY 2008 proposed APC median cost of $105.48.

TABLE 31.—PROPOSED CY 2008 APC ASSIGNMENTS OF CCT AND CCTA PROCEDURES

HCPCS code	Short descriptor	CY 2007 SI	CY 2007 APC	CY 2007 APC median cost	Proposed CY 2008 SI	Proposed CY 2008 APC	Proposed CY 2008 APC median cost
0144T	CT heart wo dye; qual calc	S	0398	$252.17	S	0282	$105.48
0145T	CT heart w/wo dye funct	S	0376	304.52	S	0383	313.81
0146T	CCTA w/wo dye	S	0376	304.52	S	0383	313.81
0147T	CCTA w/wo, quan calcium	S	0376	304.52	S	0383	313.81
0148T	CCTA w/wo, strxr	S	0377	397.29	S	0383	313.81
0149T	CCTA w/wo, strxr quan calc	S	0377	397.29	S	0383	313.81
0150T	CCTA w/wo, disease strxr	S	0398	252.17	S	0383	313.81
0151T	CT heart funct add-on	S	0282	93.98	S	0282	105.48

4. Ultrasound Ablation of Uterine Fibroids With Magnetic Resonance Guidance (MRgFUS) (APCs 0195 and 0202)

(If you choose to comment on issues in this section, please include the caption ''Ultrasound Ablation of Uterine Fibroids with Magnetic Resonance Guidance (MRgFUS)'' at the beginning of your comment.)

Magnetic resonance guided focused ultrasound (MRgFUS) is a noninvasive surgical procedure that uses high intensity focused ultrasound waves to destroy tissue in combination with magnetic resonance imaging (MRI). Currently, the two Category III CPT codes for this procedure are 0071T (Focused ultrasound ablation of uterine leiomyomata, including MR guidance; total leiomyomata volume less than 200 cc of tissue) and 0072T (Focused ultrasound ablation of uterine leiomyomata, including MR guidance; total leiomyomata volume greater or equal to 200 cc of tissue), which were implemented on January 1, 2005.

In the CY 2006 OPPS proposed rule, we proposed to continue to assign both codes to APC 0193 (Level V Female Reproductive Proc). However, at the August 2005 APC Panel meeting, the APC Panel recommended that CMS work with stakeholders to assign CPT codes 0071T and 0072T to appropriate New Technology APCs. Based on our review of several factors, which included information presented at the August 2005 APC Panel meeting, the comments received on the CY 2006 OPPS proposed rule, and our analysis of OPPS claims data for different procedures, we reassigned CPT code 0071T from APC 0193 to APC 0195 (Level IX Female Reproductive Proc) and CPT code 0072T from APC 0193 to APC 0202 (Level X Female Reproductive Proc) effective January 1, 2006, to reflect the higher level of resources we estimated were required when performing the MRgFUS procedures.

In the CY 2007 OPPS/ASC proposed rule, we proposed to continue to assign CPT code 0071T to APC 0195 and CPT code 0072T to APC 0202. We received comments on the CY 2007 proposed APC assignments recommending that we revise the APC assignments for CPT codes 0071T and 0072T. The commenters indicated that, while MRgFUS treats anatomical sites that are similar to other procedures assigned to APCs 0195 and 0202, the resources utilized differ dramatically. Several commenters recommended that the most appropriate APC assignment for the MRgFUS procedures would be APC 0127 (Level IV Stereotactic Radiosurgery), based on their analyses of the procedures' resource use and clinical characteristics.

As we stated in both the CY 2006 OPPS final rule with comment period and the CY 2007 OPPS/ASC final rule with comment period, we believe that MRgFUS treatment bears a significant relationship to technologies already in use in hospital outpatient departments (70 FR 68600 and 71 FR 68050, respectively). The use of focused ultrasound for thermal tissue ablation has been in development for decades, and the recent application of MRI to focused ultrasound therapy provides monitoring capabilities that may make the therapy more clinically useful. We continue to believe that, although MRgFUS therapy is relatively new, it is an integrated application of existing technologies (MRI and ultrasound), and its technology resembles other OPPS services that are assigned to clinical APCs for which we have significant OPPS claims data. In the CY 2007 OPPS/ASC final rule with comment period (71 FR 68050), we explained our belief that retaining MRgFUS procedures in clinical APCs with other female reproductive procedures would enable us both to set accurate payment rates and to maintain appropriate clinical homogeneity of the APCs. Furthermore, we did not agree with commenters that MRgFUS procedures shared sufficient clinical and resource characteristics with cobalt-based stereotactic radiosurgery (SRS) to reassign them to that particular clinical APC 0127, where only the single specific SRS procedure was assigned for CY 2007 and which had a CY 2007 APC median cost of $8,460.53. Consequently, in the CY 2007 OPPS/ASC final rule with comment period (71 FR 68051), we finalized payment for these procedures in APCs 0195 and 0202 as proposed.

Analysis of our hospital outpatient data for claims submitted for CY 2006 indicates that MRgFUS procedures are rarely performed on Medicare patients. As we stated in the CY 2006 OPPS final rule with comment period and CY 2007 OPPS/ASC final rule with comment period, because treatment of uterine fibroids is most common among women younger than 65 years of age, we do not expect that there ever will be many Medicare claims for the MRgFUS procedures (70 FR 68600 and 71 FR 68050, respectively). For OPPS claims submitted from CY 2005 through CY 2006, our claims data show that there were only two claims submitted for CPT code 0071T in CY 2005 and one in CY 2006. We have no hospital claims for CPT code 0072T from either of those years.

At its March 2007 meeting, the APC Panel recommended that, for CY 2008, CMS reassign CPT codes 0071T and 0072T from APCs 0195 and 0202 to APC 0067 (Level III Stereotactic Radiosurgery, MRgFUS, and MEG), which has a proposed APC median cost of $3,869.96 for CY 2008. The APC Panel discussed its general belief that while the MRgFUS procedures may not be performed frequently on Medicare patients, CMS should pay appropriately for the procedures to ensure access for Medicare beneficiaries. In addition, following discussion of the potential for reassignment of the CPT codes to New Technology APCs, the APC Panel specifically recommended that the procedures be assigned to a clinical APC at this point in their adoption into clinical practice, instead of a New Technology APC. Furthermore, since publication of the CY 2007 OPPS/ASC final rule with comment period, we have received input from interested individuals and organizations regarding the clinical and resource characteristics of MRgFUS procedures. Based on our consideration of all information available to us regarding the necessary hospital resources for the MRgFUS procedures in comparison with other procedures for which we have historical hospital claims data, for CY 2008 we are proposing to accept the APC Panel's recommendation to reassign these services to clinical APC 0067, an APC that currently contains two linear accelerator-based stereotactic radiosurgery (SRS) procedures that are conducted in a single or first session, rather than procedures for subsequent SRS treatment fractions. We agree with the APC Panel that these SRS procedures share sufficient clinical and resource similarity with the MRgFUS services, including reliance on image guidance in a single treatment session to ablate abnormal tissue, to justify their assignment to the same clinical APC. Unlike the cobalt-based SRS service that we concluded in the CY 2007 OPPS/ASC final rule with comment period was not similar to MRgFUS procedures based on clinical and resource considerations, these linear accelerator-based SRS procedures are not performed solely on intracranial lesions and generally do not require immobilization of the patient's head in a frame that is screwed into the skull, thereby exhibiting characteristics more consistent with MRgFUS treatments. In addition, based on our understanding of the MRgFUS procedures described by the two CPT codes which differ only in the volume of uterine leiomyomata treated, we believe it would be most

appropriate to assign both of these procedures to the same clinical APC, as recommended by the APC Panel. Therefore, for CY 2008 we are proposing to reassign CPT codes 0071T and 0072T to APC 0067, with a proposed APC median cost of $3,869.96, as reflected in Table 32.

TABLE 32.—PROPOSED CY 2008 APC ASSIGNMENTS OF MRGFUS PROCEDURES

HCPCS code	Short descriptor	CY 2007 SI	CY 2007 APC	CY 2007 APC median cost	Proposed CY 2008 SI	Proposed CY 2008 APC	Proposed CY 2008 APC median cost
0071T	U/s leiomyomata ablate <200	T	0195	$1,742.20	S	0067	$3,869.96
0072T	U/s leiomyomata ablate >200	T	0202	2,534.46	S	0067	3,869.96

5. Single Allergy Tests (APC 0381)

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

For CY 2008, we are proposing to continue with our methodology of differentiating single allergy tests (''per test'') from multiple allergy tests (''per visit'') by assigning these services to two different APCs to provide accurate payments for these tests in CY 2008. 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 of these CPT codes to describe all of the tests provided. However, our CY 2006 claims data available for this CY 2008 proposed rule for APC 0381 (Single Allergy Tests) do not reflect improved and more consistent hospital billing practices of ''per test'' for single allergy tests. Using the CY 2006 claims data, the median cost of APC 0381 calculated according to the standard single claims OPPS methodology is $66.17, significantly higher than the CY 2007 median cost of $16.43 for APC 0381 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 appeared to include charges that represent a ''per visit'' charge, rather than a ''per test'' charge. Therefore, consistent with our payment policy for CYs 2006 and 2007, we are proposing to calculate a ''per unit'' median cost for APC 0381, based upon 276 CY 2006 claims containing multiple units or multiple occurrences of a single CPT code, where packaging on the claims is allocated equally to each unit of the CPT code. Using this methodology, we calculated a proposed median cost of $18.96 for APC 0381 for CY 2008. We will consider whether further instructions to hospitals for reporting these procedures would be beneficial, because we are concerned that our claims data for CY 2006 reflect no apparent change in hospitals' billing practices following our January 2006 clarification. We remain hopeful that better and more accurate hospital reporting and charging practices for these single allergy test CPT codes in future years may allow us to calculate the median cost of APC 0381 using the standard OPPS process for future OPPS updates.

6. Myocardial Positron Emission Tomography (PET) Scans (APC 0307)

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

From August 2000 to December 31, 2005, under the OPPS, we assigned one clinical APC to all myocardial positron emission tomography (PET) scan procedures, which were reported with multiple G-codes through March 31, 2005. Under the OPPS, effective April 1, 2005, myocardial PET scans were reported with three CPT codes, specifically 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). From April 1, 2005 through December 31, 2005, these three CPT codes were assigned to one APC, specifically APC 0285 (Myocardial Positron Emission Tomography (PET), with a payment rate of $735.77. In CY 2006, in response to the public comments received on the CY 2006 OPPS proposed rule, and based on our claims information, myocardial PET services were assigned to two clinical APCs for the CY 2006 OPPS. The CPT codes for the single scans, specifically 78459 and 78491, were assigned to APC 0306 (Myocardial Positron Emission Tomography (PET) Imaging, Single Study, Metabolic Evaluation) with a payment rate of $800.55, and the multiple scan CPT code 78492 was assigned to APC 0307 (Myocardial Positron Emission Tomography (PET) Imaging, Multiple Studies) with a payment rate of $2,484.88, effective January 1, 2006. However, analysis of the CY 2005 claims data that were used to set the payment rates for CY 2007 revealed that when all the myocardial PET scan procedure codes were combined into a single clinical APC, as they were prior to CY 2006, the APC median cost for myocardial PET services was very similar to the median cost of their single CY 2005 clinical APC. Further, our analysis revealed that the updated differential median costs of the single and multiple study procedures no longer supported the two-level APC payment structure. Therefore, for CY 2007, CPT codes 78459, 78491, and 78492, were assigned to a single clinical APC, specifically APC 0307, which was renamed ''Myocardial Positron Emission Tomography (PET) Imaging,'' with a median cost of $726.98.

At its March 2007 meeting, the APC Panel recommended that CMS reassign CPT code 78492 to its own clinical APC, to distinguish this multiple study procedure that the APC Panel believed would require greater hospital resources from less resource intensive single study procedures. However, we are not accepting the APC Panel's recommendation because, consistent with our observations from the CY 2005 claims data, our updated CY 2006 claims data do not support the creation of a clinical APC for CPT code 78492 alone. Analysis of the latest CY 2006 claims data continues to support a single level APC payment structure for the myocardial PET scan procedures because very few single scan studies are performed and we believe single and multiple scan procedures are clinically

similar. Our claims data available for this proposed rule show a total of 2,547 procedures reported with the multiple scan CPT code 78492. Alternatively, our claims data show only a combined total of 249 procedures reported with the single scan CPT codes 78459 and 78491, less than 10 percent of all studies reported. A similar distribution is observed in the single bills available for ratesetting.

Similar to last year's findings, our claims data reveal that more hospitals are not only providing multiple myocardial PET scan services, but most myocardial PET scans are multiple studies. We believe that the assignment of CPT codes 78459, 78491, and 78492 to a single clinical APC for CY 2008 remains appropriate because the CY 2006 claims data do not support a resource differential among significant myocardial PET services that would necessitate the placement of single and multiple PET scan procedures into two separate clinical APCs. Therefore, we are proposing to continue to assign both the single and multiple myocardial PET scan procedure codes to APC 0307, with a proposed APC median cost of $2,677.71 for CY 2008. We note that the proposed CY 2008 median cost of APC 0307 is significantly higher than its CY 2007 median cost, in part because of our proposed CY 2008 packaging approach discussed in detail in section II.A.4. of this proposed rule that would package payment for diagnostic radiopharmaceuticals into the payment for their related diagnostic nuclear medicine studies, such as myocardial PET scans. We believe that the proposed median cost appropriately reflects the hospital resources associated with providing myocardial PET scans to Medicare beneficiaries in cost-efficient settings. Furthermore, we believe that the proposed CY 2008 OPPS payment rates are adequate to ensure appropriate access to these services for Medicare beneficiaries. The myocardial PET scan CPT codes and their proposed CY 2008 APC assignments are displayed in Table 33.

TABLE 33.—PROPOSED CY 2008 APC ASSIGNMENTS FOR MYOCARDIAL PET SCANS

HCPCS code	Short descriptor	CY 2007 SI	CY 2007 APC	CY 2007 APC median cost	Proposed CY 2008 SI	Proposed CY 2008 APC	Proposed CY 2008 APC median cost
78459	Heart muscle imaging (PET)	S	0307	$726.98	S	0307	$2,677.71
78491	Heart image (pet), single	S	0307	726.98	S	0307	2,677.71
78492	Heart image (pet), multiple	S	0307	726.98	S	0307	2,677.71

7. Implantation of Cardioverter-Defibrillators (APCs 0107 and 0108)

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

In CY 2003, we created four Level II HCPCS codes for implantation of single and dual chamber cardioverter-defibrillators (ICDs) with and without leads because, for the CY 2004 OPPS, we deleted the device HCPCS codes and there was no other way of determining whether the device being implanted was a single chamber or dual chamber device. We were concerned that the costs of inserting single versus dual chamber ICDs could be sufficiently different due to the two types of devices implanted such that separate APC assignments for the insertion procedures could be appropriate in the future. The HCPCS codes are G0297 (Insertion of single chamber pacing cardioverter defibrillator pulse generator); G0298 (Insertion of dual chamber pacing cardioverter defibrillator pulse generator); G0299 (Insertion or repositioning of electrode lead for single chamber pacing cardioverter defibrillator and insertion of pulse generator); and G0300 (Insertion or repositioning of electrode lead for dual chamber pacing cardioverter defibrillator and insertion of pulse generator). The pairs of codes were assigned to two different clinical APCs, depending on whether or not they included the possibility of electrode insertion, specifically APC 0107 (Insertion of Cardioverter-Defibrillator) and APC 0108 (Insertion/Replacement/Repair of Cardioverter-Defibrillator Leads).

In the same year, the OPPS ceased to recognize for payment the two CPT codes for insertion of ICDs with or without ICD leads. These CPT codes are 33240 (Insertion of single or dual chamber pacing cardioverter-defibrillator pulse generator) and 33249 (Insertion or repositioning of electrode lead(s) for single or dual chamber pacing cardioverter-defibrillator and insertion of pulse generator).

We reinstated the device category HCPCS codes on January 1, 2005. Moreover, since January 1, 2005, hospitals have been required to report devices they use or implant when there is a device code that describes the device. We began to edit to ensure that hospitals are correctly billing devices required for certain procedures in April 2005 and implemented the second phase of device edits on October 1, 2005. Therefore, we no longer need different procedural Level II HCPCS codes to identify whether hospitals inserted a single or dual chamber ICD device.

At its March 2007 meeting, the APC Panel recommended that CMS delete the Level II HCPCS codes for implantation of cardioverter-defibrillator pulse generators with or without repositioning or implantation of electrode lead(s) and authorize hospitals to report the CPT codes. The APC Panel indicated that the requirement for reporting device codes would enable CMS to continue to identify costs when different types of devices are implanted if that were to be necessary.

We analyzed the median cost data associated with APCs 0107 and 0108 as part of our preparation for the APC Panel discussion. While there is a difference in the median cost when a single chamber versus a dual chamber device is implanted, the difference has never been great enough to justify differential APC assignments for the procedures. See Table 34 below for a historical summary of all single claim median costs. (For purposes of this analysis, we display the median costs for all single claims without regard to adjustment or to whether the claims meet various selection criteria; these are not the median costs on which payments were based.)

Hospitals have consistently indicated that they would prefer to report the services furnished using the CPT codes that describe them, rather than the alphanumeric G-codes, because many private payers require that they bill the CPT codes. We also prefer to recognize CPT codes for procedures under the OPPS, when possible, to minimize the administrative coding burden on hospitals.

We believe that the differences between the median costs for the two Level II HCPCS codes assigned to each APC (that is, G0297 and G0298 for APC 0107 and G0299 and G0300 for APC 0108) do not currently support differential APC assignments for single and dual chamber ICD insertion procedures. The required device coding would allow us to continue to follow the different costs over time by examining subsets of ICD implantation procedure claims based on the type of device reported on the claims. Moreover, we are sensitive to the benefits of minimizing the reporting burden on hospitals. Therefore, for CY 2008 we are proposing to delete the Level II HCPCS codes for ICD insertion procedures and require hospitals to bill the appropriate CPT codes, along with the applicable device C-codes, for payment under the OPPS.

TABLE 34.—HISTORICAL UNADJUSTED MEDIAN COST DATA FROM ALL SINGLE CLAIMS FOR APCS 0107 AND 0108

HCPCS code	CY 2002 claims (includes 75% of device cost per manufacturer data) (CY 2004 OPPS)	Unadjusted CY 2003 claims (CY 2005 OPPS)	Unadjusted CY 2004 claims (CY 2006 OPPS)	Unadjusted CY 2005 claims (CY 2007 OPPS)	Unadjusted CY 2006 claims (CY 2008 OPPS)
APC 0107:					
33240	$17,025.21	$12,102.28			
G0297		11,886.42	$13,392.82	$10,821.06	$18,470.82
G0298		17,168.67	14,316.54	13,935.35	21,571.88
APC 0108:					
33249	$28,685.29	17,330.96			
G0299		18,561.51	18,425.79	21,367.99	23,060.55
G0300		21,006.03	19,306.96	23,680.34	26,204.89

8. Implantation of Spinal Neurostimulators (APC 0222)

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

The CPT code for insertion of a spinal neurostimulator (63685, Insertion or replacement of spinal neurostimulator pulse generation or receiver, direct or inductive coupling), which is assigned to APC 0222 (Implantation of Neurological Device), is reported for both the insertion of a nonrechargeable neurostimulator and a rechargeable neurostimulator. The costs of a nonrechargeable neurostimulator from CY 2005 claims are packaged into the payment for APC 0222 in CY 2007. We believe rechargeable neurostimulators are currently most commonly implanted for spinal neurostimulation, consistent with the information provided during our consideration of the device for pass through designation. However, in response to hospital requests we have recently expanded our procedure-to-device edits to allow device category code C1820 (Generator, neurostimulator (implantable), with rechargeable battery and charging system) to be reported with two other procedures. These procedures are CPT code 64590 (Insertion or replacement of peripheral neurostimulator pulse generator or receiver, direct or inductive coupling), assigned to APC 0222, 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), assigned to APC 0039 (Level I Implantation of Neurostimulator).

The rechargeable neurostimulator reported as device category code C1820 has received pass-through payment since January 1, 2006, and its pass-through status will expire on January 1, 2008, as discussed further in section IV.B. of this proposed rule. During the 2 years of pass-through payment when device category code C1820 has been paid at a hospital's charges reduced to cost using the overall hospital CCR, we have applied a device offset when device category code C1820 is reported with a CPT code assigned to APCs 0039 or 0222 in order to remove the costs of the predecessor nonrechargeable device from the cost-based payment of C1820. This device offset ensures that no duplicate device payment is made. As a general policy, under the OPPS we package payment for the costs of devices into the payment for the procedure in which they are used, unless those devices have OPPS pass-through status, such as the case here.

Review of our CY 2007 claims data for APC 0222 shows that the costs of the associated neurostimulator implantation procedures are higher when the rechargeable neurostimulator is implanted rather than the traditional nonrechargeable neurostimulator. We refer readers to Table 35 below for the median costs of APC 0222 under different device packaging scenarios. However, the difference in costs is not so great that retaining the implantation of both types of devices for spinal or peripheral neurostimulation in APC 0222 would cause a 2 times violation, and thereby, justify creating a new clinical APC. In addition, to pay differentially would require us to establish one or more Level II HCPCS codes for reporting under the OPPS, because the three CPT codes for which device category code C1820 is currently an allowed device do not differentiate among the device implantation procedures based on the specific device used. The creation of special Level II HCPCS codes for OPPS reporting is generally undesirable, unless absolutely essential, because it increases hospital administrative burden as the codes may not be accepted by other payers. Establishing separate coding and payment would reduce the size of the APC payment groups in a year where we are proposing to increase packaging under the OPPS through expanded payment groups.

We believe that the principles of a prospective payment system are best served by following our standard practice of retaining a single CPT code for neurostimulator implantation procedures that does not distinguish between rechargeable and nonrechargeable neurostimulators, into which the costs of both types of devices are packaged in relationship to their OPPS utilization. To the extent that the rechargeable neurostimulator may become the dominant device implanted over time for neurostimulation, the median costs of APCs 0222 and 0039 would reflect the change in surgical practice in future years. In the meantime, with the rechargeable neurostimulator coming off pass-through status for CY 2008, by following our standard practice we would be increasing the size of the APC 0222 and

APC 0039 payment bundles for CY 2008, thereby encouraging hospitals to use resources most efficiently.

Therefore, for CY 2008 we are proposing to package the costs of rechargeable neurostimulators into the payment for the CPT codes that describe the services furnished. Our proposed median cost for APC 0222 is $12,161.64, upon which the CY 2008 payment rate for APC 0222 would be based. We believe this approach is the most administratively simple, consistent with OPPS packaging principles, and supportive of encouraging hospital efficiency, yet it also provides appropriate packaged payment for implantable neurostimulators. While we welcome public comment on this issue, we request that commenters address how this specific device implantation situation differs from many other scenarios under the OPPS, where relatively general HCPCS codes describe procedures that may utilize a variety of devices with different costs, and payment for those devices is packaged into the payment for the associated procedures.

TABLE 35.—APC 0222 CY 2006 DATA BASED ON CLAIMS REPORTING DIFFERENT NEUROSTIMULATOR DEVICES

APC 0222 configurations	CY 2006 count of hospitals billing	CY 2006 pass edit, nontoken, no FB single bills	CY 2006 pass edit, nontoken, no FB median cost
APC 0222, including claims with both rechargeable and nonrechargeable neurostimulators ...	868	2,830	$12,161.64
APC 0222A, including only claims with nonrechargeable neurostimulators	781	2,412	11,607.75
APC 0222B, including only claims with rechargeable neurostimulators	238	422	18,088.71

9. Stereotactic Radiosurgery (SRS) Treatment Delivery Services (APCs 0065, 0066, and 0067)

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

For CY 2007, the CPT Editorial Panel created four new SRS Category I CPT codes in the Radiation Oncology section of the 2007 CPT manual. Specifically, the CPT Editorial Panel created CPT codes 77371 (Radiation treatment delivery, stereotactic radiosurgery (SRS) (complete course of treatment of cerebral lesion(s) consisting of 1 session); multi-source Cobalt 60 based)); 77372 (Radiation treatment delivery, stereotactic radiosurgery (SRS) (complete course of treatment of cerebral lesion(s) consisting of 1 session); linear accelerator based)), 77373 (Stereotactic body radiation therapy, treatment delivery, per fraction to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions); and 77435 (Stereotactic body radiation therapy, treatment management, per treatment course, to one or more lesions, including image guidance, entire course not to exceed 5 fractions).

Of the four CPT codes, CPT codes 77371 and 77435 were recognized under the OPPS effective January 1, 2007, while CPT codes 77372 and 77373 were not. CPT code 77371 was assigned to the same APC and status indicator as its predecessor code, HCPCS code G0243 (Multi-source photon stereotactic radiosurgery, delivery including collimator changes and custom plugging, complete course of treatment, all lesions). For CY 2007, CPT code 77371 was assigned to APC 0127 with a status indicator of ''S.'' Prior to CY 2007, CPT code 77435 was described under CPT code 0083T (Stereotactic body radiation therapy, treatment management, per day), which was assigned to status indicator ''N'' in the OPPS. The CPT Editorial Panel decided to delete CPT code 0083T on December 31, 2006, and replaced it with CPT code 77435. Because the costs of SRS treatment management were already packaged into the OPPS payment rates for SRS treatment delivery, we assigned CPT code 77435 to status indicator ''N'' which was the same status indicator that was assigned to its predecessor Category III CPT code (0083T), under the OPPS, effective January 1, 2007. We note that the OPPS treatment of these new CPT codes was open to comment in the CY 2007 OPPS/ASC final rule with comment period, and we will specifically respond to those comments, according to our usual practice, in the CY 2008 OPPS/ASC final rule with comment period.

As we explained in the CY 2007 OPPS/ASC final rule with comment period (71 FR 68025), we did not recognize CPT codes 77372 and 77373 because they do not accurately and specifically describe the HPCPCS G-codes that we currently use for linear accelerator (LINAC)-based SRS treatment delivery services under the OPPS. During CY 2006, CPT code 77372 was reported under one of two HCPCS codes, depending on the technology used, specifically, G0173 (Linear accelerator based stereotactic radiosurgery, complete course of therapy in one session) and G0339 (Image-guided robotic linear accelerator-based stereotactic radiosurgery, complete course of therapy in one session or first session of fractionated treatment). Because HCPCS codes G0173 and G0339 are more specific in their descriptors than CPT code 77372, we decided to continue using HCPCS codes G0173 and G0339 under the OPPS for CY 2007. For CY 2007, we assigned CPT code 77372 to status indicator ''B'' under the OPPS. In addition, during CY 2006, CPT code 77373 was reported under one of three HCPCS codes depending on the circumstances and technology used, specifically, 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); G0339 (Image-guided robotic linear accelerator-based stereotactic radiosurgery, complete course of therapy in one session or first session of fractionated treatment); and 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). Because HCPCS codes G0251, G0339, and G0340 are more specific in their descriptors than CPT code 77373 and are also assigned to different clinical APCs for CY 2007, we decided to continue recognizing HCPCS codes G0251, G0339, and G0340 under the OPPS for CY 2007. Therefore, for CY 2007 we assigned CPT code 77373 to status indicator ''B'' under the OPPS.

While we have had requests from certain specialty societies and other stakeholders that we recognize CPT codes 77372 and 77373 under the OPPS rather than continuing to use the current Level II HCPCS codes for hospital

outpatient facility reporting of these procedures, we have also heard from others that continued use of the G-codes under the OPPS is the most appropriate way to recognize the facility resource differences between different types of LINAC-based procedures. For the past several years, we have collected information through our claims data regarding the hospital costs associated with the planning and delivery of SRS services. As new technology emerged in the field of SRS several years ago, public commenters urged CMS to recognize cost differences associated with the various methods of SRS planning and delivery. Beginning in CY 2001, we established G-codes to capture any such cost variations associated with the various methods of planning and delivery of SRS. Based on comments received on the CY 2004 OPPS proposed rule regarding the G-codes used for SRS, we made some modifications to the coding for CY 2004 (68 FR 63431 and 63432). First, we received comments regarding the descriptors for HCPCS codes G0173 and G0251, indicating that these codes did not accurately distinguish image-guided robotic SRS systems from other forms of linear accelerator-based SRS systems to account for the cost variation in delivering these services. In response, for CY 2004 we modified the descriptor for G0173 and also created two HCPCS G-codes, G0339 and G0340, to describe complete and fractionated image-guided robotic linear accelerator-based SRS treatment. While all of these LINAC-based SRS procedures were originally assigned to New Technology APCs under the OPPS, we reassigned them to new clinical APCs for CY 2007 based on 2 full years of hospital claims data reflecting stable median costs based on significant volumes of single claims.

HCPCS codes G0173, G0251, G0339, and G0340 are more specific in their descriptors than either CPT code 77372 or 77373. In addition, their hospital claims data continue to reflect significantly different hospital resources that would lead to violations of the 2 times rule were we to reassign certain procedures to the same clinical APCs in order to crosswalk the CY 2006 historical claims data for the 4 G-codes to develop the median costs of the APCs to which the 2 CPT codes would be assigned if we were to recognize them. Therefore, we believe that we should continue to use the G-codes for reporting LINAC-based SRS treatment delivery services for CY 2008 under the OPPS to ensure appropriate payment to hospitals for the different facility resources associated with providing these complex services. That is, we are proposing to continue to assign HCPCS codes G0173 and G0339 to APC 0067 (Level III Stereotactic Radiosurgery, MRgFUS, and MEG), HCPCS code G0251 to APC 0065 (Level I Stereotactic Radiosurgery, MRgFUS, and MEG), and HCPCS code G0340 to APC 0066 (Level II Stereotactic Radiosurgery, MRgFUS, and MEG) for CY 2008.

Since we first established the full group of SRS treatment delivery codes in CY 2004, we now have 3 years of hospital claims data reflecting the costs of each of these services. Based on our latest claims data from CY 2006, the proposed APC median cost for the complete course of therapy in one session or first fraction of image-guided, robotic LINAC-based SRS, as described by HCPCS codes G0173 and G0339 respectively in APC 0067, is $3,869.96 based on 1,946 single claims available for ratesetting. The proposed CY 2008 APC median cost for each fractionated session of LINAC-based SRS, as described by HCPCS code G0251 in APC 0065, is $1,081.92 based on 1,938 single claims. The proposed CY 2008 APC median cost for the second through fifth sessions of image-guided, robotic LINAC-based fractionated SRS treatment, reported by HCPCS code G0340 in APC 0066, is $2,980.24 based on 5,209 single claims.

Therefore, for CY 2008, we are proposing to continue with the CY 2007 HCPCS coding for LINAC-based SRS treatment delivery services under the OPPS. The LINAC based SRS codes and their CY 2008 proposed APC assignments are displayed in Table 36.

TABLE 36.—PROPOSED CY 2008 APC ASSIGNMENTS FOR LINAC-BASED SRS TREATMENT DELIVERY SERVICES

HCPCS code	Short descriptor	CY 2007 SI	CY 2007 APC	CY 2007 APC median cost	Proposed CY 2008 SI	Proposed CY 2008 APC	Proposed CY 2008 APC median cost
G0173	Linear acc stereo radsur com	S	0067	$3,872.87	S	0067	$ 3,869.96
G0251	Linear acc based stero radio	S	0065	1,241.89	S	0065	1,081.92
G0339	Robot lin-radsurg com, first	S	0067	3,872.87	S	0067	3,869.96
G0340	Robt lin-radsurg fractx 2–5	S	0066	2,629.53	S	0066	2,980.24

10. Blood Transfusion (APC 0110)

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

We have a longstanding policy under the OPPS that transfusion services are billed and paid on a per encounter basis and not by the number of units of blood products transfused (Internet Only Manual 100–4, Chapter 4, Section 231.8). Under this policy, a transfusion APC payment is made to the OPPS provider for transfusing blood products once per day, regardless of the number of units or different types of blood products transfused. The OCE ensures only one payment for APC 0110 (Transfusion), regardless of the number of units of CPT code 36430 (Transfusion, blood or blood components) reported by the hospital on a single date of service. The CPT code 36430 descriptor does not include ''per unit.'' Hence, the median cost for CPT code 36430, which is assigned to APC 0110, represents the costs of transfusion of blood or blood products on the same date of service, regardless of how many units of products are transfused. In addition, for payment of the transfusion service, the OCE also requires the claim to contain a Level II HCPCS P-code for a blood product on the same date of service as the transfusion procedure.

At its March 2007 meeting, the APC Panel recommended that CMS investigate whether CPT code 36430 should identify when multiple units are transfused and trigger a discounted payment for the second and subsequent administration of additional units of blood or blood components. The APC Panel indicated that the current payment for transfusion services does not adequately pay hospitals for the costs of these complex services, and that payment on a per unit basis rather than on a per encounter basis would result in more accurate and appropriate payment.

We do not agree with the APC Panel's recommendation, and we are proposing to not accept this recommendation for

the CY 2008 OPPS. We believe that our current policy of providing a single payment for blood transfusion, regardless of the number of units transfused, is most consistent with the goals of a prospective payment system to encourage and create incentives for efficiency in providing services. Payment for transfusion services on a per encounter basis encourages the transfusion of only those blood products that are necessary for the beneficiary's treatment during the hospital outpatient encounter. Moreover, the current median cost for the transfusion service, associated with the transfusion of all blood products furnished on a date of service, has been set based on the historical reporting of all charges for transfusion on the same date of service and, therefore, represents the full cost of an episode of transfusion, rather than the cost of transfusion of a single unit of blood or blood product. Given our proposed packaging approach for the CY 2008 OPPS, it would be inconsistent for us to revise our current transfusion payment policy to provide separate payment for each unit of blood product transfused, thereby reducing the size of the current transfusion payment bundle.

Therefore, for CY 2008 we are proposing to maintain our current payment policy, which bases payment for transfusion on the costs of all transfusion services furnished on a single date of service and which examines hospital claims to ensure that payment is provided for only one unit of CPT code 36430 on a date of service. However, we remind hospitals that a claim for a single unit of CPT code 36430 should include charges for all of the hospital resource costs associated with the totality of transfusion services furnished on the date of service, so that the payment for one unit of APC 0110 is based on the costs of all transfusion services provided in a hospital outpatient encounter.

11. Screening Colonoscopies and Screening Flexible Sigmoidoscopies (APCs 0158 and 0159)

(If you choose to comment on issues in this section, please include the caption ''Screening Colonoscopies and Screening Flexible Sigmoidoscopies'' at the beginning of your comment.)

Since the implementation of the OPPS in August 2000, screening colonoscopies and screening flexible sigmoidoscopies have been paid separately. In the CY 2007 OPPS/ASC final rule with comment period (71 FR 68013), we implemented certain changes associated with colorectal cancer screening services provided in HOPDs. First, section 5113 of Pub. L. 109–171 amended section 1833(b) of the Act to add colorectal cancer screening to the list of services for which the beneficiary deductible no longer applies. This provision applies to services furnished on or after January 1, 2007. Second, sections 1834(d)(2) and (d)(3) of the Act require Medicare to pay the lesser of the ASC or OPPS payment amount for screening flexible sigmoidoscopies and screening colonoscopies. For CY 2007, the OPPS payment for screening colonoscopies, HCPCS codes G0105 (Colorectal cancer screening; colonoscopy on individual at risk) and G0121 (Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk), developed in accordance with our standard OPPS ratesetting methodology, would have slightly exceeded the CY 2007 ASC payment of $446 for these procedures. Consistent with the requirements set forth in sections 1834(d)(2) and (d)(3) of the Act, the OPPS payment rates for HCPCS codes G0105 and G0121 were set equal to the CY 2007 ASC rate of $446 effective January 1, 2007. This requirement did not impact the OPPS payment rate for screening flexible sigmoidoscopies (G0104, Colorectal cancer screening; flexible sigmoidoscopy) because Medicare did not make payment to ASCs for screening flexible sigmoidoscopies in CY 2007, so there was no payment comparison to be made for those services.

According to the final policy for the revised ASC payment system as described in the final rule for the revised ASC payment system published elsewhere in this issue of the **Federal Register**, ASCs will be paid for screening colonoscopies based on their ASC payment weights derived from the related OPPS APC payment weights and multiplied by the final ASC conversion factor (the product of the OPPS conversion factor and the ASC budget neutrality adjustment). As an office-based procedure added to the ASC list of covered surgical procedures for CY 2008, ASC payment for screening flexible sigmoidoscopies will be capped at the CY 2008 MPFS nonfacility practice expense amount. Sections 1834(d)(2) and (d)(3) of the Act would then require that the CY 2008 OPPS payment rates for these procedures be set equal to their significantly lower ASC payment rates.

However, we are proposing to use the equitable adjustment authority of section 1833(t)(2)(E) of the Act to adjust the OPPS payment rates for screening colonoscopies and screening flexible sigmoidoscopies. Section 1833(t)(2)E) of the Act provides that the Secretary shall establish adjustments, in a budget neutral manner, as determined to be necessary to ensure equitable payments under the OPPS. Sections 1834(d)(2) and (d)(3) of the Act regarding payment for screening flexible sigmoidoscopies and screening colonoscopies under the OPPS and ASC payment systems were established by Congress in 1997, many years prior to the CY 2008 initial implementation of the revised ASC payment system. The payment policies of the revised ASC payment system, as summarized in section XVI. of this proposed rule, make fundamental changes to the methodology for developing ASC payment rates based on certain principles, specifically that the OPPS payment weight relativity is applicable to ASC procedures and that ASC costs are lower than HOPD costs for providing the same procedures, that contradict the original assumptions underlying these provisions. According to the findings of the GAO in its report, released on November 30, 2006, and entitled ''Medicare: Payment for Ambulatory Surgical Centers Should Be Based on the Hospital Outpatient Payment System'' (GAO–07–86), the payment groups of the OPPS accurately reflect the relative costs of procedures performed in ASCs just as well as they reflect the relative costs of the same procedures provided in HOPDs. Screening colonoscopies were among the top 20 ASC procedures in terms of volume whose costs were specifically studied by the GAO in its work that led to this conclusion. We see no clinical or hospital resource explanation for why the OPPS relative costs from CY 2006 OPPS claims data for screening flexible sigmoidoscopies and screening colonoscopies would not provide an appropriate basis for establishing their payment rates under both the OPPS and the revised ASC payment system, according to the standard ratesetting methodologies of each payment system for CY 2008. If we were to pay for these screening procedures under the OPPS according to their ASC rates in CY 2008, we would significantly distort their payment relativity in comparison with other OPPS services. We believe it would be inequitable to pay these screening services in HOPDs at their ASC rates for CY 2008, thereby ignoring the relativity of their costs in comparison with other OPPS services which have similar or different clinical and resource characteristics. Therefore, for CY 2008 when we will be paying for screening colonoscopies and screening flexible sigmoidoscopies performed in ASCs based upon their standard revised ASC payment rates, we are proposing to

adjust the payment rates under the OPPS to pay for the procedures according to the standard OPPS payment rates. We believe that the application of sections 1834(d)(2) and (d)(3) of the Act produces inequitable results because of the revised ASC payment system to be implemented in CY 2008. We believe this proposal would provide the most appropriate payment for these procedures in the context of the contemporary payment policies of the OPPS and the revised ASC payment system.

IV. Proposed OPPS Payment for Devices

A. Proposed Treatment of Device-Dependent APCs

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

1. Background

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

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

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

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

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

For CY 2007, we based the device-dependent APC medians on CY 2005 claims, the most current data available at that time. In CY 2005 we reinstated hospital reporting of device codes and made the reporting of device codes mandatory where an appropriate code exists to describe a device utilized. In CY 2005, we also implemented HCPCS code procedure-to-device edits to facilitate complete reporting of the charges for the devices used in the procedures assigned to the device-dependent APCs. For CY 2007 ratesetting, we excluded claims for which the charge for a device was less than $1.01, in part to recognize hospital charging practices due to a recall of cardioverter-defibrillator and pacemaker pulse generators in CY 2005 for which the manufacturers provided replacement devices without cost to the beneficiary or hospital. We also found that there were other devices for which the token charge was less than $1.01, and we removed those claims from the set used to calculate the median costs of device-dependent APCs. In summary, for the CY 2007 OPPS we set the median costs for device-dependent APCs using only claims that passed the device edits and did not contain token charges for the devices. Therefore, the median costs for these APCs for CY 2007 were determined from claims data that generally represented the full cost of the required device.

2. Proposed Payment

For this proposed rule, we calculated the median costs for device-dependent APCs using three different sets of claims. We first calculated a median cost using all single procedure claims that contained appropriate device codes (where there are edits) for the procedure codes in those APCs. We then calculated a second median cost using only claims that contain allowed device HCPCS codes with charges for all device codes that were in excess of $1.00 (nontoken charge device claims). Third, we calculated the APC median cost based only upon nontoken charge device claims with correct devices that did not also contain the HCPCS modifier ''FB,'' reported in CY 2005 to identify that a procedure was performed using an item provided without cost to the provider, supplier, or practitioner, or where a credit was received for a

replaced device (examples include, but are not limited to, devices covered under warranty, devices replaced due to defects, and free samples).

As expected, the median costs calculated based upon single procedure bills that met all three criteria, that is, correct devices, no token charges, and no ''FB'' modifier, were generally higher than the median costs calculated using all single bills. We believe that the claims that meet these three criteria (appropriate device codes, nontoken device charges, and no ''FB'' modifier) reflect the best estimated costs for these device-dependent APCs when the hospital pays the full cost of the device, and we are proposing to base our CY 2008 median costs on the medians calculated based upon these claims.

As a result of the effects of the proposed CY 2008 packaging approach discussed in detail in section II.A.4. of this proposed rule on median costs, we are proposing to make some changes to CY 2007 device-dependent APCs for CY 2008. Specifically, we are proposing to delete APC 0081 (Noncoronary Angioplasty or Atherectomy); APC 0087 (Cardiac Electrophysiologic Recording/Mapping); and APC 0670 (Level II Intravascular and Intracardiac Ultrasound and Flow Reserve) due to the migration of HCPCS codes to other APCs. Some of the HCPCS codes assigned to these APCs in CY 2007 would be unconditionally packaged for CY 2008. The median costs of the remaining HCPCS codes proposed for separate payment in CY 2008 were significantly different than CY 2007 due to the proposed packaging of additional services. We believe that reconfiguration of the APCs is necessary to ensure that the HCPCS codes that would be separately paid in CY 2008 and that are assigned to these APCs in CY 2007 would be assigned to APCs that are homogeneous with regard to clinical characteristics and resource use in CY 2008. The APCs we are proposing for deletion ceased to be appropriate as a result of the reassignment of the HCPCS codes that we are proposing for continued separate payment in CY 2008.

The following seven APCs remain device-dependent APCs for CY 2008, but we are proposing to reassign certain HCPCS codes mapped to these APCs for CY 2007 either to other APCs or among these APCs for CY 2008 to ensure that, in view of the median costs that result from the proposed CY 2008 packaging approach, the HCPCS codes would be assigned to APCs that are homogeneous with regard to clinical characteristics and resource use for CY 2008: APC 0082 (Coronary Atherectomy); APC 0083 (Coronary Angioplasty and Percutaneous Valvuloplasty); APC 0085 (Level II Electrophysiologic Evaluation); APC 0086 (Ablate Heart Dysrhythm Focus); APC 0115 (Cannula/Access Device Procedures); APC 0427 (Level III Tube Changes and Repositioning); and APC 0623 (Level III Vascular Access Procedures). We also are proposing to consider APC 0084 (Level I Electrophysiologic Procedures) to be a device-dependent APC for CY 2008 because we are proposing to reassign many of the HCPCS codes that were previously in APCs 0086 and 0087 to APC 0084.

As a result of the proposed APC reconfigurations resulting from HCPCS code migration, it is not appropriate to compare the proposed CY 2008 OPPS median costs for these eight APCs to the CY 2007 final rule median costs that are the basis for the CY 2007 OPPS payment rates. When we compare the median costs for the other device-dependent APCs with stable proposed CY 2008 configurations in comparison with CY 2007, the median costs for 26 APCs increase, some of them by significant amounts, and the median costs for 5 APCs decrease. We believe that these median costs represent valid estimates of the relative costs of the services in these APCs, both with regard to the increases and the decreases that appear when the proposed CY 2008 median costs are compared to the CY 2007 median costs on which the payment rates for these APCs are based.

The only decline of more than 10 percent is found in APC 0418 (Insertion of Left Ventricular Pacing Electrode). In the case of APC 0418, we have been told that the very large increases in costs that have occurred in the past several years for this APC were the result of claims where hospitals inserted an ICD at the time of insertion of the left ventricular lead but failed to bill for the ICD implantation procedure. This incorrect reporting led to our attributing the costs of the expensive ICD device to the median cost for the insertion of the left ventricular lead, instead of attributing the cost of the ICD to a HCPCS code for the implantation of the device. We believe that the decline in the median cost for APC 0418 is the result of improvements in provider billing and that the median cost we calculated from the CY 2006 data is a reasonable estimate of the cost of the insertion of the left ventricular lead. Moreover, the relatively small number of single bills and the small number of providers furnishing the service (158 hospitals) are likely to cause the median costs to vary more than for services furnished in greater volume by more hospitals. We note that we have put into place reverse device edits for CY 2007, where we require hospitals reporting certain implantable device HCPCS codes to also report an appropriate procedure for the device's use. We believe that these reverse device edits should improve our packaging of device costs into the appropriate procedures for future OPPS updates.

We note that 12 of the APCs for which it is appropriate to compare the proposed CY 2008 APC medians to the CY 2007 final rule medians show increases that are greater than 10 percent. We have examined the data for these APCs and we believe that the increases are attributable to a combination of factors. In some of these cases, the single claims that were usable for establishing the median costs are a small percent of the total bills for the services assigned to the APC and, as we have stated previously, when small percentages of single bills are used, the APC median cost is likely to show greater fluctuation from year to year. In addition, CY 2006 claims, which are the basis for the CY 2008 proposed rule data, were the first set of claims subject to procedure-to-device edits for the entire calendar year. These edits were implemented to ensure that the charges for the necessary devices were reported on the claims. While this editing was phased in during CY 2005, beginning in April and concluding in October, CY 2006 was the first full year of procedure-to-device edits and thus hospitals that had not previously routinely reported separate device codes and charges were required by the edits to do so for all claims submitted in CY 2006. The reporting of device codes and charges for devices has historically resulted in increases in median costs for device-dependent APCs. Thus, we believe that the more complete claims data available for CY 2008 ratesetting likely contribute to the increased proposed median costs observed for some device dependent APCs.

Furthermore, we believe that the proposed increases are also attributable, in part, to our proposal to package the costs of guidance services, intraoperative services, and imaging supervision and interpretation services into the payment for major independent procedures, as described in section II.A.4. of this proposed rule. For example, CPT code 36870 (Thrombectomy, percutaneous, arteriovenous fistula, autogenous or nonautogenous graft (includes mechanical thrombus extraction and intra-graft thrombolysis)) is the most commonly reported code in device-dependent APC 0653 (Vascular Reconstruction/Fistula Repair with

Device), representing 25,805 bills of 26,138 total bills in the APC. CPT code 36870 appears with CPT code 75978 (Transluminal balloon angioplasty, venous (*e.g.* subclavian stenosis), radiological supervision and interpretation) 14,679 times and with CPT code 75790 (Angiography, arteriovenous shunt (*e.g.* dialysis patient), radiological supervision and interpretation) 15,623 times in the CY 2006 claims data. We are proposing to package payment for both CPT codes 75978 and 75790 for CY 2008. Moreover, 9 other CPT codes that we are proposing to package for CY 2008 appear with the independent CPT code 36870 more than 100 times each. Therefore, many of the claims for CPT code 36870 proposed to be used for CY 2008 ratesetting include charges for both CPT codes 75790 and 75978 and also contain charges for other CPT codes we are proposing to package, as well as uncoded revenue code charges that are packaged. Therefore, it is not surprising that our proposed median cost for APC 0653 is about 30 percent higher than the CY 2007 median cost for the same APC. Based on our review of patterns of services observed in our claims data for the device-dependent APCs and our clinical review of the procedures assigned to APCs that receive significant increases for CY 2008, we believe that the increases in the proposed median costs for certain device-dependent APCs for CY 2008 are consistent with our general expectations in the context of the comprehensive proposal for the CY 2008 OPPS.

As we have stated in the past, some variation in relative costs from year to year is to be expected in a prospective payment system. We believe that this is particularly true for low volume device-dependent APCs because relatively small numbers of providers furnish the services; the total frequencies of services furnished are low (compared to commonly furnished services like visits); the number of single bills that are available for use in calculating the full median cost of a single unit of a service is also relatively small; and the selection of claims that contain appropriate devices, lack token charges for devices, and lack the ''FB'' modifier further reduces the pool of single bills that can be used to calculate the median cost. However, even in the case of these low volume device-dependent APCs, we continue to believe that the median costs calculated from the single bills that meet the three 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.

Therefore, we are proposing to base the payment rates for CY 2008 for all device dependent APCs on their median costs calculated using only single bills that meet the three selection criteria discussed in detail above. Table 37 below contains the proposed CY 2008 median costs for these APCs. We do not believe that any special payment policies are needed, as we believe that the claims data we are proposing to use for ratesetting will ensure that the costs of the implantable devices are adequately and appropriately reflected in the median costs for these device-dependent APCs.

TABLE 37.—PROPOSED CY 2008 MEDIAN COSTS FOR DEVICE-DEPENDENT APCS

[Note that N/A indicates APCs for which the CY 2007 OPPS medians are not comparable to the CY 2008 medians, due to proposed HCPCS code migration for CY 2008.]

APC	SI	APC title	CY 2007 final rule pass edit, nontoken frequency	CY 2007 final rule pass edit, nontoken median cost	Proposed CY 2008 post cost total frequency	Proposed CY 2008 pass edit, nontoken, no FB frequency	Proposed CY 2008 pass edit, nontoken, no FB median cost	Difference between CY 2007 final rule median and proposed CY 2008 median cost	Count of providers billing in the proposed CY 2008 data
0039	S	Level I Implantation of Neurostimulator.	680	$11,450.84	2893	1035	$12,421.82	8.48	262
0040	S	Percutaneous Implantation of Neurostimulator Electrodes, Excluding Cranial Nerve.	1402	3,457.00	12769	4663	4,010.44	16.01	994
0061	S	Laminectomy or Incision for Implantation of Neurostimulator Electrodes, Excluding Cranial Nerve.	265	5,145.22	2938	1268	5,115.78	−0.57	440
0082	T	Coronary or Non Coronary Atherectomy.	N/A	N/A	16464	4374	5,584.20	N/A	925
0083	T	Coronary or Non Coronary Angioplasty and Percutaneous Valvuloplasty.	N/A	N/A	140944	37879	2,897.95	N/A	1706
0084	S	Level I Electrophysiologic Procedures.	N/A	N/A	9703	6973	647.41	N/A	600
0085	T	Level II Electrophysiologic Evaluation.	N/A	N/A	15791	3957	3,059.06	N/A	711

TABLE 37.—PROPOSED CY 2008 MEDIAN COSTS FOR DEVICE-DEPENDENT APCS—Continued

[Note that N/A indicates APCs for which the CY 2007 OPPS medians are not comparable to the CY 2008 medians, due to proposed HCPCS code migration for CY 2008.]

APC	SI	APC title	CY 2007 final rule pass edit, nontoken frequency	CY 2007 final rule pass edit, nontoken median cost	Proposed CY 2008 post cost total frequency	Proposed CY 2008 pass edit, nontoken, no FB frequency	Proposed CY 2008 pass edit, nontoken, no FB median cost	Difference between CY 2007 final rule median and proposed CY 2008 median cost	Count of providers billing in the proposed CY 2008 data
0086	T	Level III Electrophysiologic Procedures.	N/A	N/A	8370	384	5,709.52	N/A	157
0089	T	Insertion/Replacement of Permanent Pacemaker and Electrodes.	388	7,557.38	3722	570	7,710.05	N/A	765
0090	T	Insertion/Replacement of Pacemaker Pulse Generator.	505	6,007.21	7426	524	6,279.63	4.53	314
0104	T	Transcatheter Placement of Intracoronary Stents.	396	5,360.43	4638	565	5,599.90	4.47	200
0106	T	Insertion/Replacement of Pacemaker Leads and/or Electrodes.	427	3,138.16	3489	367	4,718.32	50.35	269
0107	T	Insertion of Cardioverter-Defibrillator.	584	18,607.21	9772	448	22,213.36	19.38	230
0108	T	Insertion/Replacement/Repair of Cardioverter-Defibrillator Leads.	3045	23,205.37	8732	3267	25,352.27	9.25	585
0115	T	Cannula/Access Device Procedures.	N/A	N/A	2489	1259	1,920.99	N/A	669
0202	T	Level VII Female Reproductive Proc.	4451	2,627.08	17800	10043	2,719.11	3.50	1863
0222	T	Implantation of Neurological Device.	2007	11,099.02	7957	2830	12,161.64	9.57	868
0225	S	Implantation of Neurostimulator Electrodes, Cranial Nerve.	83	13,514.45	1544	239	13,928.36	3.06	159
0227	T	Implantation of Drug Infusion Device.	319	10,657.85	3350	1001	11,242.60	5.49	460
0229	T	Transcatherter Placement of Intravascular Shunts.	882	4,184.15	53470	7225	5,642.77	34.86	1226
0259	T	Level VI ENT Procedures.	472	25,351.03	1311	783	25,434.97	0.33	166
0315	T	Level II Implantation of Neurostimulator.	516	14,845.73	807	648	16,532.22	11.36	195
0384	T	GI Procedures with Stents.	6574	1,402.31	21958	6895	1,587.03	13.17	1428
0385	S	Level I Prosthetic Urological Procedures.	267	4,840.44	881	581	5,368.16	10.90	319
0386	S	Level II Prosthetic Urological Procedures.	1788	8,395.82	4990	3346	9,045.78	7.74	862

TABLE 37.—PROPOSED CY 2008 MEDIAN COSTS FOR DEVICE-DEPENDENT APCS—Continued

[Note that N/A indicates APCs for which the CY 2007 OPPS medians are not comparable to the CY 2008 medians, due to proposed HCPCS code migration for CY 2008.]

APC	SI	APC title	CY 2007 final rule pass edit, nontoken frequency	CY 2007 final rule pass edit, nontoken median cost	Proposed CY 2008 post cost total frequency	Proposed CY 2008 pass edit, nontoken, no FB frequency	Proposed CY 2008 pass edit, nontoken, no FB median cost	Difference between CY 2007 final rule median and proposed CY 2008 median cost	Count of providers billing in the proposed CY 2008 data
0418	T	Insertion of Left Ventricular Pacing Elect.	169	18,777.92	4436	185	15,760.17	−16.07	158
0425	T	Level II Arthroplasty with Prosthesis.	410	6,550.59	1104	489	7,150.52	9.16	330
0427	T	Level III Tube Changes and Repositioning.	N/A	N/A	21092	11368	936.73	N/A	1255
0622	T	Level II Vascular Access Procedures.	25264	1,385.14	55118	33637	1,542.90	11.39	2380
0623	T	Level III Vascular Access Procedures.	N/A	N/A	66747	49861	1844.44	N/A	2701
0625	T	Level IV Vascular Access Procedures.	20	5,100.26	479	8	5,492.89	7.70	154
0648	T	Level IV Breast Surgery.	286	3,130.45	2895	382	3,330.44	6.39	388
0652	T	Insertion of Intraperitoneal and Pleural Catheters.	3676	1,805.28	5407	3138	1,997.86	10.67	996
0653	T	Vascular Reconstruction/Fistula Repair with Device.	702	1,978.84	26138	1573	2,584.62	30.61	682
0654	T	Insertion/Replacement of a permanent dual chamber pacemaker.	1179	6,891.44	29645	1735	6,724.90	−2.42	625
0655	T	Insertion/Replacement/Conversion of a permanent dual chamber pacemaker.	876	9,327.71	12769	1896	9,075.74	−2.70	1247
0656	T	Transcatheter Placement of Intracoronary Drug-Eluting Stents.	2700	6,618.18	24346	3148	7,478.29	13.00	378
0674	T	Prostate Cryoablation.	1737	6,646.07	3182	1997	7,782.75	17.10	366
0680	S	Insertion of Patient Activated Event Recorders.	972	4,436.69	2234	1465	4,506.93	1.58	689
0681	T	Knee Arthroplasty	301	12,569.11	391	286	12,029.91	−4.29	57

3. Proposed Payment When Devices Are Replaced with Partial Credit to the Hospital

As we discuss above in the context of the calculation of median costs for device dependent APCs, in recent years there have been several field actions and recalls with regard to failure of implantable devices. In many of these cases, the manufacturers have offered replacement devices without cost to the hospital or credit for the device being replaced if the patient required a more expensive device. In order to ensure that the payment we are proposing for CY 2008 pays hospitals appropriately when they incur the full cost of the device, we have calculated the proposed median costs for device dependent APCs using only claims that contain the correct device code for the procedure. We are not using claims that contain token charges for these expensive devices or that contain the ''FB'' modifier, which would signify that the device was replaced without cost or with a full credit for the cost of the device being replaced. Similarly, to ensure equitable payment when the hospital receives a device without cost or receives a full credit for the cost of the device being replaced, for CY 2007 we implemented a payment policy that reduces the

payment for selected device-dependent APCs when the hospital receives certain replacement devices without cost or receives a full credit for the device being replaced (71 FR 68077).

Subsequent to the issuance of the CY 2007 OPPS/ASC final rule with comment period, we had many inquiries from hospitals that asked whether the reduction would also apply in cases in which there was a partial credit for the cost of a device that failed or was otherwise covered under a manufacturer warranty. Those inquiring explained that cases of partial credit are the vast majority of cases involving devices that have failed or otherwise must be replaced under warranty. They indicated that in some cases the devices failed, and in other situations the patient's energy needs exceeded the capacity of the device and thus the device ceased to be useful before the end of the warranty period. They told us that a typical industry practice for some types of devices was to provide a 50 percent credit in cases of device failure (including battery depletion) under warranty if a device failed at 3 years of use (failure during the first 3 years would result in a full device credit) and to prorate the credit further over time between 3 and 5 years after the initial device implantation, as the useful life of the device declined. As promulgated in the CY 2007 OPPS/ASC final rule with comment period and codified at § 419.45, the CY 2007 reduction policy does not apply to cases in which there is a partial credit toward the replacement of the device.

In addition to our concern over the replacement of implantable devices at no cost to hospitals due to device recalls, device failure, or other clinical situations, we believe that it is equally as important that timely information be reported and analyzed regarding the performance and longevity of devices replaced in partial credit situations. This issue is particularly timely due to the recent recall of 73,000 ICDs and cardiac resynchronization therapy defibrillators (CRT–Ds) because of a faulty capacitor that can cause the batteries to deplete sooner than expected. In some cases, patients will require more frequent monitoring of their device function and early device replacement. (We refer readers to the Web site: *http://www.fda.gov/cdrh/news* for Questions and Answers posted April 20, 2007 on this recall.) Therefore, we believe that hospitals should report occurrences of devices being replaced under warranty or otherwise with a partial credit granted to the hospital so that we may be able to identify systematic failures of devices or device problems through claims analysis and so that we can make appropriate payment adjustments in these cases. Collecting data on a wider set of device replacements under full and partial credit situations would assist in developing comprehensive summary data, not just a subset of data related to devices replaced without cost or with a full credit to the hospital. We are mindful of the need to use our claims history where possible to promote early awareness of problems with implantable medical devices and to promote high quality medical care with regard to the devices and the services in which they are used.

We also are concerned with the issue of the increased Medicare and beneficiary liability for the monitoring costs that are required as a result of the recall of these 73,000 devices (worldwide, with an unknown portion being applicable to Medicare beneficiaries). Specifically, the manufacturer of the devices that have been most recently recalled recommends that patients with the recalled device consult with their physician in each case and, in some cases, begin a routine of monthly evaluations. We would expect that not only could extra visits to physicians' offices or HOPDs be necessary, but additional diagnostic tests may also be needed to care for the beneficiaries who have the recalled devices. Thus, even when the device does not immediately require replacement, we are concerned that the potential greater costs to Medicare and to the beneficiary or his or her secondary payor for these unforeseen extra services may be substantial and burdensome. We will be actively assessing how we can identify additional health care costs and Medicare expenditures associated with device recall actions and exploring what actions could be appropriate in the case of these additional monitoring and related expenses. We welcome public comment on this issue to inform our future review and analyses.

Moreover, the payment rates for the APCs into which the costs of the most expensive devices are packaged are set based on the assumption that the hospital incurs the full cost of the device. To continue to pay the full APC rate when the hospital receives a partial credit toward the cost of a very expensive device would result in excessive and inappropriate payment for the procedure and its packaged costs. Some hospitals have told us that they do not reduce their charges for the device being implanted or used in the procedure in cases in which they receive a partial credit for the device, even in cases in which the credit is for as much as 50 percent of the cost of an expensive device.

Under the OPPS, we calculate the estimated costs on which the APC payment weights are based by applying a CCR to the charges for the device. When hospitals charge the full amount for the device, although they may have received a substantial credit towards its cost, our methodology may result in median costs that reflect the full costs of these devices in all cases, including those cases in which the hospital incurs much less than the full cost of the device. It is likely that the reduced hospital costs associated with steady, low volume warranty replacements of implantable devices may never be reflected in the CCRs used to adjust charges to costs for devices, because those CCRs are overwhelmed by the volume of other items attributed to the cost centers. Therefore, our median costs for device-dependent APCs would not reflect the reduced hospital costs associated with partial credit replacement procedures and would result in overpayment for the implantation procedures under the OPPS. Moreover, in these cases either the beneficiary or a secondary insurer also would pay a copayment that reflects the full cost of the device, although the hospital may have received a substantial credit under the warranty. We believe that both Medicare and the beneficiary should share in the savings that result from the partial credit that the hospital receives.

We have considered how we might ensure that these cases of device failure or premature replacement are reported and appropriately taken into account in setting OPPS payment rates and beneficiary copayments. We are proposing to create a HCPCS modifier for CY 2008 that would be reported in all cases in which the hospital receives a partial credit toward the replacement of a medical device listed in Table 39 of this proposed rule. These devices are the same devices to which our policy governing payment when the device is furnished to the provider without cost or with full credit applies for CY 2008. As we discussed in the CY 2007 OPPS/ASC final rule with comment period (71 FR 68071), we selected these devices because they have substantial device costs and because the device is implanted in the beneficiary at least temporarily and, therefore, can be associated with an individual beneficiary. This proposed policy would enhance our ability to track the replacement of these implantable medical devices and may permit us to identify trends in device failure or

limited longevity. Moreover, it would enable us to reduce the APC payment in cases in which the hospital receives a partial credit toward the cost of the replacement device being implanted. We believe that this is a logical extension of our policy regarding reduction of the APC payment in cases in which the provider furnishes the device without cost or with a full credit to the hospital.

Specifically, as discussed in more detail below, we are proposing to reduce the payment for the APC into which the device cost is packaged by one half of the amount of the offset amount that would apply if the device were being replaced without cost or with full credit, but only where the amount of the device credit is greater than or equal to 20 percent of the cost of the new replacement device being implanted. We also are proposing to base the beneficiary's copayment on the reduced APC payment rate so that the beneficiary shares in the hospital's reduced costs. We believe that it is inequitable to set the payment rates for the procedures into which payment for these devices is packaged on the assumption that the hospital always incurs the full cost for these expensive devices but to not adjust the payment when the hospital receives a partial credit for a failed or otherwise replaced device. Accordingly, we believe that it is appropriate to make an equitable adjustment to the APC payment to ensure that the Medicare program payment made for the service and the beneficiary's liability are appropriate in these cases in which the hospital's device costs are significantly reduced. We are proposing changes to §§ 419.45(a) and (b) to reflect our proposed policy of reducing the OPPS payment when partial credit for the device cost is received by the hospital for a failed or otherwise replaced device.

Due to the absence of current reporting of the cases in which hospitals receive a partial credit for replaced devices and to our belief, based on conversations with hospital staff, that hospitals do not reduce their device charges to reflect the credits, we have no data for use to empirically determine by how much we should reduce the payment for the procedural APC into which the costs of these devices are packaged. However, device manufacturers and hospitals have told us that a common scenario is that, if a device fails 3 years after implantation, the hospital would receive a 50 percent credit towards a replacement device. Therefore, we are proposing to reduce the payment for these device-dependent APCs by half of the reduction that applies when the hospital receives a device without cost or receives a full credit for a device being replaced. That is, we are proposing to reduce the payment for the APC by half of the offset amount that represents the cost of the device packaged into the APC payment. In the absence of claims data on which to base a reduction factor, but taking into consideration what we have been told is common industry practice, we believe that reducing the amount of payment for the device-dependent APC by half of the estimated cost of the device packaging represents a reasonable and equitable reduction in these cases.

We considered whether to propose to require hospitals to reduce their charges in proportion to the partial credit they receive for the device so that, in future years, we would have cost data reported consistently on which we could consider basing the amount of reduction to the payment for the procedure in cases of a partial device credit. However, we are concerned that such a requirement could impose an administrative burden on hospitals that would outweigh the potential benefit of a more accurate reduction to payment in these cases. We are requesting comments on the extent to which any administrative burden would be balanced or compensated for by the potential payment accuracy benefit of an empirically based reduction to payment in these cases.

In addition, we are proposing to take this reduction only when the credit is for 20 percent or more of the cost of the new replacement device, so that the reduction is not taken in cases in which more than 80 percent of the cost of the replacement device has been incurred by the hospital. We believe that the burden to hospitals of requiring that they report cases in which the partial credit for the device being replaced is less than 20 percent of the cost of the new replacement device is greater than the benefit to the Medicare program and the beneficiary. In addition, if the partial credit is less than 20 percent of the cost of the new replacement device, then we believe that reducing the APC payment for the device implantation procedure by 50 percent of the packaged device cost would provide too low a payment to hospitals providing the necessary device replacement procedures. Therefore, we are proposing that the new HCPCS partial credit modifier would be reported and the partial credit reduction would be taken only in cases in which the credit is equal to or greater than 20 percent of the cost of the new replacement device.

For example, using the proposed CY 2008 offset percents in Table 38 below for illustration only, if a cochlear implant fails under warranty and must be replaced and the manufacturer provides the hospital a 45-percent credit of the cost of the new device used in the implantation procedure, the hospital would bill CPT code 69930 (Cochlear device implantation, with or without mastoidectomy) with the new modifier for partial credit devices, and Medicare would reduce the payment to the hospital by 41.52 percent of the APC payment rate (50 percent of the proposed full offset rate of 83.03 percent that would apply if the device were replaced with no cost to the provider or at full credit for the device being replaced).

Even in the absence of specific instructions from us to reduce the device charges in partial credit cases, we could monitor the charges that are submitted for devices reported with the proposed partial credit modifier to see if hospitals appear to be reflecting partial device credits in their charges for these implantable devices. We believe that we could use pattern analysis to determine if a hospital that is reporting the device with the partial credit modifier is charging at a lower rate for the same device when the modifier appears with the procedure in which the device is used than in cases without reporting of the modifier. If we find that hospitals are adjusting their charges to reflect the reduced costs of these devices, we will explore whether revising the amount of the reduction could be appropriate.

In the course of exploring whether the current regulations apply to partial credit situations, inquirers have told us that they are concerned that hospitals may refrain from returning devices that fail under the warranty period to manufacturers if hospitals would then be required to report the partial credit to Medicare and would receive a reduced Medicare payment as a result. They told us that this hospital practice could delay manufacturers' learning vital information about device failures, longevity, and overall performance. Currently, many device manufacturers encourage the return to them of all implantable devices, once they are taken out of a patient's body for any reason, for evaluation of device performance and survival analysis, which estimates the probability that a device will not malfunction during a specified period of time. We do not believe that hospitals would refrain from returning a device removed from a patient to a manufacturer in order to justify not reporting the partial credit modifier to

Medicare. We believe that hospitals have a strong interest in ensuring that manufacturers know as soon as possible when there are problems with the devices provided to their patients, whether the result would be a full or partial credit for the failed device. In addition, we believe that hospitals, key participants in the broader health care system, are concerned with device performance, patient health, and health care quality from the broader public health perspective and are committed to appropriate reporting to improve the quality of future health care that leads to better health outcomes for patients. Moreover, we do not believe that hospitals would intentionally fail to report to Medicare the service furnished correctly and completely with the partial credit modifier when the modifier applies, because the hospital would then knowingly submit incorrect information on the claim.

In summary, we are proposing to create a HCPCS modifier to be reported on a procedure code in Table 38 below if a device listed in Table 39 below is replaced with partial credit from the manufacturer that is greater than or equal to 20 percent of the cost of the replacement device and to reduce the payment for the procedure by 50 percent of the amount of the estimated packaged cost of the device being replaced when the modifier is reported with a procedure code that is assigned to an APC in Table 38. We believe that this policy is necessary to pay equitably for these services when the hospital receives a partial credit for the cost of the device being implanted.

We note that, of the proposed CY 2008 offset amounts shown in Table 38 that were in effect for CY 2007, 13 decline slightly compared to the CY 2007 final rule offset amounts. Similarly, the proposed CY 2008 offset amounts for eight of these APCs increase somewhat. As with changes in median costs, there may be several different factors that are responsible for the observed changes. With regard to the declines, we believe that it is possible that the increased packaging we are proposing for CY 2008 may cause the nondevice portion of an APC's median cost to increase and, therefore, could result in a decline in the device portion as a percent of total cost. Increases in the offset amounts may be caused by the increases observed in the CCRs, changes in the population of hospitals whose claims were used due to additional packaging, increased packaging of services that have significant device costs, higher costs of new devices, or greater efficiency in the implantation of devices, any of which could result in the device portion of the APC's median cost increasing as a percent of the total cost for the APC as compared to CY 2007. As with APC median costs, the offset amounts are expected to vary from year to year, and we do not see undue variation in the proposed CY 2008 offset amounts compared with the final CY 2007 offset amounts.

The CY 2007 final payment policy when devices are replaced without cost or when a full credit for a replaced device is furnished to the hospital applies to those APCs that met three criteria as described in the CY 2007 OPPS/ASC final rule with comment period (71 FR 68072 through 68077). Specifically, all procedures assigned to the selected APCs must require implantable devices that would be reported if device replacement procedures were performed, the required devices must be surgically inserted or implanted devices that remain in the patient's body after the conclusion of the procedures (at least temporarily), and the device offset amount must be significant, defined as exceeding 40 percent of the APC cost. We also restricted 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 replacement of an inexpensive device whose cost would not constitute a significant proportion of the total payment rate for an APC.

We examined the offset amounts calculated from the CY 2008 proposed rule data and the clinical characteristics of APCs to determine whether the APCs to which the no cost or full credit replacement policy applies in CY 2007 continue to meet the criteria for CY 2008 and to determine whether other APCs to which the policy does not apply in CY 2007 would meet the criteria for CY 2008. We concluded that one additional APC meets the criteria for inclusion under this policy and that one APC currently on the list ceases to meet the criteria. Specifically, we are proposing to add APC 0625 (Level IV Vascular Access Procedures) to the list of APCs to be adjusted in cases of full or partial credit for replaced devices and to add the device described by device code C1881 (Dialysis access system (implantable)) that is implanted in a procedure assigned to APC 0625 to the list of devices to which this policy applies. We are proposing to add APC 0625 and device code C1881 for CY 2008 because they meet the criteria for inclusion in this policy. In particular, the single surgical procedure (CPT code 36566 (Insertion of tunneled centrally inserted central venous access device, requiring two catheters via two separate venous access sites; with subcutaneous port(s)) assigned to APC 0625 always requires an implantable device that is reported, the proposed CY 2008 APC device offset percent is greater than 40 percent, and the device is of a type that is surgically implanted in the patient, where it remains at least temporarily. Furthermore, costly devices described by device code C1881 are implanted in the procedure assigned to APC 0625. We also found that APC 0229 (Transcatheter Placement of Intravascular Shunts) ceases to meet the criteria because the device offset percent for this APC, when calculated from proposed rule data, is less than 40 percent. Moreover, we believe that the devices that would be implanted in the procedures assigned to this APC are not of a type that would be amenable to removal and replacement in a device recall or warranty situation. Therefore, we are proposing to remove APC 0229 from the list of APCs to which the no cost or full credit and proposed partial credit reduction policies are applicable for CY 2008.

Table 38 presents the device offset amounts that we are proposing to apply to the specified APCs in cases of no cost or full or partial credit for replaced devices for the CY 2008 OPPS.

TABLE 38.—PROPOSED ADJUSTMENTS TO APCS IN CASES OF NO COST OR FULL OR PARTIAL CREDIT FOR REPLACED DEVICES

APC	SI	APC title	CY 2007 reduction for full credit case (percent)	Proposed CY 2008 reduction for full credit case (percent)	Proposed CY 2008 reduction for partial credit case (percent)
0039	S	Level I Implantation of Neurostimulator	78.85	82.15	41.07

TABLE 38.—PROPOSED ADJUSTMENTS TO APCS IN CASES OF NO COST OR FULL OR PARTIAL CREDIT FOR REPLACED DEVICES—Continued

APC	SI	APC title	CY 2007 reduction for full credit case (percent)	Proposed CY 2008 reduction for full credit case (percent)	Proposed CY 2008 reduction for partial credit case (percent)
0040	S	Percutaneous Implantation of Neurostimulator Electrodes, Excluding Cranial Nerve.	54.06	55.93	27.97
0061	S	Laminectomy or Incision for Implantation of Neurostimulator Electrodes, Excluding Cranial Nerve.	60.06	59.32	29.66
0089	T	Insertion/Replacement of Permanent Pacemaker and Electrodes	77.11	74.02	37.01
0090	T	Insertion/Replacement of Pacemaker Pulse Generator	74.74	75.54	37.77
0106	T	Insertion/Replacement/Repair of Pacemaker and/or Electrodes	41.88	57.20	28.60
0107	T	Insertion of Cardioverter-Defibrillator	90.44	89.43	44.72
0108	T	Insertion/Replacement/Repair of Cardioverter-Defibrillator Leads	89.40	89.26	44.63
0222	T	Implantation of Neurological Device	77.65	83.29	41.64
0225	S	Implantation of Neurostimulator Electrodes, Cranial Nerve	79.04	80.84	40.42
0227	T	Implantation of Drug Infusion Device	80.27	79.69	39.85
0259	T	Level VI ENT Procedures	84.61	83.03	41.52
0315	T	Level II Implantation of Neurostimulator	76.03	86.23	43.12
0385	S	Level I Prosthetic Urological Procedures	83.19	51.67	25.83
0386	S	Level II Prosthetic Urological Procedures	61.16	61.98	30.99
0418	T	Insertion of Left Ventricular Pacing Elect	87.32	81.38	40.69
0625	T	Level IV Vascular Access Procedures	N/A	62.63	32.32
0654	T	Insertion/Replacement of a permanent dual chamber pacemaker	77.35	75.86	37.93
0655	T	Insertion/Replacement/Conversion of a permanent dual chamber pacemaker.	76.59	74.59	37.30
0680	S	Insertion of Patient Activated Event Recorders	76.40	72.14	36.07
0681	T	Knee Arthroplasty	73.37	73.27	36.64

TABLE 39.—PROPOSED DEVICES FOR WHICH THE ''FB MODIFIER'' OR NEW PARTIAL CREDIT MODIFIER MUST BE REPORTED WITH THE PROCEDURE CODE WHEN FURNISHED WITHOUT COST/FULL CREDIT OR PARTIAL CREDIT FOR A REPLACED DEVICE

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

TABLE 39.—PROPOSED DEVICES FOR WHICH THE ''FB MODIFIER'' OR NEW PARTIAL CREDIT MODIFIER MUST BE REPORTED WITH THE PROCEDURE CODE WHEN FURNISHED WITHOUT COST/FULL CREDIT OR PARTIAL CREDIT FOR A REPLACED DEVICE—Continued

Device HCPCS code	Short descriptor
C2631	Rep dev, urinary, w/o sling.
L8614	Cochlear device/system.

B. Pass-Through Payments for Devices

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

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

a. Background

Section 1833(t)(6)(B)(iii) of the Act requires that, under the OPPS, a category of devices be eligible for transitional pass-through payments for at least 2, but not more than 3, years. This period begins with the first date on which a transitional pass-through payment is made for any medical device that is described by the category. The device category codes became effective April 1, 2001, under the provisions of the BIPA. Prior to pass-through device categories, Medicare payments for pass-through devices under the OPPS were made on a brand-specific basis. All of the initial 97 category codes that were established as of April 1, 2001, have expired; 95 categories expired after CY 2002, and 2 categories expired after CY 2003. In addition, nine new categories have expired since their creation. The three categories listed in Table 40, along with their expected expiration dates, were established for pass-through payment in CY 2006 or CY 2007, as noted. Under our established policy, we base the expiration dates for the category codes on the date on which a category was first eligible for pass-through payment.

Of these 3 device categories, there is 1 that would be eligible for pass-through payment for at least 2 years as of December 31, 2007; that is, device category code C1820 (Generator, neurostimulator (implantable), with rechargeable battery and charging system). In the CY 2007 OPPS/ASC final rule with comment period (71 FR 68078), we finalized our proposal to expire device category C1820 from pass-through device payment after December 31, 2007.

In the November 1, 2002 OPPS final rule, we established a policy for payment of devices included in pass-through categories that are due to expire (67 FR 66763). For CY 2003 through CY 2007, we packaged the costs of the

devices no longer eligible for pass-through payments into the costs of the procedures with which the devices were billed in the claims data used to set the payment rates for those years. Brachytherapy sources, which are now separately paid in accordance with section 1833(t)(2)(H) of the Act, are an exception to this established policy (with the exception of brachytherapy sources for prostate brachytherapy, which were packaged in the CY 2003 OPPS only).

b. Proposed Policy

For CY 2008, we are implementing the final decision we discussed in the CY 2007 OPPS/ASC final rule with comment period that finalizes the expiration date for pass-through status for device category C1820. Therefore, as of January 1, 2008, we will discontinue pass-through payment for device category code C1820. In accordance with our established policy, we will package the costs of the device assigned to this device category into the costs of the procedures with which the device was billed in CY 2006, the year of hospital claims data used for this proposed OPPS update.

In addition, the 2 device categories that were established for pass-through payment as of January 1, 2007, C1821 (Interspinous process distraction device (implantable)) and L8690 (Auditory osseointegrated device, includes all internal and external components), would be active categories for pass-through payment for 2 years as of December 31, 2008. Therefore, we are proposing that these categories expire from pass-through device payment as of December 31, 2008.

TABLE 40.—CURRENT PASS-THROUGH DEVICE CATEGORIES BY EXPIRATION DATE

HCPCS code	Category long descriptor	Date(s) populated	Expiration date
C1820	Generator, neurostimulator (implantable)	1/1/06	12/31/07
C1821	Interspinous process distraction device (implantable)	1/1/07	12/31/08
L8690	Auditory osseointegrated device, includes all internal and external components	1/1/07	12/31/08

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

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

a. Background

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

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

The offset list that we published for CY 2002 through CY 2004 was a list of offset amounts associated with those APCs with identified offset amounts developed using the methodology described above. As a rule, we do not know in advance which procedures residing in certain APCs may be billed with new device categories. Therefore, an offset amount was applied only when a new device category was billed with a HCPCS procedure code that was assigned to an APC appearing on the offset list.

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

For the CY 2006 OPPS update, CY 2004 hospital claims were available for analysis. Hospitals billed device C-codes in CY 2004 on a voluntary basis.

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

For CY 2006, we reviewed the single new device category established, C1820, to determine whether device costs associated with the new category were packaged into the existing APC structure based on partial CY 2005 claims data. Under our established policy, if we determine that the device costs associated with the new category are closely identifiable to device costs packaged into existing APCs, we set the offset amount for the new category to an amount greater than $0. Our review of the service indicated that the median cost for the applicable APC 0222 (Implantation of Neurological Device) contained costs for neurostimulators that were similar to neurostimulators described by the new device category C1820. Therefore, we determined that a device offset would be appropriate. We announced a CY 2006 offset amount for that category in Program Transmittal No. 804, dated January 3, 2006. (We subsequently were informed that some rechargeable neurostimulators described by device category C1820 may also be used and billed with a CPT code that maps to APC 0039 (Level I Implantation of Neurostimulator). We announced an offset amount for device category C1820 when billed with a procedure code that maps to APC 0039, in Program Transmittal No. 1209, dated March 21, 2007.)

For CY 2006, we used available partial year CY 2005 hospital claims data to calculate device percentages and potential offsets for CY 2006 applications for new device categories. Effective January 1, 2005, we require hospitals to report device HCPCS codes and their charges when hospitals bill for services that utilize devices described by the existing device category codes. In addition, during CY 2005 we implemented device edits for many services that require devices and for which appropriate device category HCPCS codes exist. Therefore, we expected that the number of claims that included device codes and their respective costs to be much more robust and representative for CY 2005 than for CY 2004.

For CY 2007, we reviewed the two new device categories, C1821 and L8690, to determine whether device costs associated with the new categories were packaged into the existing APC structure based on CY 2005 claims data. As indicated earlier, under our established policy, if we determine that the device costs associated with a new category are closely identifiable to device costs packaged into existing APCs, we set the offset amount for the new category to an amount greater than $0. Our review of the related services indicated that the median costs for the applicable APC 0256 (Level V ENT Procedures (for L8690)) and APC 0050 (Level II Musculoskeletal Procedures Except Hand and Foot (for C1821)) did not contain costs for devices that were similar to those described by the new device categories. Therefore, we set the respective offsets to $0.

We believe that use of the most current claims data to establish offset amounts when they are needed to ensure appropriate payment is consistent with our stated policy; therefore, we are proposing to continue to do so for the CY 2008 OPPS. Specifically, if we create a new device category for payment in CY 2008, to calculate potential offsets we are proposing to examine the most current available claims data, including device costs, to determine whether device costs associated with the new category are already packaged into the existing APC structure, as indicated earlier. If we conclude that some related device costs are packaged into existing APCs, we are proposing to use the methodology described earlier and first used for the CY 2003 OPPS to determine an appropriate device offset percent for those APCs with which the new category would be reported.

b. Proposed Policy

For CY 2008, we are proposing to continue to review each new device category on a case-by-case basis as we have done since CY 2004, to determine whether device costs associated with the new category are packaged into the existing APC structure. If we determine that, for any new device category, no device costs associated with the new category are packaged into existing APCs, we are proposing to continue our current policy of setting the offset amount for the new category to $0 for CY 2008. There are currently two new device categories that will continue for pass through payment in CY 2008. These categories, described by HCPCS codes L8690 and C1821, currently have an offset amount equal to $0 because we could not identify device related costs in the procedural APCs we expect would be billed with either of the two categories L8690 or C1821, that is, in APC 0256 or APC 0050, respectively. We are proposing that the offsets for CY 2008 for L8690 and C1821 remain set to $0, because we cannot identify device costs packaged in the related procedural APCs that are closely identifiable with these device categories, based on the claims data for CY 2006, the claims data year for our CY 2008 OPPS update.

We are proposing to continue our existing policy of establishing new categories in any quarter when we determine that the criteria for granting pass through status for a device category are met. If we create a new device category and determine that our CY 2006 claims data contain a sufficient number of claims with identifiable costs associated with the new category of devices in any APC with which it is billed, we are proposing to establish an offset amount greater than $0 and to reduce the transitional pass through payment for the device by the related procedural APC offset amount. If we determine that a device offset amount greater than $0 is appropriate for any new category that we create, we are proposing to announce the offset amount in the program transmittal that announces the new category.

In summary, for CY 2008, we are proposing to use CY 2006 hospital claims data to calculate device percentages and potential offsets for new device categories established in CY 2008. We are proposing to publish through program transmittals any new or updated offsets that we calculate for CY 2008, corresponding to newly

created categories or existing categories eligible for pass-through payment, respectively.

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

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

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

1. Background

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

Transitional pass-through payments are also provided for certain ''new'' drugs and biological agents 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. Under the statute, transitional pass-through payments can be made for at least 2 years but not more than 3 years. Proposed CY 2008 pass-through drugs and biologicals are assigned status indicator ''G'' in Addenda A and B to this proposed rule.

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) (or, if the drug or biological is covered under a competitive acquisition contract under section 1847B, 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) 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. This methodology for determining the pass-through payment amount is set forth in § 419.64 of the regulations, which specifies 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, as added by section 303(c) of Pub. L. 108–173, establishes the use of the average sales price (ASP) methodology as the basis for payment 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 uses several sources of data as a basis for payment, including ASP, wholesale acquisition cost (WAC), and average wholesale price (AWP). In this proposed rule, 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/01_overview.asp#TopOfPage.*

As noted above, section 1833(t)(6)(D)(i) of the Act also states that if a drug or biological is covered under a competitive acquisition contract under section 1847B of the Act, the payment rate is equal to the average price for the drug or biological for all competitive acquisition areas and the year established as calculated and adjusted by the Secretary. Section 1847B of the Act, as added by section 303(d) of Pub. L. 108–173, establishes the payment methodology for Medicare Part B drugs and biologicals under the competitive acquisition program (CAP). The Part B drug CAP was implemented July 1, 2006, and includes approximately 180 of the most commonPart B drugs provided in the physician's office setting. The list of drugs and biologicals covered under the Part B drug CAP, their associated payment rates and the Part B drug CAP pricing methodology can be found on the CMS Web site at *http://www.cms.hhs.gov/CompetitiveAcquisforBios.*

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.

The pass-through application and review process 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 2007

Section 1833(t)(6)(C)(i) of the Act specifies that the duration of transitional pass through payments for drugs and biologicals must be no less than 2 years and no longer than 3 years. In Table 41, we list the seven drugs and biologicals whose pass through status will expire on December 31, 2007, that meet that criterion.

TABLE 41.—PROPOSED DRUGS AND BIOLOGICALS FOR WHICH PASS-THROUGH STATUS EXPIRES DECEMBER 31, 2007

HCPCS code	Short descriptor	CY 2007 and proposed CY 2008 APC	CY 2007 SI	Proposed CY 2008 SI
J2278	Ziconotide injection	1694	G	K
J2503*	Pegaptanib sodium injection	1697	G	K
J7311	Fluocinolone acetonide	9225	G	K
J8501	Oral aprepitant	0868	G	K
J9027	Clofarabine injection	1710	G	K
J9264*	Paclitaxel protein bound	1712	G	K
Q4079	Natalizumab injection	9126	G	K

* Indicates that the drug was paid at a rate determined by the Part B drug CAP methodology while identified as pass-through under the OPPS.

3. Drugs and Biologicals with Proposed Pass-Through Status in CY 2008

We are proposing to continue pass-through status in CY 2008 for 13 drugs and biologicals. These items, which were approved for pass-through status between April 1, 2006 and July 1, 2007, are listed in Table 42. The APCs and HCPCS codes for these drugs and biologicals listed in Table 42 are assigned status indicator ''G'' in Addenda A and B to this proposed rule.

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). The pass-through payment amount is the difference between 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, 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) and the portion of the otherwise applicable fee schedule amount that the Secretary determines is associated with the drug or biological. Given our CY 2008 proposal to provide payment for nonpass-through separately payable drugs and biologicals at ASP+5 percent as described further in section V.B.3 of this proposed rule, we believe it would be most consistent with the statute to provide payment for drugs and biologicals with pass through status that are not part of the Part B drug CAP at a rate of ASP+6 percent, compared to ASP+5 percent as the otherwise applicable fee schedule portion associated with the drug or biological. The difference between ASP+6 percent and ASP+5 percent, therefore, would be the CY 2008 pass-through payment amount for these drugs and biologicals. Thus, we are proposing for CY 2008 to pay for pass-through drugs and biologicals that are not part of the Part B drug CAP at ASP+6 percent, equivalent to the rate these drugs and biologicals would receive in the physician's office setting in CY 2008.

Section 1842(o) of the Act also states that if a drug or biological is covered under a competitive acquisition contract under section 1847B of the Act, the payment rate is equal to the average price for the drug or biological for all competitive acquisition areas and year established as calculated and adjusted by the Secretary. For CY 2008, we are proposing to provide payment for drugs and biologicals with pass-through status that are offered under the Part B drug CAP at a rate equal to the Part B drug CAP rate. Therefore, considering ASP+5 percent to be the otherwise applicable fee schedule portion associated with these drugs or biologicals, the difference between the Part B drug CAP rate and ASP+5 percent would be the pass-through payment amount for these drugs and biologicals. HCPCS codes that are offered under the CAP program as of April 1, 2007 are identified in Table 42 with an asterisk.

In section V.B.3.b. of this proposed rule, we discuss our proposal to make separate payment in CY 2008 for new drugs and biologicals with a HCPCS code, consistent with the provisions of section 1842(o) of the Act, at a rate that is equivalent to the payment they would receive in a physician's office setting (or under section 1847B of the Act, if the drug or biological is covered under a competitive acquisition contract) only if we have received a pass-through application for the item and pass-through status has been subsequently granted. Otherwise, we are proposing to pay ASP+5 percent for these products in CY 2008.

We are proposing to use payment rates based on the ASP data from the fourth quarter of CY 2006 for budget neutrality estimates, impact analyses, and completion of Addenda A and B to this proposed rule because these are the most recent data available to us at this time. These payment rates are also the basis for drug payments in the physician's office setting, effective April 1, 2007. As updated data will be available during the development of our final rule, we are proposing to use ASP data from the second quarter of 2007 (which are the basis for drug payments in the physician's office setting, effective October 1, 2007) in budget neutrality estimates, impact analyses, and completion of Addenda A and B to the CY 2008 OPPS/ASC final rule with comment period. In addition, we are proposing to update these pass-through payment rates on a quarterly basis on our Web site during CY 2008 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. Although there are no pass-through radiopharmaceuticals at this time for CY 2008, the payment rate for a radiopharmaceutical with pass-through status would also be adjusted accordingly.

If a drug that has been granted pass-through status for CY 2008 becomes covered under the Part B drug CAP, we are proposing to make the appropriate adjustments to the payment rates for these drugs and biologicals on a quarterly basis. For drugs and biologicals that are currently covered under the CAP, we are proposing to use the payment rates calculated under that program that are in effect as of April 1, 2007. We are proposing to update these payment rates if the rates change in the future.

TABLE 42.—PROPOSED DRUGS AND BIOLOGICALS WITH PASS-THROUGH STATUS IN CY 2008

HCPCS code	Short descriptor	CY 2007 and proposed CY 2008 APC	CY 2007 and proposed CY 2008 SI
C9232	Injection, idursulfase	9232	G
C9233	Injection, ranibizumab	9233	G
C9235	Injection, panitumumab	9235	G
C9350	Porous collagen tube per cm	9350	G
C9351	Acellular derm tissue percm2	9351	G
J0129	Injection, abatacept	9230	G
J0348	Anadulafungin injection	0760	G
J0894*	Injection, decitabine	9231	G
J1740	Injection ibandronate sodium	9229	G
J2248	Injection, micafungin sodium	9227	G
J3243	Injection, tigecycline	9228	G
J3473	Hyaluronidase recombinant	0806	G
J9261	Nelarabine injection	0825	G

* Indicates that the drug is paid at a rate determined by the Part B drug CAP methodology while identified as pass-through under the OPPS.

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

1. Background

Under the CY 2007 OPPS, we currently pay for drugs, biologicals, and radiopharmaceuticals that do not have pass-through status in one of two ways: packaged payment within the payment for the associated service or separate payment (individual APCs). We explained in the April 7, 2000 OPPS final rule with comment period (65 FR 18450) that we generally package the cost of drugs and radiopharmaceuticals into the APC payment rate for the procedure or treatment with which the products are usually furnished. Hospitals do not receive separate payment from Medicare for packaged items and supplies, and hospitals may not bill beneficiaries separately for any packaged items and supplies whose costs are recognized and paid within the national OPPS payment rate for the associated procedure or service. (Program Memorandum Transmittal A 01 133, issued on November 20, 2001, explains in greater detail the rules regarding separate payment for packaged services.)

Packaging costs into a single aggregate payment for a service, procedure, or episode of care is a fundamental principle that distinguishes a prospective payment system from a fee schedule. In general, packaging the costs of items and services into the payment for the primary procedure or service with which they are associated encourages hospital efficiencies and also enables hospitals to manage their resources with maximum flexibility.

Section 1833(t)(16)(B) of the Act, as added by section 621(a)(2) of Pub. L. 108–173, sets 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 are not new and do not have pass through status was established to be $55. The methodology used to establish the $55 threshold for CY 2007 and our proposed approach for future years are discussed in more detail in section V.B.2. of this proposed rule.

In addition, for CY 2005 to CY 2007, we have provided an exemption to this packaging determination for oral and injectable 5HT3 forms of anti emetic products. We discuss in section V.B.2. of this proposed rule our proposed CY 2008 payment policy for anti emetic products.

2. Proposed Criteria for Packaging Payment for Drugs and Biologicals

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

As indicated above, in accordance with section 1833(t)(16)(B) of the Act, the threshold for establishing separate APCs for drugs and biologicals was set to $50 per administration during CYs 2005 and 2006. In CY 2007, we used the fourth quarter moving average Producer Price Index (PPI) levels for prescription preparations to trend the $50 threshold forward from the third quarter of CY 2005 (when the Pub. L. 108–173 mandated threshold became effective) to the third quarter of CY 2007. We then rounded the resulting dollar amount to the nearest $5 increment in order to determine the CY 2007 threshold adjustment amount of $55.

Following the CY 2007 methodology (which is discussed in more detail in the CY 2007 OPPS/ASC final rule with comment period (71 FR 68085 through 68086)), we used updated fourth quarter moving average PPI levels to trend the $50 threshold forward from the third quarter of CY 2005 to the third quarter of CY 2008 and again rounded the resulting dollar amount ($57.78) to the nearest $5 increment, which yielded a figure of $60. In performing this calculation, we used the most up-to-date forecasted, quarterly PPI estimates from CMS' Office of the Actuary (OACT). 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 proposed rule) and have been incorporated into our calculation for this CY 2008 proposed rule. Based on the calculations described above, we are proposing a packaging threshold for CY 2008 of $60. 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 is an appropriate mechanism to gauge Part B drug inflation. While we are not proposing for CY 2008 to change this established approach to establishing the general packaging threshold for drugs, biologicals, and radiopharmaceuticals, in view of our proposed packaging approach for the CY 2008 OPPS as outlined in section II.A.4. of this proposed rule and our desire to move the OPPS toward a more encounter-based and episode-based payment in the future, we will consider expanded packaging of payment for drugs, biologicals, and radiopharmaceuticals for a future OPPS update. We believe that consideration of expanded packaging for drugs and biologicals is particularly important given the substantial increase that has occurred in recent years in the proportion of HCPCS codes for drugs, biologicals, and radiopharmaceuticals that are paid separately, from 30 percent in CY 2003 to 50 percent in CY 2007. We are proposing for CY 2008 to expand the packaging of certain drugs and radiopharmaceuticals, specifically contrast agents and diagnostic radiopharmaceuticals as discussed in detail in section II.A.4. of this proposed rule. However, we believe that increased packaging of payment for drugs, biologicals, and radiopharmaceuticals more generally under the OPPS could provide significant incentives for hospital efficiency in adopting the most cost-effective approaches to patient care, while providing hospitals with maximum flexibility in managing their resources. Therefore, we are interested in public comments regarding recommended approaches to increase packaging of these products under the OPPS and issues we should consider as we evaluate alternative methodologies for the future.

To determine their CY 2008 proposed packaging status, we calculated the per day cost of all drugs, biologicals, and radiopharmaceuticals that had a HCPCS code in CY 2006 and were paid (via packaged or separate payment) under the OPPS using claims data from January 1, 2006, to December 31, 2006. In order to calculate the per day costs for drugs, biologicals, and radiopharmaceuticals to determine their packaging status in CY 2008, we are proposing to use the methodology that was described in detail in the CY 2006 OPPS proposed rule (70 FR 42723 through 42724) and finalized in the CY 2006 OPPS final rule with comment period (70 FR 68636 through 70 FR 68638). To calculate the proposed CY

2008 per day costs, we used an estimated payment rate for each drug and biological of ASP+5 percent (which is the payment rate we are proposing for separately payable drugs and biologicals in CY 2008, as discussed in more detail subsequently). As noted in section V.A.3. of this proposed rule, we used the manufacturer submitted ASP data from the fourth quarter of CY 2006 (rates that were used for payment purposes in the physician's office setting, effective April 1, 2007). For items that did not have an ASP based payment rate, we used their mean unit cost derived from the CY 2006 hospital claims data to determine their per day cost. We packaged items with per day cost less than or equal to $60 and identified items with per day cost greater than $60 as separately payable. Consistent with our past practice, we crosswalked historical OPPS claims data from the CY 2006 HCPCS codes that were reported to the CY 2007 HCPCS codes that we display in Addendum B to this proposed rule for payment in CY 2008. We note that HCPCS code A9568 (Technetium Tc–99 arcitumomab, diagnostic, per study dose, up to 45 millicuries), replaced HCPCS code A9549 (Technetium Tc–99 arcitumomab, diagnostic, per study dose, up to 25 millicuries) beginning January 1, 2007. Our CY 2006 claims data indicate that HCPCS code A9549 was billed an average of one time per day. As we do not have claims data available for ratesetting purposes for HCPCS code A9568, we estimated the number of units per day to also be one.

Our policy during previous cycles of the OPPS has been to use updated data to establish final determinations of the packaging status of drugs, biologicals, and radiopharmaceuticals. We note it is also our policy to make an annual packaging determination only when we develop the OPPS final rules. Only items that are identified as separately payable in the final rule will be subject to quarterly updates as discussed in section V.B.3. of this proposed rule. For our calculation of per day costs of drugs, biologicals, and radiopharmaceuticals in the CY 2008 OPPS/ASC final rule with comment period, we are proposing to use ASP data from the first quarter of CY 2007, which would be the basis for calculating payment rates for drugs and biologicals in the physician's office setting using the ASP methodology, effective July 1, 2007, along with the updated hospital claims data from CY 2006.

Consequently, the packaging status for drugs, biologicals, and radiopharmaceuticals for the final rule using the updated data may be different from their packaged status determined based on the data we are using for this proposed rule. Under such circumstances, we are proposing to apply the following policies to these drugs, biologicals, and radiopharmaceuticals whose relationship to the $60 threshold changes based on the final updated data:

- Drugs, biologicals, and radiopharmaceuticals that were paid separately in CY 2007 and that are proposed for separate payment in CY 2008, and then have per day costs equal to or less than $60 based on the updated ASPs and hospital claims data used for the CY 2008 final rule with comment period, would continue to receive separate payment in CY 2008.
- Drugs, biologicals, and radiopharmaceuticals that are packaged in CY 2007 and that are proposed for separate payment in CY 2008, and then have per day costs equal to or less than $60 based on the updated ASPs and hospital claims data used for the CY 2008 final rule with comment period, would remain packaged in CY 2008.
- Drugs, biologicals, and radiopharmaceuticals for which we are proposing packaged payment in CY 2008 but then had per day costs greater than $60 based on the updated ASPs and hospital claims data used for the CY 2008 final rule with comment period, would receive separate payment in CY 2008.

We note that in sections II.A.4.c.(5) and (6) of this proposed rule that we are proposing to package payment for all diagnostic radiopharmaceuticals and contrast agents that would not otherwise be packaged according to the proposed CY 2008 packaging threshold for drugs, biologicals and radiopharmaceuticals. Tables 17 and 19 in sections II.A.4.c.(5) and (6) of this proposed rule list the diagnostic radiopharmaceuticals and contrast agents, respectively, that we are proposing to package in CY 2008. We discuss our reasons for treating diagnostic radiopharmaceuticals and contrast agents differently from other drugs, biologicals, and therapeutic radiopharmaceuticals below.

For CY 2008, we also are proposing to continue exempting the oral and injectable forms of 5HT3 anti-emetic products from packaging, thereby making separate payment for all of the 5HT3 anti-emetic products. As we stated in the CY 2005 OPPS final rule with comment period (69 FR 65779 through 65780), it is our understanding that chemotherapy is very difficult for many patients to tolerate, as the side effects are often debilitating. In order for Medicare beneficiaries to achieve the maximum therapeutic benefit from chemotherapy and other therapies with side effects of nausea and vomiting, anti-emetic use is often an integral part of the treatment regimen. We believe that we should continue to ensure that Medicare payment rules do not impede a beneficiary's access to the particular anti-emetic that is most effective for him or her as determined by the beneficiary and his or her physician.

TABLE 43.—PROPOSED ANTI-EMETICS TO EXEMPT FROM PROPOSED CY 2008 $60 PACKAGING THRESHOLD

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

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

a. Payment for Specified Covered Outpatient Drugs

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

(1) Background

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

Under section 1833(t)(14)(B)(ii) of the Act, certain drugs and biologicals are designated as exceptions and are not included in the definition of ''specified covered outpatient drugs.'' (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, as added by section 621(a)(1) of Pub. L. 108 173, 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.

In establishing the CY 2006 payment rates, we evaluated the three data sources that were available to us for setting the CY 2006 payment rates for drugs and biologicals. As described in the CY 2006 OPPS final rule with comment period (70 FR 68639 through 68644), these data sources were the GAO reported average purchase prices for 55 specified covered outpatient drug categories for the period July 1, 2003, to June 30, 2004, collected via a survey of 1,400 acute care Medicare-certified hospitals; ASP data; and mean costs derived from CY 2004 hospital claims data. For the CY 2006 OPPS final rule with comment period, we used ASP data from the second quarter of CY 2005, which were used to set payment rates for drugs and biologicals in the physician's office setting effective October 1, 2005, and updated claims data.

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

As we noted in the CY 2006 OPPS final rule with comment period, findings from a MedPAC survey of hospital charging practices indicated that hospitals set charges for drugs, biologicals, and radiopharmaceuticals high enough to reflect their pharmacy handling costs as well as their acquisition costs. In consideration of this information, we stated in the CY 2006 OPPS final rule with comment period that payment rates derived from hospital claims data also included acquisition and pharmacy handling costs because they are derived directly from hospital charges (70 FR 68642). In CYs 2006 and 2007, we finalized a policy of providing payment to HOPDs for drugs, biologicals, and associated pharmacy handling costs at a rate of ASP+6 percent. In addition, in CY 2006 we had proposed to collect pharmacy overhead charge data via special pharmacy overhead HCPCS codes that hospitals would report. We did not finalize this proposal for CY 2006 because of hospital concerns regarding the administrative burden associated with reporting pharmacy overhead with these special HCPCS codes (70 FR 68657 through 68665).

(2) Proposed Payment Policy

The provision in section 1833(t)(14)(A)(iii) of the Act, as described above, continues to be applicable to determining payments for SCODs for CY 2008. This provision requires that in CY 2008 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, 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. In addition, section 1833(t)(14)(E)(ii) authorizes the Secretary to adjust APC weights for SCODs to take into account the MedPAC report relating to overhead and related expenses, such as pharmacy services and handling costs.

During the March 2007 APC Panel meeting, the APC Panel recommended that CMS implement a three-phase plan to address OPPS payment for pharmacy overhead costs. The first phase of the recommended plan involves CMS working with interested stakeholders to develop a system of defining pharmacy overhead categories for outpatient drugs that require different levels of pharmacy resources. In addition, this phase includes a provision recommending that CMS provide payment for pharmacy overhead costs by setting payment rates for the developed categories through New Technology APCs, presumably while collecting hospital cost data on these services. The second phase of the recommended plan calls for CMS to review estimates of pharmacy overhead costs as identified by the GAO and MedPAC, and to consider external survey data from stakeholders. The third and final phase of the recommended plan calls for specific billing of pharmacy overhead costs using HCPCS codes (corresponding to the categories developed in phase one, with payment rates resulting from submitted hospital claims data) on the same claim as a drug administration service. The APC Panel recommended that the overhead payments be made in addition to the current ASP+6 percent payment rates for separately payable drugs and biologicals that do not have pass-through status. We also have met with interested stakeholders who have presented proposals similar to the APC Panel's recommended plan with various modifications to that recommendation, including suggestions for the assignment of specific drugs and biologicals to various overhead categories and potential overhead payment rates for such categories in the first phase of the APC Panel's recommended plan. In addition, some stakeholders have recommended that CMS conduct a survey of pharmacy overhead costs in the second phase of the APC Panel's recommended plan.

While we appreciate the APC Panel's recommendation, as well as similar suggestions from other stakeholders, we are not proposing to adopt the APC Panel's recommendation for CY 2008. As discussed in section II.A.4. of this proposed rule, for CY 2008, we are proposing to expand packaging for a number of different groups of services. Given our belief that packaging can be helpful in promoting hospital efficiency and long-term cost containment, we do not believe it would be desirable to take steps that would ultimately lead to payment for pharmacy overhead costs being unpackaged under the OPPS. In addition, we note that the APC Panel recommended that CMS establish separate payment amounts for pharmacy overhead in addition to the current combined payment for drug acquisition

costs and pharmacy overhead of ASP+6 percent. As we discussed in the CY 2006 OPPS final rule with comment period (70 FR 68657) and in the CY 2007 OPPS/ASC final rule with comment period (71 FR 68089 through 68092), findings from a MedPAC survey of hospital charging practices indicated that hospitals set charges for drugs, biologicals, and radiopharmaceuticals high enough to reflect their pharmacy handling costs as well as their acquisition costs. We believe that our payment rates for drug acquisition costs and pharmacy overhead should be determined based on the costs reflected in our claims data, as these costs reflect both acquisition costs and overhead costs. We also believe that establishing additional payment for pharmacy overhead beyond our proposed payment rates based on claims data would distort the relative relationship of costs across HOPD services, which is the basis of the OPPS.

While we are not proposing to adopt the APC Panel's recommendation for CY 2008, we considered several other options for payment for drug acquisition costs and pharmacy overhead for CY 2008. First, we considered proposing again the methodology we had proposed for CY 2006, which involved the establishment of three drug overhead categories that hospitals would use to report pharmacy overhead charges associated with a drug provided in the HOPD. Until such data were available for ratesetting purposes, we considered continuing our CY 2007 methodology of bundling average hospital acquisition and pharmacy overhead payments. While this approach has the advantage of not paying separately for pharmacy overhead until we would have claims data on which to establish separate payment rates for drug acquisition costs and pharmacy overhead, its goal would still be to ultimately unpackage OPPS payment for pharmacy overhead. We have decided not to propose this option because we believe it is undesirable to take steps that would ultimately lead to pharmacy overhead being unpackaged at the same time that we are proposing measures to expand packaging under the OPPS and are considering moving toward more episode-based and encounter-based payment. Furthermore, we note that, as we considered this approach, we were mindful of the comments we received in response to our CY 2006 proposed rule expressing concern about the additional administrative burden on staff and coders that this methodology might cause.

Second, we considered continuing our CY 2007 methodology of providing a single bundled payment representing average hospital acquisition costs and associated pharmacy overhead costs. As stated previously, we believe that hospitals are including pharmacy overhead costs in their charges for drugs, consistent with MedPAC's findings. While we continue to believe that a combined payment amount for drug acquisition costs and pharmacy overhead based on our claims data is a reasonable methodology, adequately accounts for acquisition costs and overhead, and is consistent with our broader packaging efforts, we have decided to propose a slight variant of this approach for CY 2008 instead.

For CY 2008, we are proposing to continue our methodology of providing a combined payment rate for drug and biological acquisition costs and pharmacy overhead. However, in addition, we are proposing to instruct hospitals to remove the pharmacy overhead charge from the charge for the drug or biological and instead report the pharmacy overhead charge on an uncoded revenue code line on the claim beginning in CY 2008. This proposed change, from a CY 2007 policy where hospitals include pharmacy overhead in their charges for the drug or biological to a CY 2008 policy of including the pharmacy overhead charges on an uncoded revenue code line, would allow us to package pharmacy overhead costs for drugs and biologicals into payment for the associated procedure, likely a drug administration procedure, in future years when the CY 2008 claims data become available for ratesetting. We are proposing to apply this policy to the reporting of charges for all drugs and biologicals, including contrast agents, irrespective of the item's packaged or separately payable status for the CY 2008 OPPS. We are not proposing to apply this policy to the reporting of overhead charges for radiopharmaceuticals given the explicit instructions we gave hospitals beginning in CY 2006 to include the charges for radiopharmaceutical overhead and handling in the charges for the radiopharmaceutical product.

This proposal would not change our current policy of packaging payment for pharmacy overhead with payment for another item or service. Rather, in future years it would only change the types of items or services with which pharmacy overhead is packaged. Once CY 2008 claims data become available for ratesetting, this proposal would lead to pharmacy overhead for separately payable drugs being packaged with payment for the associated procedure, likely a drug administration procedure, rather than the current policy where pharmacy overhead for separately payable drugs is packaged with the payment for the drug.

We note that, in the case of current OPPS payment for packaged drugs, payment for both the drugs and their associated pharmacy overhead costs is already packaged into payment for the associated separately payable procedures, including drug administration services as discussed in detail in section II.A.1.b.(2) of this proposed rule. Packaging pharmacy overhead for separately payable drugs and biologicals into the payments for drug administration would enhance the accuracy of payments by packaging overhead for similar drugs into the commonly associated separately payable services, for example, by packaging the pharmacy overhead for a chemotherapy drug with the chemotherapy drug administration code also included on the claim. In addition, this methodology is consistent with the increased packaging efforts discussed earlier in this proposed rule. Because we would not expect to have claims data reflecting these reporting changes until CY 2010, we are proposing to continue to provide a combined payment rate for acquisition costs and pharmacy overhead for separately payable drugs and biologicals in CY 2008 similar to the combined payment rate provided in CYs 2006 and 2007 that represents the average hospital acquisition cost and pharmacy overhead cost.

Under our proposal, hospitals would be asked to report pharmacy overhead charges on an uncoded revenue code line. By having hospitals report pharmacy overhead on an uncoded revenue code line, they would have the flexibility to decide whether they reported a pharmacy overhead charge per drug or per episode of drug administration services. The pharmacy overhead charges reported through an uncoded revenue code line would be like any other charge for an uncoded revenue code line on the claim. For example, hospitals may already report charges for some drugs or pharmacy-related services through an uncoded revenue code charge. Our proposal would mean that hospitals would be reporting pharmacy overhead on an uncoded revenue code line, in addition to any drugs or pharmacy-related services that they may already be reporting in that manner. According to our standard OPPS ratesetting methodology, we would package all such uncoded revenue code lines on the claim to develop the median cost for the separately payable service with which the pharmacy charges are reported.

We note that when we proposed establishing specific HCPCS codes for hospitals to report pharmacy overhead for CY 2006, commenters expressed a number of concerns about how this reporting and charging methodology would be different from the approach for other private payers. Some commenters voiced concern that while the proposal would have required hospitals to modify their billing systems to separate the pharmacy overhead charge from the drug charge for Medicare claims, hospitals would need to bill them as a single line item for other payers. Some commenters were concerned that this might require hospitals to charge Medicare differently from all other payers for the same services. With regard to our current proposal for CY 2008 to have hospitals report a charge for the drug and a charge for pharmacy overhead via an uncoded revenue code line, we believe our current approach is consistent with Medicare regulations. So long as hospitals provide the same total charge to all payers, it would be acceptable to report that charge as a line item for one payer and two (or more) line items for another payer.

For this proposed rule, we evaluated two data sources that we have available to us for setting the CY 2008 payment rates for drugs and biologicals. The first source of drug pricing information that we have is the ASP data from the fourth quarter of CY 2006, which were used to set payment rates for drugs and biologicals in the physician's office setting, effective April 1, 2007. We have ASP-based prices for approximately 500 drugs and biologicals (including contrast agents) payable under the OPPS. However, we currently do not have any ASP data on radiopharmaceuticals.

The second source of cost data that we have for drugs, biologicals, and radiopharmaceuticals is the mean and median costs derived from the CY 2006 hospital claims data. As section 1833(t)(14)(A)(iii) of the Act clearly specifies that payment for SCODs in CY 2008 be equal to the ''average'' acquisition cost for the drug, we limited our analysis to the mean costs of drugs determined using the hospital claims data, instead of using median costs.

In our data analysis, we compared the payment rates for drugs and biologicals using data from both sources described above. After determining the proposed CY 2008 packaging status of drugs and biologicals, we estimated aggregate expenditures for all drugs and biologicals (excluding radiopharmaceuticals) that would be separately payable in CY 2008 using mean costs from the hospital claims data and the ASP-based payment amounts, and calculated the equivalent average ASP-based payment rate under both payment methodologies.

The results of our data analysis indicate that using mean unit cost to set the payment rates for the drugs and biologicals that would be separately payable in CY 2008 would be equivalent to basing their payment rates, on average, at ASP+5 percent. Therefore, we are proposing to continue to provide a bundled payment for CY 2008 at ASP+5 percent while hospitals change their charge practices to bill pharmacy overhead charges on an uncoded revenue center line as discussed above. As stated previously, we believe that this methodology would continue to provide accurate payments for average acquisition costs of Part B drugs and pharmacy overhead costs during this transition. In addition, as described in section II.A.4. of this proposed rule, for contrast agents we are proposing a supplemental approach which would package payment for all contrast media under the CY 2008 OPPS, and our specific rationale for this modified approach is described in our discussion of payment for diagnostic radiopharmaceuticals included in section V.A.3.a.(4)(b) of this proposed rule.

(3) Proposed Payment for Blood Clotting Factors

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

For CY 2007, we are providing payment for blood clotting factors under the OPPS at ASP+6 percent plus an additional payment for the furnishing fee that is also a part of the payment for blood clotting factors furnished in physicians' offices under Medicare Part B. The CY 2007 updated furnishing fee is $0.152 per unit.

For the CY 2008 OPPS, we are proposing to pay for blood clotting factors at ASP+5 percent and to continue our policy for payment of the furnishing fee using the updated amount for CY 2008 as presented in the CY 2008 MPFS final rule.

We have consistently noted that we would update the payment amount for the furnishing fee each year (based on the consumer price index) so that the payment amount for the furnishing fee is equal to the furnishing fee payment amount noted in the MPFS final rule. As discussed in greater detail in the CY 2008 MPFS proposed rule, the CPI data for the 12 month period ending in June 2007 is not yet available. In the CY 2008 MPFS final rule, we will include the actual figure for the percent change in the CPI for medical care for the 12-month period ending June 2007, and the updated furnishing fee for CY 2008 we have calculated based on that figure.

Because the furnishing fee update is based on the percentage increase in the CPI for medical care for the 12 month period ending with June of the previous year and the Bureau of Labor Statistics releases the applicable CPI data after the OPPS and MPFS proposed rules are published, we have not been able to include the actual updated furnishing fee in the CY 2006 through CY 2008 OPPS and MPFS proposed rules. Rather, we announced in these proposed rules that we intended to include the actual figure for the percent change in the applicable CPI, and the updated furnishing fee calculated based on that figure in the associated final rule. Given the timing of the availability of the applicable data and our timeframe for preparing proposed rules, this process is unavoidable and likely to remain unchanged in the future. We believe that including a discussion of the furnishing fee update in annual rulemaking does not provide an advantage over other means of announcing this information, so long as the current statutory update methodology continues in effect. We believe that the public's need for information and adequate notice regarding the updated furnishing fee can be better met by issuing program instructions which will eliminate the discussion of the furnishing fee update annually in rulemaking. In addition, by communicating the updated furnishing fee in program instruction, the actual figure for the percent change in the applicable CPI and the updated furnishing fee calculated based on that figure can be announced more timely than when included as part of the annual rulemaking process. Because the furnishing fee update process is statutorily determined and is based on an index that is not affected by administrative discretion or public comment, we do not believe our proposed means of communicating the update will adversely affect stakeholders or the public. Therefore, for CY 2009 and thereafter, until such time as the update methodology may be modified, we are proposing to announce the blood clotting furnishing fee using applicable program instructions and posting on the CMS Web site. For additional information and instructions on how to submit comments on this proposal, we refer readers to the CY 2008 MPFS proposed rule.

(4) Proposed Payment for Radiopharmaceuticals

(a) Background

Section 303(h) of Pub. L. 108–173 exempted radiopharmaceuticals from ASP pricing in the physician's office setting. Beginning in the CY 2005 OPPS final rule with comment period, we have exempted radiopharmaceutical manufacturers from reporting ASP data for payment purposes under the OPPS (for more information, we refer readers to the CY 2005 OPPS final rule with comment period and the CY 2006 OPPS final rule with comment period, 69 FR 65811 and 70 FR 68655, respectively). Consequently, we do not have ASP data for radiopharmaceuticals for consideration for CY 2008 OPPS ratesetting. In accordance with section 1833(t)(14)(B)(i)(I) of the Act, radiopharmaceuticals are classified under the OPPS as SCODs. Accordingly, payments for radiopharmaceuticals are to be made at average acquisition cost as determined by the Secretary and subject to any adjustment for overhead costs. Radiopharmaceuticals are also subject to the policies affecting all similarly classified OPPS drugs and biologicals, such as pass-through payments and packaging determinations, discussed earlier in this proposed rule.

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. This methodology was finalized as an interim proxy for average acquisition cost because of the unique circumstances associated with providing radiopharmaceutical products to Medicare beneficiaries. The single OPPS payment represented Medicare payment for both the acquisition cost of the radiopharmaceutical and its associated pharmacy overhead costs. We clearly stated in both the CY 2006 and CY 2007 OPPS final rules with comment period that we did not intend to maintain this methodology permanently (70 FR 68656 and 71 FR 68096, respectively), and that we would continue to actively seek other methodologies for setting payments for radiopharmaceuticals in future years.

During the CY 2006 and CY 2007 rulemaking processes, we encouraged hospitals and the radiopharmaceutical stakeholders to assist us in developing a viable long-term prospective payment methodology for these products under the OPPS. We are pleased to note that we have had many discussions over this past year with interested parties regarding the availability and limitations of radiopharmaceutical cost data. In addition, we have received several suggestions from interested parties on how to structure future payment methodologies. Many of the proposals we have received have suggested that we consider differentiating radiopharmaceutical products into two different categories by cost, at least in part because stakeholders have speculated that charge compression leads to inappropriately low calculated costs for expensive radiopharmaceuticals. For CY 2008, we are making separate payment proposals for diagnostic radiopharmaceuticals and therapeutic radiopharmaceuticals. While we have not grouped radiopharmaceuticals based on cost, we note that the therapeutic radiopharmaceuticals typically are more expensive than the diagnostic radiopharmaceuticals. We identified all diagnostic radiopharmaceuticals specifically as those Level II HCPCS codes that include the term ''diagnostic'' along with a radiopharmaceutical in their long code descriptors. Therefore, we were able to distinguish therapeutic radiopharmaceuticals from diagnostic radiopharmaceuticals as those Level II HCPCS codes that have the term ''therapeutic'' along with a radiopharmaceutical in their long code descriptors. We note that all radiopharmaceutical products fall into one category or the other; their use as a diagnostic radiopharmaceutical or therapeutic radiopharmaceutical is mutually exclusive.

(b) Proposed Payment for Diagnostic Radiopharmaceuticals

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

As discussed in section II.A.4. of this proposed rule, we are proposing to package payment for diagnostic radiopharmaceuticals and contrast agents with per day costs over $60 as part of our packaging proposal for CY 2008. Radiopharmaceuticals and contrast agents currently are defined as SCODs in section 1833(t)(14)(B) of the Act, and we currently package payment for diagnostic radiopharmaceuticals and contrast agents with per day costs of $55 or less. However, our proposal for CY 2008 also includes packaging payment for all diagnostic radiopharmaceuticals and contrast agents, regardless of their per day cost. 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. The proportion of drugs, biologicals, and radiopharmaceuticals that are separately paid has increased in recent years, from 30 percent of HCPCS codes for these products in CY 2003 to 50 percent in CY 2007, a pattern that has been noted previously for procedural services as well. Our proposal to package payment for diagnostic radiopharmaceuticals and contrast agents regardless of per day cost furthers the fundamental principles of a prospective payment system.

We believe our proposal to treat diagnostic radiopharmaceuticals and contrast agents differently from other SCODs is appropriate for several reasons. First, the statutory requirement that we must pay separately for drugs and biologicals for which the per day cost exceeds $50 under section 1833(t)(16)(B) of the Act has expired. Therefore, we are not restricted to the extent to which we can package payment for SCODs and other drugs, nor are we required to treat all classes of drugs in the same manner with regard to whether they are packaged or separately paid. We have used this flexibility to make different packaging determinations for several years with regard to specific anti-emetic drugs. While we are proposing to continue to establish an updated cost threshold for packaging drugs, biologicals, and radiopharmaceuticals, we are also proposing an approach specific to diagnostic radiopharmaceuticals and contrast agents that would otherwise be separately paid.

Second, we see diagnostic radiopharmaceuticals and contrast agents as functioning effectively as supplies that enable the provision of an independent service. More specifically, contrast agents are always provided in support of a diagnostic or therapeutic procedure that involves imaging and diagnostic radiopharmaceuticals are always provided in support of a diagnostic nuclear medicine scan. This is different from many other SCODs, for example, therapeutic radiopharmaceuticals, where the therapeutic radiopharmaceutical itself is the primary therapeutic modality. Given the inherent function of contrast agents and diagnostic radiopharmaceuticals as

supportive to the performance of an independent procedure, we view the packaging of payment for contrast agents and diagnostic radiopharmaceuticals as a logical initial step to expand packaging for SCODs. As we consider moving to additional encounter-based and episode-based payment in future years, we may consider additional options for packaging more SCODs in the future.

Third, section 1833(t)(14)(A)(iii) of the Act requires that payment for SCODs be set prospectively based on a measure of average hospital acquisition cost. While we have ASP data for contrast agents, the lack of ASP data as a source of average acquisition cost for radiopharmaceuticals and the varying inclusion of overhead and handling costs in the charge for a radiopharmaceutical resulted in payment for radiopharmaceuticals at charges reduced to cost on a temporary basis for CYs 2006 and 2007.

We now believe our claims data offer an acceptable proxy for average hospital acquisition cost and associated handling and preparation costs for radiopharmaceuticals. 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. This issue is discussed in greater detail under section V.B.3.a.(4)(c) of this proposed rule regarding our proposed CY 2008 payment methodology for therapeutic radiopharmaceuticals. We have relied on mean unit costs derived from our claims data as one proxy for average acquisition cost and pharmacy overhead, and we use these data to determine the packaging status for SCODs. However, in light of improved data for radiopharmaceuticals in the CY 2006 claims, we believe that the line item estimated cost for a diagnostic radiopharmaceutical in our claims data is a reasonable approximation of average acquisition and preparation and handling costs for diagnostic radiopharmaceuticals. Further, because the standard OPPS packaging methodology packages the total estimated cost for each radiopharmaceutical on each claim (including the full range costs observed on the claims) with the cost of associated nuclear medicine procedures for ratesetting, this packaging approach is consistent with considering the average cost for radiopharmaceuticals, rather than the median. We also note that we believe our improved claims data could support the establishment of separate, prospective payment rates for diagnostic radiopharmaceuticals with per day costs exceeding our general packaging threshold (analogous to our proposal for therapeutic radiopharmaceuticals). However, we are proposing to package all diagnostic radiopharmaceuticals because we believe additional packaging of payment for supportive and ancillary services, including diagnostic radiopharmaceuticals, would provide additional incentives for efficiency and greater flexibility for hospitals to manage their resources.

In the case of contrast agents, while we have ASP data that can be a proxy for average hospital acquisition cost and associated handling and preparation costs, payment for almost all contrast agents would be packaged under the OPPS for CY 2008 based on the $60 per day packaging threshold. Therefore, as discussed in more detail in section V.B.3.a.(4) of this proposed rule, we believe it would be most appropriate to package payment for all contrast agents for CY 2008, to better provide for accurate payment for the associated tests and procedures that promotes hospital efficiency.

In summary, we view diagnostic radiopharmaceuticals and contrast agents as ancillary and supportive of the diagnostic tests and therapeutic procedures in which they are used. In light of our authority to make different packaging determinations, and the improved reporting of hospital charges for radiopharmaceutical handling in the CY 2006 claims data, we propose to package payment for contrast agents and diagnostic radiopharmaceuticals for CY 2008.

(c) Proposed Payment for Therapeutic Radiopharmaceuticals

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

For CY 2008, we are proposing to continue separate payment for therapeutic radiopharmaceuticals that have a mean per day cost of more than $60, consistent with the packaging methodology applied to other nonpass-through drugs and biologicals. We believe that therapeutic radiopharmaceuticals are distinct from diagnostic radiopharmaceuticals because the primary purpose of providing a therapeutic radiopharmaceutical is the radiopharmaceutical treatment itself, whereas a diagnostic radiopharmaceutical is administered in support of the performance of a diagnostic nuclear medicine study that is the primary service. For separately payable therapeutic radiopharmaceuticals, we are proposing to establish CY 2008 payment rates based on their mean unit costs from our CY 2006 OPPS claims data.

In the CY 2007 OPPS/ASC final rule with comment period (71 FR 68095), we again reiterated our intent to develop a suitable prospective payment methodology for radiopharmaceutical products paid under the OPPS in future years, beginning in CY 2008. Since the start of the temporary cost-based payment methodology for radiopharmaceuticals in CY 2006, we have met with several interested parties on this topic and have received several suggestions from these stakeholders regarding payment methodologies that we could employ for future use under the OPPS.

In considering payment options for therapeutic radiopharmaceuticals for CY 2008, we examined several alternatives. First, we considered retaining the CY 2007 methodology of providing payment for therapeutic radiopharmaceuticals at a hospital's charges reduced to cost using the hospital's overall CCR. While this option would provide consistency in the payment methodology from year to year, we have noted on several occasions, including in the CY 2007 OPPS/ASC final rule with comment period and in various public forums such as the APC Panel meetings, that this methodology was not intended to be the basis of providing payment to hospitals for these products beyond CY 2007. Payment on a claim-specific cost 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. In addition, we have stated that we believe that using hospitals' overall CCRs to determine payments could result in an overstatement of radiopharmaceutical costs, which are likely reported in several cost centers, such as diagnostic radiology, that have lower CCRs than hospitals' overall CCRs (71 FR 68095). For these reasons, we are not proposing to use this methodology to set their payment rates for CY 2008.

The second option we considered, and are proposing, as a methodology for providing payment for therapeutic radiopharmaceuticals in CY 2008, is to establish prospective payment rates for

separately payable therapeutic radiopharmaceuticals using mean costs derived from the CY 2006 claims data, where the costs are determined using our standard methodology of applying hospital-specific departmental CCRs to radiopharmaceutical charges, defaulting to hospital-specific overall CCRs only if appropriate departmental CCRs are unavailable. As we stated in the CY 2007 OPPS/ASC proposed rule, we believe this methodology provides us with the most consistent, accurate, and efficient methodology for prospectively establishing payment rates for separately payable therapeutic radiopharmaceuticals (71 FR 49587). We believe that adopting prospective payment based on historical hospital claims data is appropriate because it serves as our most accurate available proxy for the average hospital acquisition cost of separately payable therapeutic radiopharmaceutical products. In addition, we have found that our general prospective payment methodology based on historical hospital claims data results in more consistent, predictable, and equitable payment amounts across hospitals and likely provides incentives to hospitals for efficiently and economically providing these outpatient services. Therefore, we expect that the hospital-specific payment variability found under a charge-reduced-to-cost methodology would no longer affect these products under our CY 2008 proposal.

Although we received comments to our CY 2007 proposed rule indicating that CY 2005 claims data used for that update did not incorporate associated overhead charges into the radiopharmaceutical charge, in the CY 2007 OPPS/ASC final rule with comment period (71 FR 68095) we stated that we expected that hospitals would have adapted to the CY 2006 HCPCS coding changes for some radiopharmaceuticals and responded to our instructions to include their charges for radiopharmaceutical handling in their charges for the radiopharmaceutical products so these costs would be reflected in the CY 2008 ratesetting process. This continues to be our expectation, and we believe that the CY 2006 claims data that we are using to set the CY 2008 OPPS payment rates reflect both the radiopharmaceutical charge and associated overhead charges. As discussed at the March 2007 APC Panel meeting, our CY 2006 claims data show that a greater proportion of radiopharmaceuticals experienced an increase in their median costs from CY 2005 to CY 2006 than experienced a decrease. We indicated that this trend is consistent with the agency's expectations that hospitals would comply with our instructions to include charges for radiopharmaceutical handling in their charges for the radiopharmaceutical products for CY 2006. Therefore, we believe that setting CY 2008 prospective payment rates based on CY 2006 hospital claims data as described above serves as an acceptable combined proxy for average hospital acquisition costs and radiopharmaceutical handling.

During meetings with external stakeholders over the past year, we have been presented with several other suggestions regarding OPPS payment for therapeutic radiopharmaceuticals in CY 2008. One of these options included a suggestion that we employ alternative trimming methodologies in order to produce a claims-based mean cost that would more accurately reflect hospital purchase prices for these products. However, no specific trimming approaches for radiopharmaceuticals were offered for our consideration for CY 2008. We have chosen not to propose a methodology based on special OPPS data trimming for the CY 2008 proposed payment of therapeutic radiopharmaceuticals for the following reasons. First, the OPPS has a standard data trimming methodology to calculate drug, biological, and radiopharmaceutical per day costs from hospital claims data. This includes both a specific trim on units for drugs, biologicals, and radiopharmaceuticals that is ±3 standard deviations from the geometric mean, and a standard trim of any line-item with a cost per unit that is ±3 standard deviations from the geometric mean that is applied across all items and services. Both trims are conducted on the transformed variable, taking the natural log of both units and cost per unit, in order to trim evenly relative to the center of the distribution. Both units and costs per unit are never negative, and there are some therapeutic radiopharmaceuticals with very high units and costs per unit in our hospital claims data. These trims are conservative and typically eliminate only the most egregious observations, ones that could be due to erroneous reporting. For therapeutic radiopharmaceuticals, the unit trim alone removed all items that would have been eliminated under the cost trim, and with the exception of HCPCS code A9563 (Sodium phosphate P–32, therapeutic, per millicurie), this trim removed observations with unit costs below the mean unit cost listed in Table 44 below. That is, overall, the result of applying our trimming methodology increased the mean unit cost reported in Table 44.

As a payment system based on relative payment weights, altering the trimming methodology for a particular set of services could unduly influence the relativity of the resulting payment weights for those particular services and could inappropriately redistribute payments in a budget neutral OPPS. We have no reason to believe that hospitals report costs differently for radiopharmaceuticals than they do for other items. As we discuss further in section II.A.1. of this proposed rule, what is important for setting appropriate payment rates under a prospective payment system is accuracy in estimating the relative costliness of services, and not the nominal value of the observed cost. Second, we are not convinced that employing an alternative trimming methodology would result in the most appropriate cost estimates for therapeutic radiopharmaceuticals. We believe that because hospitals were paid in CY 2006 for each therapeutic radiopharmaceutical they reported according to a claim-specific charge that was reduced to cost for payment, hospitals had an incentive to accurately account for the full costs of these products in establishing their charges. In addition, we have no way of knowing the specific clinical scenario that resulted in any given claim with certain reported units and charges for a therapeutic radiopharmaceutical. Therefore, we do not believe it would be appropriate to utilize a ratesetting methodology that could disregard correctly coded claims. While we appreciate this recommendation, we are not proposing a payment methodology that includes additional trimming of hospital claims data for therapeutic radiopharmaceutical products for CY 2008.

Recommendations other than trimming have centered around providing CMS with external data on radiopharmaceutical costs. One specific recommendation that we received from interested stakeholders requested that we allow hospitals to submit their invoices to CMS. With the invoice information, CMS could establish a prospective payment rate for radiopharmaceuticals that would be calculated taking into consideration the total amount invoiced for the radiopharmaceutical, transportation costs, and applicable rebates. While this payment rate would not include payment for certain radiopharmaceutical overhead and handling costs, stakeholders suggested that these costs could be packaged into

the associated procedure payment rather than the payment for the radiopharmaceutical. Stakeholders also generally have recommended that we could collect external data from various sources (such as manufacturers, nuclear pharmacies, and others) to use for therapeutic radiopharmaceutical ratesetting purposes in CY 2008.

We are not proposing a methodology using external data for CY 2008 for the following reasons. First, any approach relying on external data has the same disadvantage previously discussed of differentially influencing the relativity of payment weights for radiopharmaceuticals in the budget neutral OPPS payment system, where we utilize a standard ratesetting methodology for other services. In addition, it is not clear that invoice information from hospitals or cost information from nuclear pharmacies would be more accurate than hospitals' costs for radiopharmaceuticals that we currently calculate based on hospitals' charges reduced to cost by application of a CCR, and such information would generally exclude the costs of the hospital's handling of the radiopharmaceuticals. However, we note that we do not currently identify separate costs for this radiopharmaceutical handling that we could then package into the costs of the associated diagnostic nuclear medicine studies and treatment procedures. Moreover, hospitals currently have the flexibility to set their charges for therapeutic radiopharmaceuticals, taking into account a variety of factors, including acquisition costs and transportation costs, so we believe it is likely that hospitals are already taking this information into consideration when establishing their charges. Further, we have already instructed hospitals to include overhead charges for radiopharmaceuticals in the charge for the radiopharmaceutical product. We have received several reports that hospitals have made these changes, when necessary, and that other changes are in process to conform to our instructions. A ratesetting approach based on external data would likely present a burden to those hospitals that have been working over the past 2 years to align their charging practices with our stated instructions. Adoption of any methodology systematically relying on external data also would be administratively burdensome for CMS because we would need to collect, process, and review external information to ensure that it was valid, reliable, and representative of a diverse group of hospitals so that it could be used to establish rates for all hospitals. For these reasons, we are not proposing to collect hospital invoices or otherwise rely on external data in order to establish prospective payment rates for therapeutic radiopharmaceuticals for CY 2008.

The eight therapeutic radiopharmaceuticals that we are proposing to pay separately in CY 2008 under our proposed methodology of mean units costs calculated from CY 2006 hospitals claims are listed in Table 44 below.

TABLE 44.—THERAPEUTIC RADIOPHARMACEUTICALS PROPOSED FOR PROSPECTIVE PAYMENT IN CY 2008

HCPCS code	Short descriptor	Proposed CY 2008 APC	Proposed CY 2008 SI	Proposed CY 2008 mean cost
A9517	I131 iodide cap, rx	1064	K	$6.22
A9530	I131 iodide sol, rx	1150	K	11.74
A9543	Y90 ibritumomab, rx	1643	K	12,030.02
A9545	I131 tositumomab, rx	1645	K	8,283.41
A9563	P32 Na phosphate	1675	K	118.02
A9564	P32 chromic phosphate	1676	K	122.17
A9600	Sr89 strontium	0701	K	610.07
A9605	Sm 153 lexidronm	0702	K	1,446.05

We note that we have received anecdotal reports from some industry stakeholders asserting that the mean costs for the most expensive radiopharmaceuticals are understated in our claims data. We specifically invite comment on how the CY 2008 OPPS payment rates that we are proposing for therapeutic radiopharmaceuticals compare with the acquisition and associated handling costs of an efficient provider. We also are soliciting suggestions on approaches that could be adopted by Medicare or industry groups to promote improvements in hospital reporting of charges and costs for therapeutic radiopharmaceuticals to the extent that they are warranted and feasible. Some stakeholders have stated that charge compression may be adversely affecting our estimates of the mean cost for expensive radiopharmaceuticals. As discussed in more detail in section II.A.1 of this proposed rule, while we are not proposing to implement adjustments for charge compression for CY 2008 based on the RTI Report, which focused only on inpatient charges, we are proposing steps to explore this issue further for the future. We are proposing to develop an all-charges model that would compare variation in CCRs with variation in charges to establish disaggregated CCRs that could be applied to both inpatient and outpatient charges. We are also proposing to evaluate the results of that methodology for purposes of determining whether the resulting disaggregated CCRs should be proposed for to adjust for charge compressions in developing the CY 2009 OPPS payment rates.

During its March 2007 meeting, the APC Panel made two recommendations regarding radiopharmaceuticals. First, the APC Panel recommended that CMS work with stakeholders on issues related to payment for radiopharmaceuticals, including evaluating claims data for different classes of radiopharmaceuticals and ensuring that a nuclear medicine procedure claim always includes at least one reported radiopharmaceutical agent. As discussed in section II.A.4. of this proposed rule, we are proposing to accept the APC Panel's recommendation, and we welcome public comment on the burden hospitals would experience should we require such precise reporting. We also are seeking comment specifically on the importance of such a requirement in light of our discussion in section II.A.4. of this proposed rule on the representation of radiopharmaceuticals in the single claims for diagnostic nuclear medicine procedures, the presence of uncoded revenue code charges specific to diagnostic radiopharmaceuticals on claims without

a coded radiopharmaceutical, and our proposal to package payment for all diagnostic radiopharmaceuticals for CY 2008.

Second, the APC Panel recommended that we consider the use of external data and work with stakeholders to determine the correct code descriptor units for each radiopharmaceutical, including HCPCS code A9524 (Iodine I–131 iodinated serum albumin, diagnostic, per 5 microcuries). We appreciate the APC Panel's recommendation. We are always open to meeting with interested stakeholders and examining any data they may provide to us. However, we are unable to accept the APC Panel's recommendation concerning the development of specific code descriptors because decisions regarding the creation of permanent HCPCS codes, including code descriptors, are coordinated by the National HCPCS Panel and are outside the scope of the OPPS. For further information on the HCPCS coding process, we refer readers to the CMS Web site at: *http://www.cms.hhs.gov/MedHCPCSGenInfo/01_Overview.asp#TopOfPage*. We encourage interested parties to submit requests for revisions of code descriptors to the National HCPCS Panel for its consideration.

b. Proposed Payment for Nonpass-Through Drugs, Biologicals, and Radiopharmaceuticals with HCPCS Codes, but without OPPS Hospital Claims Data

(If you choose to comment on issues in this section, please include the caption OPPS: Nonpass-Through Coded Drugs, Biologicals, and Radiopharmaceuticals without Claims Data.)

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 and biologicals in CY 2005, and because we had no hospital claims data to use in establishing a payment rate for them, we investigated several payment options for CY 2005 and discussed them in detail in the CY 2005 OPPS final rule with comment period (69 FR 65797 through 65799).

For CYs 2005, 2006, and 2007, we finalized our policy to provide separate payment for new drugs, biologicals, and radiopharmaceuticals with HCPCS codes, but which did not have pass through status at a rate that was equivalent to the payment they received in the physician's office setting, established in accordance with the ASP methodology.

As discussed in the CY 2005 OPPS final rule with comment period (69 FR 65797), and the CY 2006 OPPS final rule with comment period (70 FR 68666), new drugs, biologicals, and radiopharmaceuticals may be expensive, and we are concerned that packaging these new items might jeopardize beneficiary access to them. In addition, we do not want to delay separate payment for these items solely because a pass-through application was not submitted. However, we note that for CY 2008 we are proposing to explicitly account for the pass-through payment amount associated with pass-through drugs and biologicals, in the context of our CY 2008 proposal for the payment of separately payable nonpass-through drugs and biologicals at ASP+5 percent. Therefore, for CY 2008, we are proposing to provide payment for these new drugs and biologicals with HCPCS codes as of January 1, 2008, but which do not have pass-through status and are without OPPS hospital claims data, at ASP+5 percent, consistent with our proposed payment methodology for other nonpass-through drugs and biologicals. This proposal would ensure that we are treating new nonpass-through drugs and biologicals like other drugs and biologicals under the OPPS, unless they are granted pass-through status. Only if they were pass-through drugs and biologicals would they receive a different payment for CY 2008, generally equivalent to the payment these drugs and biologicals would receive in the physician's office setting, consistent with the requirements of the statute.

In accordance with the ASP methodology, in the absence of ASP data, we are proposing to continue the policy we implemented during CYs 2005, 2006, and 2007 of using the WAC for the product to establish the initial payment rate. However, we note that if the WAC is also unavailable, we would make payment at 95 percent of the product's most recent AWP. We are also proposing to assign status indicator ''K'' to HCPCS codes for new drugs and biologicals for which we have not received a pass-through application. We further note that with respect to new items for which we do not have ASP data, once their ASP data become available in later quarter submissions, their payment rates under the OPPS will be adjusted so that the rates are based on the ASP methodology and set to ASP+5 percent. We are also proposing to base payment for new therapeutic radiopharmaceuticals with HCPCS codes as of January 1, 2008, but which do not have pass-through status, on the WACs for these products as ASP data for radiopharmaceuticals are not available. In addition, we note that if the WACs are also unavailable, we would make payment for the therapeutic radiopharmaceuticals at 95 percent of their most recent AWPs. Analogous to new drugs and biologicals, we are proposing to assign status indicator ''K'' to HCPCS codes for new therapeutic radiopharmaceuticals for which we have not received a pass-through application. Consistent with other ASP-based payments, we are proposing to make any appropriate adjustments to the payment amounts for drugs and biologicals in the CY 2008 OPPS/ASC final rule with comment period and also on a quarterly basis on our Web site during CY 2008 if later quarter ASP submissions (or more recent WACs or AWPs) indicate that adjustments to the payment rates for these drugs and biologicals are necessary. The payment rates for new therapeutic radiopharmaceuticals would also be adjusted accordingly. We also are proposing to make appropriate adjustments to the payment rates for new drugs and biologicals in the event that they become covered under the CAP in the future. We note that the new CY 2008 HCPCS codes for drugs, biologicals, and therapeutic radiopharmaceuticals are not available at the time of the development of this proposed rule; however, they will be included in the CY 2008 OPPS/ASC final rule with comment period.

There are several nonpass-through drugs and biologicals that were payable in CY 2006 and/or CY 2007 for which we do not have any CY 2006 hospital claims data. In order to determine the packaging status of these items for CY 2008, we calculated an estimate of the per day cost of each of these items by multiplying the payment rate for each product based on ASP+5 percent, similar to other nonpass-through drugs and biologicals paid 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 are proposing to package items for which we estimate the per administration cost to be less than or equal to $60, which is the general packaging threshold that we are proposing for drugs, biologicals, and radiopharmaceuticals in CY 2008. We are proposing to pay separately for items with an estimated per administration cost greater than $60 (with the

exception of diagnostic radiopharmaceuticals and contrast agents which we are proposing to package regardless of cost, as discussed in more detail above). We are proposing that the CY 2008 payment for separately payable items without CY 2006 claims data would be based on ASP+5 percent, similar to other separately payable nonnpass-through drugs and biologcals under the OPPS. In accordance with the ASP methodology used in the physician office setting, in the absence of ASP data, we would use the WAC for the product to establish the initial payment rate. However, we note that if the WAC is also unavailable, we would make payment at 95 percent of the most recent AWP available.

Table 45A below lists all of the nonpass-through drugs and biologicals without available CY 2006 claims data to which these policies would apply in CY 2008.

TABLE 45A.—DRUGS AND BIOLOGICALS WITHOUT CY 2006 CLAIMS DATA

HCPCS code	Short descriptor	ASP-Based payment rate	Estimated average number of units per administration	Proposed CY 2008 SI
C9234	Inj, alglucosidase alfa	$126.00	130	K
J0288	Ampho b cholesteryl sulfate	11.89	35	K
J0364	Apomorphine hydrochloride	2.96	6	N
J1324	Enfuvirtide injection	22.69	180	K
J1562	Immune globulin subcutaneous	12.60	130	K
J2170	Mecasermin injection	11.81	15.6	K
J2315	Naltrexone, depot form	1.88	380	K
J3355	Urofollitropin, 75 iu	50.22	2	K
J7345	Non-human, non-metab tissue	35.76	16	K
J8650	Nabilone oral	16.80	6	K
J9261	Nelarabine injection	82.54	52.5	K
Q4085	Euflexxa, inj	115.19	1	K

During the March 2007 APC Panel meeting, the APC Panel reiterated its August 2006 recommendation to allow hospitals to report all HCPCS codes for drugs. In general, OPPS recognizes the lowest available administrative dose of a drug if multiple HCPCS codes exist for the drug; for the remainder of the doses, we assign a status indicator ''B'' indicating that another code exists for OPPS purposes. For example, if drug X has 2 HCPCS codes, 1 for a 1 ml dose and a second for a 5 ml dose, the OPPS would assign a payable status indicator to the 1 ml dose and status indicator ''B'' to the 5 ml dose. Hospitals would then need to bill the appropriate number of units for the 1 ml dose in order to receive payment under the OPPS. While we were not prepared to accept this recommendation when we developed the CY 2007 OPP/ASC final rule with comment period, we indicated in that rule that we would continue to consider the APC Panel's recommendation for future OPPS updates (71 FR 68083 through 68084). After further consideration of this issue, we are now accepting the APC Panel's recommendation because we have concluded that recognizing all of these HCPCS codes for payment under the OPPS should not have a significant effect on our payment methodology for drugs. We are proposing to allow hospitals to submit claims by reporting any HCPCS code for a Part B drug that is covered under the OPPS, regardless of the unit determination in the HCPCS code descriptor, beginning in CY 2008. Stakeholders have told us that this policy would reduce the administrative burden associated with our current requirement that hospitals report drugs using only the HCPCS codes with the lowest increments in their code descriptors. Whenever possible, we seek to reduce hospitals' administrative burden in submitting claims for payment under the OPPS, and we appreciate the APC Panel's recommendation in this area.

As these HCPCS codes were previously unrecognized in the OPPS, we do not have claims data to determine the appropriate packaging status. Therefore, we are proposing to assign these HCPCS codes the same status indicator as the associated recognized HCPCS code (that is, the lowest dose), as shown in Table 45B. We believe that this approach is the most appropriate and reasonable way to implement this proposed change without impacting payment. However, once claims data are 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 code-specific methodology for determining a code's packaging status for a given update year. We plan to closely follow our claims data to ensure that our annual packaging determinations for the different HCPCS codes describing the same drug do not create inappropriate payment incentives for hospitals to report certain HCPCS codes instead of others. In our analysis for this proposed rule, we also estimated the packaging status of these currently unrecognized HCPCS codes by adjusting the calculated average number of units per day for the associated recognized HCPCS code with claims data to account for the different dosage descriptors. We then multiplied this adjusted average number of units per day value by the most recent ASP data available for the unrecognized HCPCS code (listed in Table 45B). We note this methodology yielded the same packaging determinations and resulting status indicators for the currently unrecognized HCPCS codes for CY 2008 as for the recognized HCPCS code for the same drug.

TABLE 45B.—PREVIOUSLY UNRECOGNIZED HCPCS CODES AND PROPOSED STATUS INDICATORS FOR CY 2008

HCPCS codes not recognized in CY 2007	CY 2007 SI	Short descriptor	Fourth quarter CY 2006 ASP	Associated HCPCS code recognized in CY 2007	Proposed CY 2008 SI
J1470	B	Gamma globulin 2 CC inj	$23.66	J1460	K
J1480	B	Gamma globulin 3 CC inj	35.47		K
J1490	B	Gamma globulin 4 CC inj	47.31		K
J1500	B	Gamma globulin 5 CC inj	59.14		K
J1510	B	Gamma globulin 6 CC inj	71.02		K
J1520	B	Gamma globulin 7 CC inj	82.72		K
J1530	B	Gamma globulin 8 CC inj	94.62		K
J1540	B	Gamma globulin 9 CC inj	106.54		K
J1550	B	Gamma globulin 10 CC inj	118.27		K
J1560	B	Gamma globulin > 10 CC inj	118.24		K
J8521	B	Capecitabine, oral, 500 mg	13.18	J8520	K
J9094	B	Cyclophosphamide lyophilized, 200 mg	3.97	J9093	N
J9095	B	Cyclophosphamide lyophilized, 500 mg	9.93		N
J9096	B	Cyclophosphamide lyophilized, 1g	17.09		N
J9097	B	Cyclophosphamide lyophilized, 2g	39.71		N
J9140	B	Dacarbazine 200 MG inj	9.34	J9130	N
J9290	B	Mitomycin 20 MG inj	68.52	J9280	K
J9291	B	Mitomycin 40 MG inj	137.03		K
J9062	B	Cisplatin 50 MG injection	12.26	J9060	N
J9080	B	Cyclophosphamide 200 MG inj	3.83	J9070	N
J9090	B	Cyclophosphamide 500 MG inj	15.75		N
J9091	B	Cyclophosphamide 1.0 grm inj	19.17		N
J9092	B	Cyclophosphamide 2.0 grm inj	38.34		N
J9110	B	Cytarabine hcl 500 MG inj	8.22	J9100	N
J9182	B	Etoposide 100 MG inj	5.13	J9181	N
J9260	B	Methotrexate sodium inj, 50 mg	2.59	J9250	N
J9375	B	Vincristine sulfate 2 MG inj	15.41	J9370	N
J9380	B	Vincristine sulfate 5 MG inj	38.52		N

There are seven drugs and biologicals, shown in Table 45C below, that were payable in CY 2006 for which we lack CY 2006 claims data and for which we are not able to determine the per day cost based on the ASP methodology. As we are unable to determine the packaging status and subsequent payment rates, if applicable, for these drugs and biologicals for CY 2008 based on the ASP methodology or claims data, we are proposing to package payment for these drugs and biologicals in CY 2008.

TABLE 45C.—DRUGS AND BIOLOGICALS WITHOUT INFORMATION ON PER DAY COST THAT ARE PROPOSED FOR PACKAGING IN CY 2008

HCPCS code	Short descriptor	Proposed CY 2008 SI
90393	Vaccina ig, im	N
90477	Adenovirus vaccine, type 7.	N
90581	Anthrax vaccine, sc	N
90727	Plague vaccine, im	N
J0200	Alatrofloxacin mesylate.	N
J0395	Arbutamine HCl injection.	N

TABLE 45C.—DRUGS AND BIOLOGICALS WITHOUT INFORMATION ON PER DAY COST THAT ARE PROPOSED FOR PACKAGING IN CY 2008—Continued

HCPCS code	Short descriptor	Proposed CY 2008 SI
J1452	Intraocular Fomivirsen na.	N

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

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

A. Total Allowed Pass-Through Spending

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

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

For devices, developing an estimate of pass-through spending in CY 2008 entails estimating spending for two groups of items. The first group of items consists of those device categories that were eligible for pass-through payment in CY 2006 or CY 2007, or both years, and that would continue to be eligible for pass-through payment in CY 2008. The second group contains items that we know are newly eligible, or project would be newly eligible, for device

pass-through payment in the remainder of CY 2007 or beginning in CY 2008.

For drugs and biologicals, section 1833(t)(6)(D)(i) of the Act establishes the pass-through payment amount for drugs and biologicals eligible for pass-through payment 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, 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 proposing to pay for nonpass-through separately payable drugs and biologicals under the CY 2008 OPPS at the ASP+5 percent, which represents the otherwise applicable fee schedule amount associated with a pass-through drug or biological, while we would pay for pass-through drugs and biologicals at the ASP+6 percent or the Part B drug CAP rate, if applicable, our estimate of drug and biological pass-through payment for CY 2008 is not zero. Similar to estimates for devices, the first group of drugs and biologicals requiring a pass-through payment estimate consists of those products that were eligible for pass-through payment in CY 2006 or CY 2007, or both years, and that would continue to be eligible for pass-through payment in CY 2008. The second group contains products that we know are newly eligible, or project would be newly eligible, for drug or biological pass-through payment in the remainder of CY 2007 or beginning in CY 2008. The sum of the CY 2008 pass-through estimates for these two groups of drugs and biologicals would equal the total CY 2008 pass-through spending estimate for drugs and biologicals with pass-through status.

B. Proposed Estimate of Pass-Through Spending

We are proposing to set the applicable percentage limit at 2.0 percent of the total OPPS projected payments for CY 2008, consistent with our OPPS policy from CY 2004 through CY 2007.

As we discuss in section IV.B. of this proposed rule there are two device categories receiving pass-through payment in CY 2007 that would continue for payment during CY 2008. In accordance with the methodology we have used to make estimates in previous years, in cases where we have relevant claims data for the procedures associated with a device category, we are proposing to project these data forward using inflation and utilization factors based on total growth in OPPS services as projected by CMS' Office of the Actuary (OACT) to estimate the upcoming year's pass-through spending for this first group of device categories. As we stated in the CY 2007 OPPS/ASC final rule with comment period (71 FR 68101), we may use an alternate growth factor for any specific device category based on our claims data or the device's clinical characteristics, or both. We developed estimated OPPS utilization of the procedures and costs associated with the two device categories continuing for pass-through payment into CY 2008, based upon examination of our historical claims data, information provided in the pass-through device category applications, and the devices' clinical characteristics. Based on these estimates, we estimate pass-through spending attributable to the first group (that is, the two device categories continuing in CY 2008) described above to be $18.1 million for CY 2008. The two device categories continuing in CY 2008, which are reflected in this $18.1 million estimate for CY 2008 pass-through spending, are listed in Table 46A.

TABLE 46A.—PROPOSED CY 2008 DEVICES WITH CURRENT PASS-THROUGH CATEGORIES CONTINUING INTO CY 2008

HCPCS code	APC	Current pass-through device category
C1821	1821	Interspinous process distraction device (implantable).
L8690	1032	Auditory osseointegrated device, includes all internal and external components.

To estimate CY 2008 pass-through spending for device categories in the second group (that is, device categories that we know at the time of the development of this proposed rule would be newly eligible for pass-through payment in CY 2007 continuing into CY 2008 (of which there are none); additional device categories that we estimate could be approved for pass-through status subsequent to the development of this proposed rule and before January 1, 2008; and projections for new categories that could be established in the second through fourth quarters of CY 2008), we are proposing to use the following approach. In general, as described for the first group of device categories above, if we have relevant claims data, we may project these data forward using OACT inflation and utilization factors based on total growth in OPPS services, or we may use an alternate growth factor for any specific new device category based on our claims data or the device's clinical characteristics, or both. At this time, we anticipate that any new categories for January 1, 2008, would be determined after the publication of this proposed rule, but before publication of the CY 2008 final rule with comment period. If we do not have any relevant CY 2006 claims data upon which to base a spending estimate for CY 2008, we are proposing to use price information and utilization estimates from applicants. To account for the contingency of new device categories that we project could become eligible for pass-through status in the second, third, or fourth quarter of CY 2008, we are proposing to use the general methodology as described above, while also considering the most recent OPPS experience in approving new pass-through device categories.

Therefore, we are proposing that the estimate of pass-through device spending in CY 2008 incorporate both CY 2008 estimates of pass-through spending for device categories made effective January 1, 2007, and estimates for those device categories projected to be approved during subsequent quarters of CY 2007 and CY 2008.

To estimate CY 2008 pass-through spending for drugs and biologicals in the first group, specifically those drugs and biologicals initially eligible for pass-through status in CY 2006 or CY 2007 and proposed for continuation of pass-through payment in CY 2008, we are proposing to utilize the most recent Medicare physician's office data regarding their utilization, information provided in the pass-through applications, historical hospital claims data, pharmaceutical industry information, and clinical information regarding the products, in order to project the CY 2008 OPPS utilization of the products. For the 13 known drugs

and biologicals that are proposed for continuation of pass-through payment in CY 2008, we then estimated the total pass-through payment amount as the difference between ASP+6 percent or the Part B drug CAP rate, as applicable, and ASP+5 percent, aggregated across the projected CY 2008 OPPS utilization of these products. Based on these estimates, we estimate pass-through spending attributable to the first group (that is, the drugs and biological continuing with pass-through eligibility in CY 2008) described above to be about $1.3 million for CY 2008. This $1.3 million estimate of CY 2008 pass-through spending for the first group of pass-through drugs reflects the 13 current pass-through drugs that are continuing on pass-through status into CY 2008, which are listed in Table 46B.

TABLE 46B.—PROPOSED CY 2008 PASS-THROUGH DRUGS WITH CURRENT PASS-THROUGH STATUS CONTINUING INTO CY 2008

HCPCS code	Short descriptor	CY 2007 and proposed CY 2008 APC
C9232	Injection, idursulfase	9232
C9233	Injection, ranibizumab	9233
C9235	Injection, panitumumab	9235
C9350	Porous collagen tube per cm	9350
C9351	Acellular derm tissue per cm2	9351
J0129	Injection, abatacept	9230
J0348	Anadulafungin injection	0760
J0894*	Injection, decitabine	9231
J1740	Injection ibandronate sodium	9229
J2248	Injection, micafungin sodium	9227
J3243	Injection, tigecycline	9228
J3473	Hyaluronidase recombinant	0806
J9261	Nelarabine injection	0825

To estimate CY 2008 pass-through spending for drugs and biologicals in the second group (that is, drugs and biologicals that we know at the time of the development of this proposed rule would be newly eligible for pass-through payment in CY 2007 continuing into CY 2008 (of which there are none); additional drugs and biologicals that we estimate could be approved for pass-through status subsequent to the development of this proposed rule and before January 1, 2008; and projections for new drugs and biologicals that could be initially eligible for pass-through payment in the second through fourth quarters of CY 2008), we are proposing to use the following approach. At this time, we anticipate that any new drugs and biologicals for January 1, 2008, would be determined after the publication of this proposed rule, but before publication of the CY 2008 final rule with comment period. We are proposing to use utilization estimates from applicants, pharmaceutical industry data, and clinical information to base pass through spending estimates for these drugs and biologicals for CY 2008. To account for the contingency of new drugs and biologicals that we project could become eligible for pass through status in the second, third, or fourth quarter of CY 2008, we are proposing to use the general methodology as described above, while also considering the most recent OPPS experience in approving new pass-through drugs and biologicals. Based on these estimates, we estimate pass-through spending attributable to this second group of drugs and biologicals to be about $0.6 million for CY 2008.

Therefore, we are proposing that the estimate of pass through drug and biological spending in CY 2008 incorporate both CY 2008 estimates of pass-through spending for drugs and biologicals with pass-through status in CY 2007 that would continue for CY 2008 and estimates for those drugs and biologicals projected to be approved during subsequent quarters of CY 2007 and CY 2008. The total estimate of pass-through spending for drugs and biologicals under the CY 2008 OPPS is nearly $2 million.

In the CY 2005 OPPS final rule with comment period (69 FR 65810), we indicated that we are accepting pass-through applications for new radiopharmaceuticals that are assigned a HCPCS code on or after January 1, 2005. (Prior to this date, radiopharmaceuticals were not included in the category of drugs paid under the OPPS, and, therefore, were not eligible for pass-through status.) There are no radiopharmaceuticals that were eligible for pass-through payment in CY 2005 or at the time of publication of this proposed rule in CY 2007. In addition, we have no information identifying new radiopharmaceuticals to which a HCPCS code might be assigned on or after January 1, 2008, for which pass through payment status would be sought. We also have no data regarding payment for new radiopharmaceuticals with pass-through status under the methodology that we specified in the CY 2005 OPPS final rule with comment period. However, we do not believe that pass through spending for new radiopharmaceuticals in CY 2008 will be significant enough to materially affect our estimate of total pass-through spending in CY 2008. Therefore, we are not including radiopharmaceuticals in our proposed estimate of pass through spending for CY 2008. We discuss the methodology for determining the CY 2008 payment amount for new radiopharmaceuticals without pass through status in section V.B.3.b. of this proposed rule.

In accordance with the methodology described above, we estimate that total pass-through spending for the 2 device categories and 13 drugs and biologicals that are continuing for pass-through payment into CY 2008 and those that first become eligible for pass-through status subsequent to this proposed rule in CY 2007 or during CY 2008 would equal approximately $54 million, which represents 0.15 percent of total OPPS projected payments for CY 2008.

Because we estimate that pass-through spending in CY 2008 would not amount to 2.0 percent of total projected OPPS CY 2008 spending, we are proposing to return 1.85 percent of the pass-through pool to adjust the conversion factor, as we discuss in section II.C. of this proposed rule.

VII. Proposed Payment for Brachytherapy Sources

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

A. Background

Section 1833(t)(2)(H) of the Act, as added by section 621(b)(2)(C) of Pub. L. 108–173, mandated the creation of separate groups of covered OPD services that classify brachytherapy devices separately from other services or groups of services. The additional groups must reflect the number, isotope, and radioactive intensity of the devices of brachytherapy furnished, including separate groups for palladium-103 and iodine-125 devices.

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

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

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

Section 621(b)(3) of Pub. L. 108–173 required the GAO to conduct a study to determine appropriate payment amounts for devices of brachytherapy, and to submit a report on its study to the Congress and the Secretary, including recommendations on the appropriate payments for such devices. This report was due to Congress and to the Secretary no later than January 1, 2005. The GAO's final report, ''Medicare Outpatient Payments: Rates for Certain Radioactive Sources Used in Brachytherapy Could Be Set Prospectively'' (GAO–06–635), was published on July 24, 2006. We summarized and discussed the report's findings and recommendations in the CY 2007 OPPS/ASC final rule with comment period (71 FR 68103 through 68105). The GAO report principally recommended that we use OPPS historical claims data to determine prospective payment rates for two of the most frequently used brachytherapy sources, iodine-125 and palladium-103, and also recommended that we consider using claims data for the third source studied, high dose rate (HDR) iridium-192.

The GAO report concluded that CMS could set prospective payment rates based on claims data for iodine and palladium sources, because the sources' unit costs are generally stable, both sources have identifiable unit costs that do not vary substantially and unpredictably over time, and reasonably accurate claims data are available. On the other hand, the GAO report explained that it was not able to determine a suitable methodology for paying separately for HDR iridium. The report noted that iridium is reused across multiple patients, making its unit cost more difficult to determine. However, the report also indicated that CMS has outpatient claims data from all hospitals that have used iridium and that in order to identify a suitable methodology for separate payment, CMS would be able to use these data to establish an average cost and evaluate whether that cost varies substantially and unpredictably.

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 rates on median costs for each source from our CY 2005 claims data (71 FR 68102 through 71 FR 68114). We also indicated that 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 (71 FR 68112). We changed the definition of status indicator ''K'' to ensure that ''K'' appropriately describes brachytherapy sources to accommodate the use of ''K'' for prospective payment for brachytherapy sources (71 FR 68110).

Subsequent to publication of the CY 2007 OPPS/ASC final rule with comment period, section 107(a) of the MIEA–TRHCA 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. This requirement for cost-based payment ends after December 31, 2007. Therefore, we have continued payment for sources based on charges reduced to cost through CY 2007. We also have continued using status indicator ''H'' to denote nonpass through brachytherapy sources paid on a cost basis as a result of enactment of this provision rather than using status indicator ''K'' to denote prospective payment for nonpass-through brachytherapy sources, as finalized in the CY 2007 OPPS/ASC final rule with comment period.

Section 107(b)(1) of the MIEA–TRHCA 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 devices beginning July 1, 2007. Section 107(b)(2) of the MIEA TRHCA authorized the Secretary to implement this new requirement by ''program instruction or otherwise.'' This new requirement is in addition to the requirement for separate payment groups based on the number, isotope, and radioactive intensity of brachytherapy devices previously established by section 1833(t)(2)(H) of the Act. We note that commenters on the CY 2007 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 via program transmittal, effective July 1, 2007 (Program Transmittal No. 1259, dated June 1, 2007). From comments to our CY 2007 proposed rule and industry input, we are currently aware of three sources that are currently available in stranded and non-stranded forms: iodine-125; palladium-103; and cesium-131.

Therefore, in Program Transmittal No. 1259, we created six new HCPCS codes to differentiate the stranded and non-stranded versions of these three sources.

These six new HCPCS codes replace the three prior brachytherapy source HCPCS codes for iodine, palladium and cesium (C1718, C1720, and C2633, all of which are deleted as of July 1, 2007), respectively, effective July 1, 2007. In this program transmittal, we also provided specific billing instructions to hospitals on how to report stranded sources. We instructed providers, when billing for stranded sources, to bill the number of units of the appropriate source HCPCS C-code according to the number of brachytherapy sources in the strands and specifically *not* to bill as one unit per strand. If a hospital applies both stranded and non-stranded sources to a patient in a single treatment, the hospital should bill the stranded and non-stranded sources separately, according to the differentiated HCPCS codes listed in the table found in that program transmittal and included in Table 48 below. We expect that these instructions will clearly indicate how hospitals are to bill for stranded and non-stranded brachytherapy sources, and that hospital reporting of sources according to these instructions will promote accurate claims data for the various source codes in the future. In Program Transmittal No. 1259, we also added the term ''non-stranded'' to the descriptors for all sources that currently have only non-stranded versions of a source.

In Program Transmittal No. 1259, we indicated that if we receive information that any of the other sources now designated as non-stranded are marketed as a stranded source, we will create coding information 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. If a hospital purchases an FDA-approved and marketed radioactive source consisting of a radioactive isotope (consistent with our definition of a brachytherapy source eligible for separate payment as discussed below), for which we do not yet have a separate source code established, it should bill such sources using the appropriate NOS code listed in Program Transmittal No. 1259, that is, C2698 (Brachytherapy source, stranded, not otherwise specified, per source) for stranded NOS sources, or C2699 (Brachytherapy source, non stranded, not otherwise specified, per source) for non-stranded NOS sources, which are also listed in Table 48 below. For example, if a new FDA-approved stranded source comes onto the market and there is currently only a billing code for the non stranded source, the hospital should bill the stranded source under C2698 (stranded NOS source) until a specific stranded billing code for the source is established.

In Program Transmittal No. 1259, we reiterated our longstanding policy that hospitals and other parties are invited to submit recommendations to us for new HCPCS codes to describe new sources consisting of a radioactive isotope, including a detailed rationale to support recommended new sources. We will continue to endeavor to add new brachytherapy source codes and descriptors to our systems for payment on a quarterly basis. Such recommendations should be directed to the Division of Outpatient care, Mail Stop C4–05–17, Centers for Medicare and Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244.

Finally, we note that in the CY 2007 OPPS/ASC final rule with comment period, we established a definition for brachytherapy source for which separate payment under section 1833(t)(2)(H) of the Act is required (71 FR 68113). We considered the definition of ''brachytherapy source'' in the context of current medical practice and in regard to the language in section 1833(t)(2)(H) of the Act, which refers to brachytherapy sources as ''a seed or seeds (or radioactive source).'' We believed that this provision of the Act mandating separate payment refers to sources that are themselves radioactive, meaning that the source contains a radioactive isotope. Furthermore, we indicated that the statutory language is likewise clear that devices of brachytherapy paid separately must reflect the number, isotope, and radioactive intensity of such devices furnished. Accordingly, we further believed that section 1833(t)(2)(H) of the Act applies only to radioactive devices of brachytherapy. In the CY 2007 OPPS/ASC final rule with comment period, we also stated that we would not consider specific devices, beams of radiation, or equipment that do not constitute separate sources that utilize radioactive isotopes to deliver radiation to be brachytherapy sources for separate payment, as such items do not meet the statutory requirements provided in section 1833(t)(2)(H) of the Act (71 FR 68113).

B. Proposed Payments for Brachytherapy Sources

As indicated above, the provision to pay for brachytherapy sources at charges reduced to cost expires after December 31, 2007, in accordance with section 1833(t) (16)(C) of the Act, as amended by section 107(a) of the MIEA–TRHCA. However, under section 1833(t)(2)(H) of the Act, we are still required to create APC groupings that classify devices of brachytherapy separately from other services or groups of services in a manner reflecting the number, isotope, and radioactive intensity of the devices of brachytherapy furnished. In addition, section 1833(t)(2)(H) of the Act, as amended by section 107(b)(1) of the MIEA–TRHCA, requires separate payment groups based on stranded and non-stranded brachytherapy devices on or after July 1, 2007.

We are proposing to pay separately for each of the sources listed in Table 48 below on a prospective basis for CY 2008, with payment rates to be determined using the CY 2006 claims-based median cost per source for each brachytherapy device. Consistent with our policy regarding APC payments made on a prospective basis, we are proposing that the cost of brachytherapy sources be subject to the outlier provision of section 1833(t)(5) of the Act. As indicated in section II.A.2. of this proposed rule, for CY 2008 we are proposing specific prospective payment rates for brachytherapy sources, which will be subject to scaling for budget neutrality.

We believe that adopting prospective payment for brachytherapy sources is appropriate for a number of reasons. The general OPPS payment methodology is a prospective payment system using median costs based on claims data. This prospective payment methodology results in more consistent, predictable and equitable payment amounts per source across hospitals, and it prevents some of the extremely high and low payment amounts found under a charges reduced to cost methodology. The proposed prospective payment would also provide hospitals with incentives for efficiency in the provision of brachytherapy services to Medicare beneficiaries. Moreover, the proposed approach is consistent with our payment methodology for the vast majority of items and services paid under the OPPS. Indeed, section 1833(t)(2)(C) of the Act requires us to establish prospective payment rates for the OPPS system based on median costs (or mean costs if elected by the Secretary). As of CY 2007, only pass-through devices, radiopharmaceuticals, and brachytherapy sources were paid at charges reduced to cost. Based on the proposals in this CY 2008 proposed rule, only pass-through devices would continue to be paid at charges reduced to cost for CY 2008. We note that section 107(a) of the MIEA–TRHCA specifically extended the payment period for brachytherapy sources based on a

hospital's charges adjusted to cost for only one additional year, CY 2007.

Analysis of the CY 2006 claims data suggests that the estimated median cost under the proposed prospective payment approach is higher than the estimated median payment amount under a charges reduced to cost methodology for most brachytherapy sources. We note that estimated median cost under the proposed approach is calculated based on the relevant department CCR whereas payments under a charge reduced to cost methodology are calculated based on each hospital's overall CCR. As shown in Table 47, for 9 of the 11 brachytherapy HCPCS codes that were in existence in CY 2006 and had claims data, the estimated median cost based on the departmental CCR is higher than the median estimated payment under the charges reduced to cost methodology.

TABLE 47.—COMPARISON OF CY 2006 ESTIMATED MEDIAN PAYMENTS UNDER CHARGES REDUCED TO COSTS AND ESTIMATED MEDIAN COSTS

CY 2006 HCPCS code	CY 2006 short descriptor	CY 2006 median estimated payment charges reduced to cost (based on overall CCR)	CY 2006 median cost (based on departmental CCR)
C1716	Brachytx source, Gold 198	$29.30	$31.56
C1717	Brachytx source, HDR Ir-192	143.20	171.26
C1718	Brachytx source, Iodine 125	31.41	37.71
C1719	Brachytx source,Non-HDR Ir-192	18.75	56.69
C1720	Brachytx source, Palladium 103	46.90	55.05
C2616	Brachytx source, Yttrium-90	10,811.30	11,796.07
C2632	Brachytx sol, I–125, per mCi	21.80	28.27
C2633	Brachytx source, Cesium-131	63.67	63.61
C2634	Brachytx source, HA, I–125	26.03	29.56
C2635	Brachytx source, HA, P–103	40.85	46.48
C2636	Brachytx linear source, P–103	56.39	36.64

Note: The short descriptions for some of the HCPCS codes in this table were revised after CY 2006. See Table 48 for the current long descriptions.

With the proposed adoption of prospective payment for brachytherapy sources, there would be opportunities for hospitals to receive additional payments under certain circumstances through the outlier provisions and the 7.1 percent rural adjustment. As noted previously, consistent with our policy regarding APC payments made on a prospective basis, we are proposing that the cost of brachytherapy sources be subject to the outlier provision of section 1833(t)(5) of the Act. Therefore, the source could receive an outlier payment, if the costs of furnishing brachytherapy sources exceed the outlier threshold. Also, as noted in section II.F. of this proposed rule, as a result of our CY 2008 proposal to pay prospectively for brachytherapy sources, we also are proposing to include brachytherapy payments in the group of services eligible for the 7.1 percent payment increase for rural SCHs, including EACHs.

We are proposing a payment methodology for separately paid brachytherapy sources for CY 2008 based upon their median unit costs calculated using CY 2006 claims data. Because we are required to create separate APC groups for stranded and non stranded sources and because our CY 2006 billing codes do not differentiate stranded and non–stranded sources, we are proposing to make certain assumptions when we estimate the median costs for stranded and non–stranded (low activity) iodine–125, palladium–103, and cesium–131 based on our CY 2006 aggregate claims data. As stated above, commenters to our CY 2007 proposed rule stated that the cost of stranded iodine, palladium and cesium sources are higher than non-stranded versions of these sources but provided no data. Given the reported cost differences between stranded and non-stranded sources and the statutory requirement that we establish separate payment groups for stranded and non-stranded sources, we believe it is appropriate to establish different stranded and non-stranded payment rates for iodine-125, palladium-103, and cesium-131 sources. However, in order to establish separate stranded and non-stranded payment rates for these three sources, we are proposing to make the following assumptions in our calculation of their median costs. Assuming that the reportedly lower cost non-stranded sources would be unlikely to be in the top 20 percent of the cost distribution in our aggregate (stranded and non-stranded) CY 2006 claims data, we are proposing to calculate the median cost for these 3 non-stranded sources based on the bottom 80 percent of the cost distribution in our aggregate claims data for each source. Likewise, assuming that the reportedly higher cost stranded sources would be unlikely to be in the bottom 20 percent of the cost distribution in our aggregate CY 2006 claims data, we are proposing to calculate the median cost for these 3 stranded sources based on the top 80 percent of the cost distribution for our aggregate data. This approach to calculating median costs for stranded and non-stranded iodine-125, palladium-103, and cesium-131 sources results in proposed Medicare payment rates based on the 60th percentile of our aggregate data for stranded sources and the 40th percentile of our aggregate data for non-stranded sources, which, after examining the range of our cost data for these sources, appear to provide a reasonable cost differential between stranded and non-stranded sources, until we have claims data reported separately for stranded and non-stranded sources.

We are proposing this approach for stranded and non-stranded iodine-125, palladium-103, and cesium-131 sources as a transitional measure, until we have sufficient claims data for separately coded stranded and non-stranded sources upon which to calculate the median costs for these sources specifically. (The first partial year claims data for separately coded stranded and non-stranded sources will be available in CY 2007 claims data for ratesetting in CY 2009.) This methodology has the benefits of a prospective payment methodology discussed above and complies with the

requirements of the MIEA–TRHCA to recognize separate payment for stranded and non-stranded sources.

Furthermore, we are proposing to pay the two NOS codes, C2698 and C2699, based on a rate equal to the lowest stranded or non-stranded prospective payment rate for such sources, respectively, paid on a per source basis (as opposed, for example, to per mci). This payment methodology for NOS sources provides payment to a hospital for new sources, while encouraging interested parties to quickly bring new sources to our attention, so specific coding and payment can be established. As noted earlier, we may establish new brachytherapy source codes on a quarterly basis.

Because brachytherapy sources will no longer be paid on the basis of their charges reduced to cost after December 31, 2007, we are proposing to discontinue our use of payment status indicator ''H'' for APCs assigned to brachytherapy sources. For CY 2008, we are proposing to use status indicator ''K'' for all brachytherapy source APCs. As indicated earlier, the definition of status indicator ''K'' was changed for CY 2007 to accommodate prospective payment for brachytherapy sources.

For CY 2008, we also are proposing to implement the policy we established in the CY 2007 OPPS/ASC final rule with comment period (which was superseded by section 107 of the MIEA–TRHCA) regarding payment for new brachytherapy sources for which we have no claims data. As discussed above, we are proposing 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. Because we are proposing to pay prospectively for brachytherapy sources beginning in CY 2008, we are proposing to implement this policy beginning in CY 2008.

There is currently one brachytherapy source, Ytterbium-169 (HCPCS C2637, Brachytherapy Source, Ytterbium-169, per source), which has its own HCPCS code, but for which we believe we lack claims data on its costs. In the CY 2007 OPPS/ASC proposed rule (71 FR 49598 through 49599), we indicated that it was our understanding that Ytterbium-169 had not yet been marketed, and furthermore that we had no CY 2005 claims data, external data, or other information on its pricing on which to base its payment rate for CY 2007. In response to the CY 2007 proposed rule, we received no cost data or other information that we could use to establish an informed prospective payment rate for Ytterbium-169. Therefore, in the CY 2007 OPPS/ASC final rule with comment period (71 FR 68112), we finalized a policy of assigning HCPCS code C2637, Ytterbium-169, with the nonpayable status indicator ''B'' and indicated that if we later receive relevant information, we could establish a payable status indicator and appropriate payment rate for the Ytterbium source in a future OPPS quarterly update. This policy was superceded by section 107(a) of the MIEA–TRHCA, which required payment for brachytherapy sources in CY 2007 based on charges reduced to costs. For this CY 2008 proposed rule, we believe that we continue to lack claims data or other information on the costs of Ytterbium-169 on which to base an informed prospective payment rate. Our CY 2006 claims data show three claims for HCPCS code C2637, Ytterbium-169, with a median cost of $718.08. We believe these three claims may be incorrectly coded claims that do not represent claims for Ytterbium-169, as the manufacturer of Ytterbium-commented on the CY 2007 OPPS proposed rule that Ytterbium-169 would first become available for market in 2007. Consequently, at this time, we are proposing to not recognize HCPCS code C2637, and again we are assigning it to status indicator ''B'' under the OPPS for CY 2008. However, if in public comments to this proposed rule or later in CY 2007 or CY 2008, we receive relevant and reliable information on the hospital cost for Ytterbium-169 and information that this source is being marketed, we would propose to establish a prospective payment rate for Ytterbium-169 in the CY 2008 final rule or in a quarterly OPPS update, respectively.

Table 48 includes a complete listing of the HCPCS codes, long descriptors, and APC assignments that we currently use for brachytherapy sources paid under the OPPS as of July 1, 2007, and the status indicators, estimated median costs, and payment rates that we are proposing for CY 2008. We note that some of the HCPCS codes for which we are proposing payment rates for CY 2008 are not shown in Addendum B of this proposed rule because that addendum is based on HCPCS codes effective as of April 2007. As indicated earlier, there are some brachytherapy source HCPCS codes that were added as of July 1, 2007. While these HCPCS codes are not shown in Addendum B, the proposed payment rates for all brachytherapy sources are shown in Table 48.

While we are inviting public comment on all aspects of this CY 2008 proposal, we particularly encourage comment on our proposed median costs estimates for stranded and non-stranded iodine-125, palladium-103, and cesium-131, including the submission of any available information or data on cost differences between stranded and non stranded sources. We also are interested in receiving information regarding the historical and current relative market share for stranded versus non-stranded sources, particularly as used in the care of Medicare beneficiaries and with respect to brachytherapy treatments for different clinical conditions.

TABLE 48.—PROPOSED SEPARATELY PAYABLE BRACHYTHERAPY SOURCES FOR CY 2008

HCPCS code	Long descriptor	APC	Proposed CY 2008 median cost	Proposed CY 2008 payment rate	Proposed CY 2008 status indicator
A9527	Iodine I–125, sodium iodide solution, therapeutic, per millicurie	2632	$28.27	$28.62	K
C1716	Brachytherapy source, non-stranded, Gold-198, per source	1716	31.56	31.95	K
C1717	Brachytherapy source, non-stranded, High Dose Rate Iridium-192, per source.	1717	171.26	173.40	K
C1719	Brachytherapy source, non-stranded, Non-High Dose Rate Iridium-192, per source.	1719	56.69	57.40	K
C2616	Brachytherapy source, non-stranded, Yttrium-90, per source	2616	11,796.07	11,943.79	K
C2634	Brachytherapy source, non-stranded, High Activity, Iodine-125, greater than 1.01 mCi (NIST), per source.	2634	29.56	29.93	K

TABLE 48.—PROPOSED SEPARATELY PAYABLE BRACHYTHERAPY SOURCES FOR CY 2008—Continued

HCPCS code	Long descriptor	APC	Proposed CY 2008 median cost	Proposed CY 2008 payment rate	Proposed CY 2008 status indicator
C2635	Brachytherapy source, non-stranded, High Activity, Palladium-103, greater than 2.2 mCi (NIST), per source.	2635	46.48	47.06	K
C2636	Brachytherapy linear source, non-stranded, Palladium-103, per 1MM	2636	36.64	37.09	K
C2637	Brachytherapy source, non-stranded, Ytterbium-169, per source	2637	N/A	N/A	B
C2638	Brachytherapy source, stranded, Iodine-125, per source	2638	*42.33	42.86	K
C2639	Brachytherapy source, non-stranded, Iodine-125, per source	2639	**31.51	31.91	K
C2640	Brachytherapy source, stranded, Palladium-103, per source	2640	*61.47	62.24	K
C2641	Brachytherapy source, non-stranded, Palladium-103, per source	2641	**44.73	45.29	K
C2642	Brachytherapy source, stranded, Cesium-131, per source	2642	*96.52	97.72	K
C2643	Brachytherapy source, non-stranded, Cesium-131, per source	2643	**50.72	51.35	K
C2698	Brachytherapy source, stranded, not otherwise specified, per source	2698	42.33	42.86	K
C2699	Brachytherapy source, non-stranded, not otherwise specified, per source	2699	29.56	29.93	K

* Estimated median cost for stranded version is based on the 60th percentile of the aggregate (stranded and non stranded) claims data for this source.

** Estimated median cost for non-stranded version is based on the 40th percentile of the aggregate (stranded and non stranded) claims data for this source.

VIII. Proposed OPPS Drug Administration Coding and Payment

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

A. Background

In CY 2005, in response to the recommendations made by commenters and the hospital industry, OPPS transitioned to the use of CPT codes for drug administration services. (For information on coding for drug administration services prior to CY 2005, see 71 FR 68115.) These CPT codes allowed for more specific reporting of services, especially regarding the number of hours for an infusion, and provided consistency in coding between Medicare and other payers. However, at that time, we did not have any data to revise the CY 2005 per-visit APC payment structure for infusion services. In order to collect data for future ratesetting purposes, we implemented claims processing logic that collapsed payments for drug administration services and paid a single APC amount for those services for each visit, unless a modifier was used to identify drug administration services provided in a separate encounter on the same day. Hospitals were instructed to bill all applicable CPT codes for drug administration services provided in a HOPD, without regard to whether or not the CPT code would receive a separate APC payment during OPPS claims processing.

While hospitals just 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 G-codes were developed in anticipation of substantial revisions to the drug administration CPT codes by the CPT Editorial Panel that were expected for CY 2006.

In CY 2006, as anticipated, the CPT Editorial Panel revised its coding structure for drug administration services, incorporating new concepts such as initial, sequential, and concurrent services into a structure that previously distinguished services based on type of administration (chemotherapy/nonchemotherapy), method of administration (injection/infusion/push), and for infusion services, first hour and additional hours. For CY 2006, we implemented 20 of the 33 CY 2006 drug administration CPT codes that did not reflect the concepts of initial, sequential, and concurrent services, and we created 6 new HCPCS C-codes that generally paralleled the CY 2005 CPT codes for the same services. We chose not to implement the full set of CY 2006 CPT codes because of our concerns regarding the interface between the complex claims processing logic required for correct payments and hospitals' challenges in correctly coding their claims to receive accurate payments for these services.

For CY 2007, as a result of comments to our proposed rule and feedback from the hospital community and the APC Panel, we implemented the full set of CPT codes, including the concepts of initial, sequential and concurrent. 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. We assigned all CY 2007 HCPCS codes for drug administration services to six new drug administration APCs (as listed in Table 34 of the CY 2007 OPPS/ASC final rule with comment period), with payment rates based on median costs for the APCs as calculated from CY 2005 claims data. In that final rule, we provided a crosswalk that illustrated how we performed our annual payment rate update methodology for these services using CY 2005 data.

As indicated in the CY 2007 OPPS/ASC final rule with comment period (71 FR 68122), because the newly recognized CPT codes discriminate among services more specifically than the CY 2006 C-codes, as was the case when the OPPS transitioned from more general Q-codes to more specific CPT codes for the reporting of drug administration services in CY 2005, for a period of 2 years drug administration services will be paid based on the costs of their predecessor HCPCS codes until updated data are available for review.

B. Proposed Coding and Payment for Drug Administration Services

During the March 2007 APC Panel meeting, the APC Panel recommended that CMS pay separately for CPT code 90768 (Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); concurrent infusion (list separately in addition to code for primary procedure)) at the same rate as CPT code 90767 (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)).

As discussed in section II.A.4. of this proposed rule, 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. As we discussed in the CY 2007 OPPS/ASC final rule with comment period (71 FR 68122), CPT code 90768 was first introduced in CY 2007 and consistent with our established ratesetting methodology, we do not anticipate OPPS hospital claims data from CY 2007 to be available for ratesetting purposes until CY 2009. In addition, as the services identified with CPT code 90768 were provided in previous years, it is our determination that these costs are already represented in our currently available hospital claims data. Payment for these services was provided in previous years through the billing of more general drug administration codes. Although more exhaustive codes for drug administration services are now available, this does not indicate that these services did not receive OPPS payments in previous years.

As data are not available for drug administration services for purposes of CY 2008 ratesetting, and as we believe that the costs for the drug administration services identified by CPT code 90768 are included in our hospital claims data used for ratesetting purposes, we are not accepting the APC Panel's recommendation to provide a separate APC payment for this service. Furthermore, we note that in section II.A.4. of this proposed rule, we have proposed to expand packaging of certain (nondrug administration) services. We believe that continuing to package CPT code 90786 is consistent with these broader efforts.

For CY 2008, we examined CY 2006 claims data available for this proposed rule and continue to believe the CY 2007 drug administration APC configuration reflects clinically and resource homogeneous groupings of procedures. We note that there is a violation of the 2 times rule in APC 0438 (Level III Drug Administration) as proposed for CY 2008. The violation is related to the comparatively low median cost of CPT code 90773 (Therapeutic, prophylactic or diagnostic injection (specify substance or drug); intra-arterial) for which we have a significantly greater number of CY 2006 single claims available for ratesetting than previous years. The CY 2005 predecessor code for this service, CPT code 90783 (Therapeutic, prophylactic or diagnostic injection (specify material injected); intra-arterial), had a higher median cost that was more similar to the costs of other services also assigned to APC 0438. We continue to believe that this intra-arterial injection procedure is similar from both clinical and hospital resource perspectives to the related intravenous push injection procedures that are assigned to the same clinical APC and, therefore, we are proposing to except APC 0438 from the 2 times rule for CY 2008. We continue to ask hospitals to report all CPT drug administration codes, and we expect hospitals to report CPT codes consistently with CPT coding guidelines and applicable instructions.

We note that in this section of the CY 2007 proposed rule we discussed IVIG preadministration-related services; for CY 2008, this topic is discussed in section III.C.2.b. of this proposed rule.

IX. Proposed Hospital Coding and Payments for Visits

A. Background

Currently, CMS instructs hospitals to use the CY 2007 CPT codes, as well as six HCPCS codes that became effective January 1, 2007, to report clinic and emergency department visits and critical care services on claims paid under the OPPS. The codes are listed below in Table 49.

TABLE 49.—CY 2007 CPT EVALUATION AND MANAGEMENT (E/M) AND LEVEL II HCPCS CODES USED TO REPORT CLINIC AND EMERGENCY DEPARTMENT VISITS AND CRITICAL CARE SERVICES

HCPCS code	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).
99215	Office or other outpatient visit for the evaluation and management of an established patient (Level 5).
99241	Office consultation for a new or established patient (Level 1).
99242	Office consultation for a new or established patient (Level 2).
99243	Office consultation for a new or established patient (Level 3).
99244	Office consultation for a new or established patient (Level 4).
99245	Office consultation for a new or established patient (Level 5).
Emergency Department Visit 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).

TABLE 49.—CY 2007 CPT EVALUATION AND MANAGEMENT (E/M) AND LEVEL II HCPCS CODES USED TO REPORT CLINIC AND EMERGENCY DEPARTMENT VISITS AND CRITICAL CARE SERVICES—Continued

HCPCS code	Descriptor
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	Each additional 30 minutes.
G0390	Trauma response associated with hospital critical care services.

Presently, there are three types of visit codes to describe three types of services: Clinic visits, emergency department visits, and critical care services. CPT indicates that office or other outpatient visit codes are used to report E/M services provided in the physician's office or in an outpatient or other ambulatory facility. For OPPS purposes, we refer to these as clinic visit codes. CPT also indicates that emergency department visit codes are used to report E/M services provided in the emergency department, defined as an ''organized hospital-based facility for the provision of unscheduled episodic services to patients who present for immediate medical attention. The facility must be available 24 hours a day.'' For OPPS purposes, we refer to these as emergency department visit codes that specifically apply to the reporting of visits to Type A emergency departments on or after January 1, 2007, as discussed in further detail later in this section. We established five new Level II HCPCS codes to report visits to Type B emergency departments beginning in CY 2007 because there are currently no CPT codes that fully describe services provided in this type of facility. CPT defines critical care services as the ''direct delivery by a physician(s) of medical care for a critically ill or critically injured patient.'' It also states that ''critical care is usually, but not always, given in a critical care area, such as * * * the emergency care facility.'' In addition to reporting critical care services, hospitals may utilize the new HCPCS code G0390 for the reporting of a trauma response in association with critical care services for the CY 2007 OPPS.

The majority of CPT code descriptors are applicable to both physician and facility resources associated with specific services. However, we have acknowledged from the beginning of the OPPS that we believe that CPT E/M codes were defined to reflect the activities of physicians and do not necessarily describe well the range and mix of services provided by hospitals during visits of clinic and emergency department patients and critical care encounters. In the April 7, 2000 OPPS final rule with comment period (65 FR 18434), we instructed hospitals to report facility resources for clinic and emergency department visits using CPT E/M codes and to develop internal hospital guidelines to determine what level of visit to report for each patient. While awaiting the development of a national set of facility-specific codes and guidelines, we have advised hospitals that each hospital's internal guidelines should follow the intent of the CPT code descriptors, in that the guidelines should be designed to reasonably relate the intensity of hospital resources to the different levels of effort represented by the codes.

Critical care services are considered to be outpatient visits, and our current payment policy for trauma activation ties separate payment to the reporting of hospital critical care services. We are not proposing to change our OPPS payment policy for critical care services for CY 2008, and our CY 2008 proposal for payment of trauma activation is described in section II.A.4. of this proposed rule. Therefore, we will no longer include references to critical care services in the sections below that describe hospital outpatient visits.

B. Proposed Policies for Hospital Outpatient Visits

1. Clinic Visits: New and Established Patient Visits and Consultations

As discussed earlier, the majority of all CPT code descriptors are applicable to both physician and facility resources associated with specific services. However, we believe that CPT E/M codes were defined to reflect the activities of physicians and do not describe well the range and mix of services provided by hospitals during visits of clinic and emergency department patients. While awaiting the development of a national set of guidelines, we have advised hospitals that each hospital's internal guidelines should follow the intent of the CPT code descriptors, in that the guidelines should be designed to reasonably relate the intensity of hospital resources to the different levels of effort represented by the codes. In the CY 2007 OPPS/ASC proposed rule (71 FR 49607), we proposed to establish five new codes to replace hospitals' reporting of the CPT clinic visit E/M codes for new and established patients listed in Table 49 above. In the CY 2007 OPPS/ASC final rule with comment period (71 FR 68127 through 68128), we specified that we would not create new codes to replace existing CPT E/M codes for reporting hospital visits until national guidelines are developed, in response to commenters who were concerned about implementing hospital-specific Level II HCPCS codes without national guidelines. We also discussed our intention to reconsider whether G-codes would be appropriate for the OPPS once national guidelines are established.

In that same rule (71 FR 68138), we finalized our proposal to pay clinic visits at five payment rates, rather than three payment rates. Prior to CY 2007, under the OPPS, outpatient visits provided by hospitals were paid at three payment levels for clinic visits, even though hospitals reported five resource-based coding levels of clinic visits using CPT E/M codes. Because the three payment rates for clinic visits were based on five levels of CPT codes, in general the two lowest levels of CPT codes (Levels 1 and 2) were assigned to the low level visit APC and the two highest levels of CPT codes (Levels 4 and 5) were assigned to the high level visit APC, while the single middle level CPT code (Level 3) was assigned to the mid-level visit APC. Historical hospital claims data have generally reflected significantly different median costs for the two levels of services assigned to the low and high level visit APCs. We noted that payment at only three levels may not be the most accurate method of payment for those very common

hospital levels of visits that clearly demonstrated differential hospital resources. Consequently, for the CY 2007 OPPS, we mapped the data from the CY 2005 CPT E/M codes and other HCPCS codes assigned previously to the three clinic visit APCs to five new clinic visit APCs to develop median costs for these APCs. We mapped the CPT E/M codes and other HCPCS codes to the clinic visit APCs based on their median costs and clinical homogeneity considerations. Table 50, which includes the median costs based on CY 2006 claims data processed through December 31, 2006, displays the HCPCS code and APC median costs at the five payment levels that we are proposing for the CY 2008 OPPS.

TABLE 50.—PROPOSED ASSIGNMENT OF CLAIMS DATA FROM CY 2006 CPT E/M AND LEVEL II HCPCS CODES TO VISIT APCS FOR CY 2008

CY 2008 APC title	CY 2008 APC	Proposed CY 2008 APC median	APC service frequency (million)	HCPCS code	Short descriptor
Level 1 Hospital Clinic Visits	0604	$52.72	3.8	92012	Eye exam established pat.
				99201	Office/outpatient visit, new (Level 1).
				99211	Office/outpatient visit, est (Level 1).
				99241	Office consultation (Level 1).
				G0101	CA screen; pelvic/breast exam.
				G0245	Initial foot exam pt lops.
				G0379	Direct admit hospital observ.
Level 2 Hospital Clinic Visits	0605	$63.01	7.3	90862	Medication management.
				92002	Eye exam, new patient.
				92014	Eye exam and treatment.
				99202	Office/outpatient visit, new (Level 2).
				99212	Office/outpatient visit, est (Level 2).
				99213	Office/outpatient visit, est (Level 3).
				99242	Office Consultation (Level 2).
				99243	Office Consultation (Level 3).
				99431	Initial care, normal newborn.
				G0246	Followup eval of foot pt lop.
				G0344	Initial preventive exam.
				M0064	Visit for drug monitoring.
Level 3 Hospital Clinic Visits	0606	$85.96	2.9	92004	Eye exam, new patient.
				99203	Office/outpatient visit, new (Level 3).
				99214	Office/outpatient visit, est (Level 4).
				99244	Office consultation (Level 4).
Level 4 Hospital Clinic Visits	0607	$108.08	.8	99204	Office/outpatient visit, new (Level 4).
				99215	Office/outpatient visit, est (Level 5).
				99245	Office consultation (Level 5).
Level 5 Hospital Clinic Visits	0608	$138.88	.08	99205	Office/outpatient visit, new (Level 5).
				G0175	OPPS service, sched team conf.

In the CY 2007 OPPS/ASC proposed rule (71 FR 49617), we solicited comment as to whether a distinction between new and established visits was necessary because we were planning to transition to G-codes and did not want to unnecessarily create codes for both new and established patients. The AMA defines an established patient as ''one who has received professional services from the physician or another physician of the same specialty who belongs to the same group practice, within the past 3 years.'' To apply this definition to hospital visits, we stated in the April 7, 2000 final rule with comment period (65 FR 18451) that the meanings of ''new'' and ''established'' pertain to whether or not the patient already has a hospital medical record number. If the patient has a hospital medical record that was created within the past 3 years, that patient is considered an established patient to the hospital. The same patient could be ''new'' to the physician but an ''established'' patient to the hospital. The opposite could be true if the physician has a longstanding relationship with the patient, in which case the patient would be an ''established'' patient with respect to the physician and a ''new'' patient to the hospital.

Some commenters who responded to prior OPPS rules have stated that the hospital resources used for new and established patients to provide a specific level of service are very similar, and that it is unnecessary and burdensome from a coding perspective to distinguish between the two types of visits. On the other hand, other commenters have noted, and CY 2005 and CY 2006 claims data have shown, that it may be appropriate to continue using different codes for new and established patients because of the observed median cost differences in the claims data. In addition, during the March 2007 APC Panel meeting, the Observation and Visit Subcommittee of the APC Panel discussed whether the coding distinction between new and established patient visits is necessary. Ultimately, the APC Panel recommended that CMS eliminate the ''new'' and ''established'' patient distinctions in the reporting of hospital clinic visits. During its discussion, the APC Panel suggested that hospitals bill the appropriate level clinic visit code according to the resources expended while treating the beneficiary, based on each hospital's internal guidelines. The APC Panel also suggested that each hospital's internal guidelines reflect resource cost differences (if a difference exists) between new and established patients. For example, a visit that involves certain interventions may be coded as Level 3 for a new patient and Level 2 for an established patient. The APC Panel also made another recommendation which is contingent upon CMS adopting its recommendation

to eliminate the new and established patient distinction reporting requirement. That is, the APC Panel further recommended that CMS map each of the five levels of outpatient clinic visit codes (which do not distinguish between new and established patients) to five separate APCs, thereby paying at five payment rates. For example, the APC Panel recommended mapping the Level 1 patient visit to the Level 1 Clinic Visit APC, mapping the Level 2 patient visit to the Level 2 Clinic Visit APC, and mapping the Level 3 patient visit to the Level 3 Clinic Visit APC. In the current and proposed clinic visit APC configuration, as indicated in Table 50, the APC level assignment does not always correspond to the visit level described by each code. For example, CPT 99213 is a Level 3 clinic visit code for an established patient, which would seem to logically map to the Level 3 Clinic Visit APC. However, because CPT 99213 has a proposed median cost of $64.73, we mapped this code to the Level 2 Clinic Visit APC, which has a proposed median cost of $63.01. The APC Panel indicated that its recommendation would ensure that each visit level would receive its own payment rate, rather than both the Level 2 and 3 patient visit codes receiving the same payment rate.

During CY 2006 and earlier, there was no payment difference between new and established patient visits of the same level, as both were always mapped to the same clinical APC. However, hospital claims data regarding the median costs of the specific CPT clinic visit E/M codes consistently indicate that new patients are more resource-intensive than established patients across all visit levels. The CY 2006 claims data confirm that the cost difference between new and established patient visits increases as the visit level increases.

In both the CY 2007 OPPS/ASC proposed and final rules (71 FR 49617 and 71 FR 68128), respectively, we encouraged public comment that discussed the potential differences in hospital clinic resource consumption between new and established patient visits. We received only a few comments related to this distinction in response to the CY 2007 OPPS/ASC proposed rule and even fewer comments in response to the CY 2007 OPPS/ASC final rule with comment period. For CY 2008, because hospitals will be reporting CPT E/M codes for clinic visits, which distinguish between new and established patients, and because we see meaningful and consistent cost differences between visits for new and established patients, we are proposing to continue to recognize the CPT codes for new and established patient clinic visits under the OPPS, consistent with their CPT code descriptors. Further, we are not adopting the recommendation of the APC Panel to eliminate this differentiation for the reasons noted. We are proposing to reexamine whether the coding distinction between new and established patient visits is necessary as we consider national guidelines. We continue to encourage public comment about hospitals' experiences with assigning visit levels to new and established patients according to their own internal guidelines.

Table 51 lists the CY 2008 proposed median costs of new and established patient clinic visit codes which are based on CY 2006 claims data processed through December 31, 2006.

TABLE 51.—PROPOSED CY 2008 MEDIAN COSTS OF NEW AND ESTABLISHED PATIENT VISIT CPT CODES

Clinic visit level	Proposed CY 2008 new patient visit median cost	Proposed CY 2008 established patient visit median cost
Level 1	$56.08	$50.70
Level 2	63.18	58.84
Level 3	74.99	64.73
Level 4	109.12	84.17
Level 5	138.06	102.89

As noted above, the APC Panel also recommended that CMS map each level of patient visits to its corresponding APC, thereby paying at five payment levels. The APC Panel members noted that this mapping system would eliminate any payment incentive to distinguish between new and established patients but would ensure five payment levels.

For CY 2008, we are proposing to map the clinic visit codes for new patients to the five Clinic Visit APCs, one code to each level, based on the hospital resources observed in historical claims data as they are mapped for CY 2007 and in accordance with the APC Panel's recommendation. However, for CY 2008, we are proposing to maintain the CY 2007 mapping for the clinic visit codes for established patients. As indicated in Table 51 above, we are proposing to map the Level 1 established patient visit to the Level 1 Clinic Visit APC, which results in the Level 1 Clinic Visit APC containing both the Level 1 new and established patient visit codes, in accordance with the APC Panel recommendation. Similarly, we are proposing to map both the Level 2 new and established patient visit codes to the Level 2 Clinic Visit APC. However, we also are proposing to map the Level 3 established patient visit code to the Level 2 Clinic Visit APC because our cost data indicate that the costs associated with a Level 3 established patient visit most closely resemble the costs associated with the Level 2 Clinic Visit APC and the Level 2 new and established patient visits. If CPT code 99213 for an established Level 3 clinic visit was mapped to the Level 3 Clinic Visit APC, which has a proposed median cost of $85.96, we would significantly overpay CPT 99213 every time it was billed. We are proposing to map the Level 3 new patient visit to the Level 3 Clinic Visit APC, consistent with the APC Panel recommendation. We are proposing to map the Level 4 established patient visit to the Level 3 Clinic Visit APC and the Level 5 established patient visit to the Level 4 Clinic Visit APC. The only CPT E/M code that we are proposing to map to the Level 5 Clinic Visit APC for CY 2008 payment is the Level 5 new patient visit. These APC assignments that we are proposing for CY 2008, consistent with the CY 2007 APC assignments, were determined for each HCPCS code based on CY 2008 proposed rule median cost data and clinical considerations. We are not persuaded by the APC Panel recommendation, which would require us to ignore significant cost differences based on resource data that are clinically consistent and instead map each code to its corresponding level APC.

Historical cost data for these frequently provided services are extremely consistent. In addition, from a clinical perspective, we believe that in some cases, in the context of a five level structure for visit reporting, the hospital resources required for a given visit level may only be slightly different from those used for a visit that is one level higher or lower. For example, it is not surprising that particularly among visits for established patients in the middle of the range, such as a Level 2 established patient visit and a Level 3 established patient visit, the hospital resource costs calculated from claims data are similar because these patients would often utilize reasonably comparable hospital resources.

We performed data analyses to determine how the median costs of the clinic visit APCs would change if we fully adopted the APC Panel's recommendation and mapped all of the new and established patient visit codes to the corresponding level of clinic visit APC. Our results are shown in Table 52.

TABLE 52.—CY 2008 MEDIAN COST COMPARISON OF CLINIC VISIT APCS IN TWO DIFFERENT CONFIGURATIONS

APC	APC median cost in the proposed CY 2008 configuration	APC median cost in the recommended APC panel configuration
Level 1 Clinic Visit	$53	$53
Level 2 Clinic Visit	63	60
Level 3 Clinic Visit	86	66
Level 4 Clinic Visit	108	88
Level 5 Clinic Visit	139	110

The APC median cost distribution does not improve when mapping each new and established patient visit code to its corresponding level of APC. In fact, the APC Panel's recommended configuration results in lower payment rates for the Levels 2 through 5 Clinic Visit APCs, and an identical payment rate for the Level 1 Clinic Visit APC because our proposed mapping and the APC Panel's recommendation for this APC are the same. In general, under the OPPS, we rely on resource cost data calculated from hospital claims data to determine appropriate APC mapping of HCPCS codes and to set payment rates. While we acknowledge that it might be more predictable for hospitals to receive the same payment rate for new and established patients of the same visit level, robust cost data clearly indicate that this would not be the most accurate payment method. Historical hospital cost data indicate that new patient visits are costlier than established patient visits of the same level, a finding that is consistent with the perspective of our medical advisors. Because we are proposing that hospitals continue to use CPT E/M codes to report clinic visits for CY 2008, including separate codes for new and established patients, we see no reason to adjust the clinic visit APC configurations. Therefore, for CY 2008, we are proposing to map the CPT E/M codes and other Level II HCPCS codes to the Clinic Visit APCs as configured in Table 50 and not fully adopt the APC Panel's recommendation to map each code to its corresponding APC level. We will reexamine using the claims data for CY 2009 OPPS ratesetting and will also reconsider whether this mapping is appropriate in the future as we continue to work on developing national guidelines.

The APC Panel also recommended that CMS not recognize the CPT consultation codes: CPT 99241 (Office consultation for a new or established patient (Level 1)), CPT 99242 (Office consultation for a new or established patient (Level 2)), CPT 99243 (Office consultation for a new or established patient (Level 3)), CPT 99244 (Office consultation for a new or established patient (Level 4)), and CPT 99245 (Office consultation for a new or established patient (Level 5)). The APC Panel recommended that CMS instruct hospitals to build consultation services into their internal hospital guidelines related to reporting outpatient clinic visit levels based on the complexity and resources used for these outpatient visits.

CPT defines a consultation as ''a type of service provided by a physician whose opinion or advice regarding evaluation and/or management of a specific problem is requested by another physician or other appropriate source.'' CPT recognizes two subcategories of consultations, specifically office or other outpatient and inpatient consultations, although only the office consultations would be applicable under the OPPS. Nevertheless, the differentiation of consultations from new and established patient clinic visits would appear to be clinically unnecessary under the OPPS in order to provide proper OPPS payment for hospital outpatient visits.

In the CY 2007 OPPS/ASC final rule with comment period (71 FR 68128), we noted our belief that it may be unnecessary for hospitals to report consultation CPT codes if either a new or established patient visit code accurately describes the service provided. We stated that we were particularly interested in hearing whether consultation codes are a useful measure of hospital resource use under the OPPS, and how consultation visits are different, from a hospital resource perspective, from new patient visits and established patient visits. We observed that we did not want to create an incentive for hospitals to bill a consultation code instead of a new or established patient code because we did not believe that consultation codes necessarily reflected different resource utilization than either new or established patient codes (71 FR 68138). Therefore, for CY 2007, we finalized a payment policy that assigned the consultation code to the same clinical APC as the established patient visit code for each level of service. For example, CPT code 99242, the Level 2 consultation code is mapped to APC 0605 (Level 2 Clinic Visits), which is where CPT code 99212, the Level 2 established patient code, is mapped for CY 2007. Moving the consultation codes to the same APC as the corresponding established patient visit code eliminated any incentive for hospitals to bill a consultation code instead of a new or established patient code.

TABLE 53.—CY 2008 MEDIAN COSTS AND FREQUENCIES OF CPT CONSULTATION VISIT CODES

Code descriptor	Median cost	Frequency
Level 1 Consultation	$66.48	62,000

TABLE 53.—CY 2008 MEDIAN COSTS AND FREQUENCIES OF CPT CONSULTATION VISIT CODES—Continued

Code descriptor	Median cost	Frequency
Level 2 Consultation	65.78	73,000
Level 3 Consultation	81.95	155,000
Level 4 Consultation	109.96	176,000
Level 5 Consultation	139.61	94,000

Consultation services are provided with much less frequency than all levels of established patient visits and low level new patient visits but are provided more frequently than high level new patient visits. The median costs for consultation codes are generally similar to or slightly higher than the corresponding median costs of the same level of new patient visits.

Aside from the APC Panel recommendation, we have received few comments from the public related to this issue. We continue to believe that consultation codes are unnecessary and superfluous in the hospital outpatient setting because hospitals could appropriately bill either a new or established patient visit code, instead of a consultation, as appropriate in these cases. In the interest of simplifying billing, for CY 2008, we are proposing to assign status indicator ''B'' to the consultation codes (that is, not paid under the OPPS) and instruct hospitals to bill a new or established visit code instead of an office consultation code, thereby adopting the APC Panel's recommendation not to recognize these consultation codes. As appropriate, hospitals may build consultation services into their internal hospital guidelines related to reporting clinic visit levels based on the complexity and resources used for these visits.

In summary, for CY 2008, we are proposing that hospitals continue to use the CPT codes to bill for clinic visits and to distinguish between new and established patient visits. For CY 2008, the CPT codes for new and established visits would continue to be payable under the OPPS, but we would reconsider in the future whether there should be a distinction between new and established patient visits as we continue to work on developing national guidelines. For CY 2008, we are proposing to change the status of the consultation codes so that these codes are no longer recognized for payment under the OPPS.

2. Emergency Department Visits

As described above, CPT defines an emergency department as ''an organized hospital based facility for the provision of unscheduled episodic services to patients who present for immediate medical attention. The facility must be available 24 hours a day.'' Prior to CY 2007, under the OPPS, we restricted the billing of emergency department CPT codes to services furnished at facilities that met this CPT definition. Facilities open less than 24 hours a day should not report the emergency department CPT codes.

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

Section 489.24 of the EMTALA regulations defines ''dedicated emergency department'' as any department or facility of the hospital, regardless of whether it is located on or off the main hospital campus, that meets at least one of the following requirements: (1) It is licensed by the State in which it is located under applicable State law as an emergency room or emergency department; (2) It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or (3) During the calendar year immediately preceding the calendar year in which a determination under the regulations is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment.

We believe that every emergency department that meets the CPT definition of emergency department also qualifies as a dedicated emergency department under EMTALA. However, we are aware that there are some departments or facilities of hospitals that meet the definition of a dedicated emergency department under the EMTALA regulations but that do not meet the more restrictive CPT definition of an emergency department. For example, a hospital department or facility that meets the definition of a dedicated emergency department may not be available 24 hours a day, 7 days a week. Nevertheless, hospitals with such departments or facilities incur EMTALA obligations with respect to an individual who presents to the department and requests, or has requested on his or her behalf, examination or treatment for an emergency medical condition. However, because they did not meet the CPT requirements for reporting emergency visit E/M codes, prior to CY 2007, these facilities were required to bill clinic visit codes for the services they furnished under the OPPS. We had no way to distinguish in our hospital claims data the costs of visits provided in dedicated emergency departments that did not meet the CPT definition of emergency department from the costs of clinic visits.

Some hospitals requested that they be permitted to bill emergency department visit codes under the OPPS for services furnished in a facility that met the CPT definition for reporting emergency department visit E/M codes, except that they were not available 24 hours a day. These hospitals believed that their resource costs were more similar to those of emergency departments that met the CPT definition than they were to the resource costs of clinics. Representatives of such facilities argued that emergency department visit payments would be more appropriate, on the grounds that their facilities treated patients with emergency conditions whose costs exceeded the resources reflected in the clinic visit APC payments, even though these emergency departments were not available 24 hours per day. In addition, these hospital representatives indicated that their facilities had EMTALA obligations and should, therefore, be able to receive emergency department visit payments. While these emergency departments may have provided a broader range and intensity of hospital

services and required significant resources to assure their availability and capabilities in comparison with typical hospital outpatient clinics, the fact that they did not operate with all capabilities full-time suggested that hospital resources associated with visits to emergency departments or facilities available less than 24 hours a day might not be as great as the resources associated with emergency departments or facilities that were available 24 hours a day and that fully met the CPT definition.

To determine whether visits to emergency departments or facilities (referred to as Type B emergency departments) that incur EMTALA obligations but do not meet more prescriptive expectations that are consistent with the CPT definition of an emergency department (referred to as Type A emergency departments) have different resource costs than visits to either clinics or Type A emergency departments, in the CY 2007 OPPS/ASC final rule with comment period (71 FR 68132), we finalized a set of five 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 in § 489.24 but that are not Type A emergency departments, as described in Table 54 below. These codes are called ''Type B emergency department visit codes.'' We believed the creation of G-codes for Type B emergency departments was necessary because there were no CPT codes that fully described this type of facility. If we were to continue instructing Type B emergency departments to bill clinic visit codes, we would have no way to track resource costs for Type B emergency department visits as distinct from clinic visits. In that rule we explained that these new 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 (71 FR 68132).

TABLE 54.—CY 2007 FINAL LEVEL II HCPCS CODES TO BE USED TO REPORT EMERGENCY DEPARTMENT VISITS PROVIDED IN TYPE B EMERGENCY DEPARTMENTS

HCPCS code	Short descriptor	Long descriptor
G0380	Lev 1 hosp type B ED visit	Level 1 hospital emergency department visit provided in a Type B emergency department. (The ED must meet at least one of the following requirements: (1) It is licensed by the State in which it is located under applicable State law as an emergency room or emergency department; (2) It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or (3) During the calendar year immediately preceding the calendar year in which a determination under this section is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment).
G0381	Lev 2 hosp type B ED visit	Level 2 hospital emergency department visit provided in a Type B emergency department. (The ED must meet at least one of the following requirements: (1) It is licensed by the State in which it is located under applicable State law as an emergency room or emergency department; (2) It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or (3) During the calendar year immediately preceding the calendar year in which a determination under this section is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment).
G0382	Lev 3 hosp type B ED visit	Level 3 hospital emergency department visit provided in a Type B emergency department. (The ED must meet at least one of the following requirements: (1) It is licensed by the State in which it is located under applicable State law as an emergency room or emergency department; (2) It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or (3) During the calendar year immediately preceding the calendar year in which a determination under this section is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment).

TABLE 54.—CY 2007 FINAL LEVEL II HCPCS CODES TO BE USED TO REPORT EMERGENCY DEPARTMENT VISITS PROVIDED IN TYPE B EMERGENCY DEPARTMENTS—Continued

HCPCS code	Short descriptor	Long descriptor
G0383	Lev 4 hosp type B ED visit	Level 4 hospital emergency department visit provided in a Type B emergency department. (The ED must meet at least one of the following requirements: (1) It is licensed by the State in which it is located under applicable State law as an emergency room or emergency department; (2) It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or (3) During the calendar year immediately preceding the calendar year in which a determination under this section is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment).
G0384	Lev 5 hosp type B ED visit	Level 5 hospital emergency department visit provided in a Type B emergency department. (The ED must meet at least one of the following requirements: (1) It is licensed by the State in which it is located under applicable State law as an emergency room or emergency department; (2) It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or (3) During the calendar year immediately preceding the calendar year in which a determination under this section is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment).

For CY 2007, we assigned the five new Type B emergency department visit codes for services provided in a Type B emergency department to the five newly-established Clinic Visit APCs, 0604, 0605, 0606, 0607, and 0608 (71 FR 68140). This payment policy for Type B emergency department visits is similar to our previous policy which required services furnished in emergency departments that had an EMTALA obligation but did not meet the CPT definition of emergency department to be reported using CPT clinic visit E/M codes, resulting in payments based upon clinic visit APCs. As mentioned above, CPT and CMS required an emergency department to be open 24 hours per day in order for it to be eligible to bill emergency department E/M codes. While maintaining the same payment policy for Type B emergency department visits in CY 2007, we believe the reporting of specific 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 in the future whether a proposal of 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 departments. The OPPS rulemaking cycle for CY 2009 will be the first year that we will have cost data for these new Type B emergency department HCPCS codes available for analysis.

In the CY 2007 OPPS/ASC proposed rule (71 FR 49609), we proposed to create five G-codes to be reported by the subset of provider-based emergency departments or facilities of the hospital, called Type A emergency departments, that are available to provide services 24 hours a day, 7 days per week and meet one or both of the following requirements related to the EMTALA definition of a dedicated emergency department, specifically: (1) It is licensed by the State in which it is located under the applicable State law as an emergency room or emergency department; or (2) It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment. These codes were called ''Type A emergency visit codes'' and were proposed to replace hospitals' reporting of the CPT emergency department visit E/M codes listed in Table 49 above. Our intention was to allow hospital-based emergency departments or facilities that were historically appropriately reporting CPT emergency department visit E/M codes to bill these new Type A emergency department visit codes. In the CY 2007 OPP/ASC, final rule with comment period (71 FR 68132), we postponed finalizing G-codes to replace CPT codes for Type A emergency department visits until national guidelines are established, and stated that we would again consider their possible utility once the national guidelines are adopted. However, for CY 2007, we finalized the definition of Type A emergency departments to distinguish them from Type B emergency departments. For CY 2007 (71 FR 68140), we assigned the five CPT E/M emergency department visit codes for services provided in a Type A emergency departments to the five newly-created Emergency Department Visit APCs, 0609, 0613, 0614, 0615, and 0616.

We believe that our distinction between Type A and Type B emergency departments refined and clarified the CPT definition of ''emergency department'' for use in the hospital

context. As we have previously noted, the CPT codes were defined to reflect the activities of physicians and do not always describe well the range and mix of services provided by hospitals during visits of emergency department patients. For example, one feature that distinguishes Type A hospital emergency departments from other departments of the hospital is that Type A emergency departments do not generally provide scheduled care, but rather regularly operate to provide immediately available unscheduled services.

We were pleased that the majority of commenters to the CY 2007 OPPS/ASC proposed rule agreed with our general distinction between Type A and Type B emergency departments. We note that after the publication of the CY 2007 OPP/ASC final rule with comment period, numerous readers requested clarification about one paragraph that appeared in that final rule. The paragraph is reprinted below (71 FR 68132).

''We are aware that hospitals operate many types of facilities which they view in aggregate as an integrated healthcare system. For purposes of determining EMTALA obligations, under § 489.24(b) of the regulations, each hospital is evaluated individually to determine its own particular obligations. As we have discussed previously, hospital facilities or departments of the hospital that meet the definition of a dedicated emergency department consistent with the EMTALA regulations may bill Type A emergency department codes (CPT emergency department visit codes) or Type B emergency department codes (HCPCS G-codes), depending on whether or not the dedicated emergency department meets the definition of a Type A emergency department, which includes operating 24 hours per day, 7 days a week. For purposes of determining whether to bill Type A or Type B emergency department codes, each hospital must be evaluated individually and should make a decision specific to each area of the hospital to determine which codes would be appropriate. Where a hospital maintains a separately identifiable area or part of a facility which does not operate on the same schedule (that is, 24 hours per day, 7 days a week) as its emergency department, that area or facility would not be considered an integral part of the emergency department that operates 24 hours per day, 7 days a week for purposes of determining its emergency department type for reporting emergency visit services. Instead, the facility or area would be evaluated separately to determine whether it is a Type A emergency department, Type B emergency department, or clinic. We would expect the hospital providing services in such facilities or areas to evaluate the status of those areas and bill accordingly. In general, it is not appropriate to consider a satellite emergency department or an area of the emergency department as if it were available 24 hours a day simply because the main emergency department is available 24 hours a day. It may be appropriate for a Type A emergency department to 'carve out' portions of the emergency department that are not available 24 hours a day, where visits would be more appropriately billed with Type B emergency department codes.''

In response to the questions we received, we posted on the CMS Web site a ''Frequently Asked Questions'' list that described various examples of treating an emergency department as either a Type A emergency department or a Type B emergency department. In each case, the posted answer stated that hospitals should contact their fiscal intermediary to ensure that the fiscal intermediary and the hospital are in agreement regarding the emergency room status as either Type A or Type B. The response to the posted examples has been positive and the number of inquiries we are receiving has subsided.

Notwithstanding our subsequent clarification, we are not proposing to modify the definitions of Type A or Type B emergency departments for CY 2008 because we believe that our current definition accurately distinguishes between these two types of emergency departments. While we will not know definitively until CY 2009 how the costs of services provided in Type A emergency departments differ from the costs of services provided in Type B emergency departments, we believe that our current distinction between Type A and B emergency departments is appropriate and is most likely to capture any resource cost differences between the two types of emergency departments. However, we are specifically soliciting public comment regarding any additional operational clarifications that we could provide to assist hospitals in determining whether an emergency department is considered to be Type A or Type B.

We specifically indicated for CY 2007 that hospitals should individually consider separately identifiable areas or parts of facilities that did not operate on the same schedule as the main emergency department that was open 24 hours a day, 7 days per week to determine the appropriate codes for reporting services provided in those separately identifiable areas. Because we consider the main distinguishing feature between Type A and Type B emergency departments to be the full-time versus part-time availability of staffed areas for emergency medical care, not the process of care or the site of care (on the hospital's main campus or offsite), our final CY 2007 policy explained that hospitals needed to assess separately identifiable areas individually for their status as Type A or Type B emergency departments. We are interested specifically in comments that describe how this policy could be further clarified in light of hospitals' operational responsibility to efficiently provide emergency services, holding constant the definitions that were developed for CY 2007 and described above. We do not believe a policy change in the reporting of these Type A and Type B emergency department codes would be appropriate for CY 2008, in light of our desire to capture consistent and accurate hospital cost data by HCPCS code for consideration for the CY 2009 OPPS. For CY 2008, we are proposing that Type A emergency department visits would continue to be paid based on the five Emergency Department Visit APCs, while Type B emergency department visits would continue to be paid based on the five Clinic Visit APCs.

C. Proposed Visit Reporting Guidelines

1. Background

As described in section IX.A. of this proposed rule, since April 7, 2000, we have instructed hospitals to report facility resources for clinic and emergency department outpatient hospital visits using the CPT E/M codes and to develop internal hospital guidelines for reporting the appropriate visit level.

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

In the August 9, 2002 OPPS proposed rule (67 FR 52133), we proposed 10 new G-codes (Levels 1–5 Facility Emergency Services and Levels 1–5 Facility Clinic Services) for use in the OPPS to report hospital visits, with the goal of ultimately applying national guidelines to these codes and discontinuing the use of CPT E/M codes under the OPPS. We also solicited public comments regarding national guidelines for hospital coding of emergency department and clinic visits. We discussed different types of models, reflecting on the advantages and disadvantages of each. We reviewed in detail the considerations around various discrete types of specific guidelines, including guidelines based on staff interventions, based upon staff time spent with the patient, based on resource intensity point scoring, and

based on severity acuity point scoring related to patient complexity. In that proposed rule, we also stated that we were concerned about counting separately paid services (for example, intravenous infusions, x-rays, electrocardiograms, and laboratory tests) as ''interventions'' or including their associated ''staff time'' in determining the level of service. We believed that the level of service should be determined by resource consumption that is not otherwise captured in payments for other separately payable services.

In response to comments, in the November 1, 2002 OPPS final rule (67 FR 66793), we stated that we would not create new codes to replace existing CPT E/M codes for reporting hospital visits until national guidelines are developed. We noted that an independent panel of experts would be an appropriate forum to develop codes and guidelines that are simple to understand and implement. We explained that organizations such as the American Hospital Association (AHA) and the American Health Information Management Association (AHIMA) had such expertise and would be capable of creating hospital visit guidelines and providing ongoing provider education. We also articulated a set of principles that any national guidelines for facility visit coding should satisfy, including that coding guidelines should be based on facility resources, should be clear to facilitate accurate payments and be usable for compliance purposes and audits, should meet HIPAA requirements, should only require documentation that is clinically necessary for patient care, and should not facilitate upcoding or gaming. We stated that the distribution of codes reported for each type of hospital outpatient visit (clinic or emergency department) should result in a normal curve. We concluded that we believed the most appropriate forum for development of code definitions and guidelines was an independent expert panel that would make recommendations to CMS.

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

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

In an attempt to validate the modified AHA/AHIMA guidelines and examine the distribution of services that would result from their application to hospital clinic and emergency department visits paid under the OPPS, we contracted for a study that began in September 2004 and concluded in September 2005 to retrospectively code, under the modified AHA/AHIMA guidelines, hospital visits by reviewing hospital visit medical chart documentation gathered through the Comprehensive Error Rate Testing (CERT) work. While a review of documentation and assignment of visit levels based on the modified AHA/AHIMA guidelines to 12,500 clinic and emergency department visits was initially planned, the study was terminated after a pilot review of only 750 visits. The contractor identified a number of elements in the guidelines that were difficult for coders to interpret, poorly defined, nonspecific, or regularly unavailable in the medical records. The contractor's coders were unable to determine any level for about 25 percent of the clinic cases and about 20 percent of the emergency cases reviewed. The only agreement observed between the levels reported on the claims and levels according to the modified AHA/AHIMA guidelines was the classification of Level 1 services, where the review supported the level on the claims 54 to 70 percent of the time. In addition, the vast majority of the clinic and emergency department visits reviewed were assigned to Level 1 during the review. Based on these findings, we believed that it was not necessary to review additional records after the initial sample. The contractor advised that multiple terms in the guidelines required clearer definition and believed that more examples would be helpful. Although we believe that all of the visit documentation for each case was available for the contractor's review, we were unable to determine definitively that this was the case. Thus, there is some possibility that the contractor's assignments would have differed if additional documentation from the medical records were available for the visits. In summary, while testing of the modified AHA/AHIMA guidelines was helpful in illuminating areas of the guidelines that would benefit from refinement, we were unable to draw conclusions about the relationship between the distribution of current hospital reporting of visits using CPT E/M codes that are assigned according to each hospital's internal guidelines and the distribution of codes under the AHA/AHIMA guidelines, nor were we able to demonstrate a normal distribution of visit levels under the modified AHA/AHIMA guidelines. In CY 2007, we posted to the CMS Web site a summary of the contractor's report.

Despite the inconclusive findings from the validation study, after reviewing the AHA/AHIMA guidelines, as well as approximately a dozen other guidelines for outpatient visits submitted by various hospitals and hospital associations, we stated in the CY 2007 OPPS/ASC final rule with

comment period (71 FR 68141) that we believed that the AHA/AHIMA guidelines are the most appropriate and well-developed guidelines for use in the OPPS of which we are aware. Our particular interest in these guidelines is based upon the broad-based input into their development, the desire for CMS to move to promulgate national outpatient hospital visit coding guidelines in the near future, and full consideration of the characteristics of alternative types of guidelines. We also believe that hospitals would react favorably to guidelines developed and supported by the AHA and AHIMA, national organizations that have great interest in hospital coding and payment issues, and possess significant medical, technical and practical expertise due to their broad membership, which includes hospitals and health information management professionals. Anecdotally, we have been told that a number of hospitals are successfully utilizing the AHA/AHIMA guidelines to report levels of hospital visits. However, other organizations have expressed concern that the AHA/AHIMA guidelines may result in a significant redistribution of hospital visits to higher levels, reducing the ability of the OPPS to discriminate among the hospital resources required for various different levels of visits. We, too, remain concerned about the potential redistributive effect on OPPS payments for other services or among levels of hospital visits when national guidelines for outpatient visit coding are adopted. We recognize that there may be difficulty crosswalking historical hospital claims data from current CPT E/M codes reported based on individual internal hospital guidelines to payments for any new coding system developed, in order to provide appropriate payment levels for hospital visits reported based on national guidelines in the future.

There are several types of concerns with the AHA/AHIMA guidelines that have been identified based upon extensive staff review and contractor use of the guidelines during the validation study. We believe the AHA/AHIMA guidelines would require refinement prior to their adoption by the OPPS, as well as continued refinement over time after their implementation. Our modified version of the AHA/AHIMA guidelines provides some possibilities for addressing certain issues. Our eight general areas of concern regarding the AHA/AHIMA model are reviewed below. In addition, we have posted to the CMS Web site both the original AHA/AHIMA guidelines and our modified draft version.

We continue to commit that we would provide a minimum of 6 to 12 months notice to hospitals prior to implementation of national guidelines to provide sufficient time for providers to make the necessary systems changes and educate their staff.

2. CY 2007 Work on Visit Guidelines

There are several areas of the AHA/AHIMA guidelines that we identified in the CY 2007 OPPS/ASC final rule with comment period that would require refinement and further input from the public prior to implementation as national guidelines. These areas include the need for five rather than three levels of codes for clinic and emergency department visits to accommodate the current five levels of OPPS payment; clarification of documentation that would support certain interventions; reconsideration of the inclusion of separately payable services as proxies for hospital resources used in visits; examination of the valuing of certain interventions; assessment of the need for modifications to address the different clinical characteristics of specialty clinic visits; consistency with the Americans with Disabilities Act; reevaluation of the way in which additional hospital resources required for the treatment of new patients are captured; and recommendations for guidelines for the reporting of visits to Type B emergency departments.

We have had a number of meetings and discussions with interested stakeholders over the past several months regarding the AHA/AHIMA guidelines, the CMS modified draft version, the contractor pilot work to test the guidelines, the concerns we identified in the CY 2007 OPPS/ASC final rule, and alternative guidelines. We are aware that the AHA and AHIMA are having an ongoing dialogue with members of their Hospital Evaluation and Management Coding Panel and reviewing their previously recommended model guidelines as well as other models currently in use. We have not received any additional suggestions or modifications from the AHA and AHIMA to date. We have received a number of new suggestions for guidelines from other stakeholders, including individual hospitals and associations, that have engaged in a variety of data collection and pilot application activities in preparing their recommendations. For example, one wound care organization created and presented an independent model that could apply to certain specialty clinics. The organization claimed that several hospital outpatient specialty clinics had already successfully implemented these as their internal guidelines, but requested that CMS designate them as the national wound care clinic guidelines. One provider group tested several sets of guidelines that resembled the ACEP model and compared the results across a set of hospitals. This provider group believes that an ACEP-type model would be the most successful type of national guidelines, assuming that the guidelines were flexible in serving as a guide to visit level reporting. While using several varieties of ACEP-type guidelines in different hospitals, the group noted that across hospitals a specific intervention was almost always assigned to the same clinic visit level. The group concluded that this indicated that the ACEP model and its variations could likely be successfully implemented as national guidelines. Another association reviewed and tested the CMS modified AHA/AHIMA guidelines that were posted to the CMS Web site. This association found it cumbersome to assign the Level 2 and Level 4 Clinic Visit codes because those levels could only be assigned when a certain number of interventions and/or contributory factors were performed. The association suggested changes to the CMS modified AHA/AHIMA guidelines for ease of use and application to specialty clinics, particularly oncology clinics. One developer of national clinic and emergency department visit guidelines noted that many hospitals had successfully used the presenting problem-based guidelines that it had created. The developer noted that its system was easy to use, produced consistent coding decisions resulting in a normal distribution of visits, and even served as a tool to track effectiveness and efficiency.

We appreciate the thoughtful information that has been provided to us so far regarding hospitals' experiences and the insightful responses by the public to our concerns about the AHA/AHIMA model. We are currently actively engaged in evaluating and comparing various guideline models and suggestions that have been provided to us, and we continue to welcome additional public input on this important and complex area of the OPPS. The public input we have received continues to reflect a wide variety of perspectives on the types and content of the guidelines different commenters recommend that we should implement nationally for the OPPS, and no single approach appears to be broadly endorsed by the stakeholder

community. In addition, commenters have described the successful application of many types of internal hospital guidelines with diverse characteristics for the reporting of hospital clinic and emergency department visit levels that they believe accurately capture the required hospital resources.

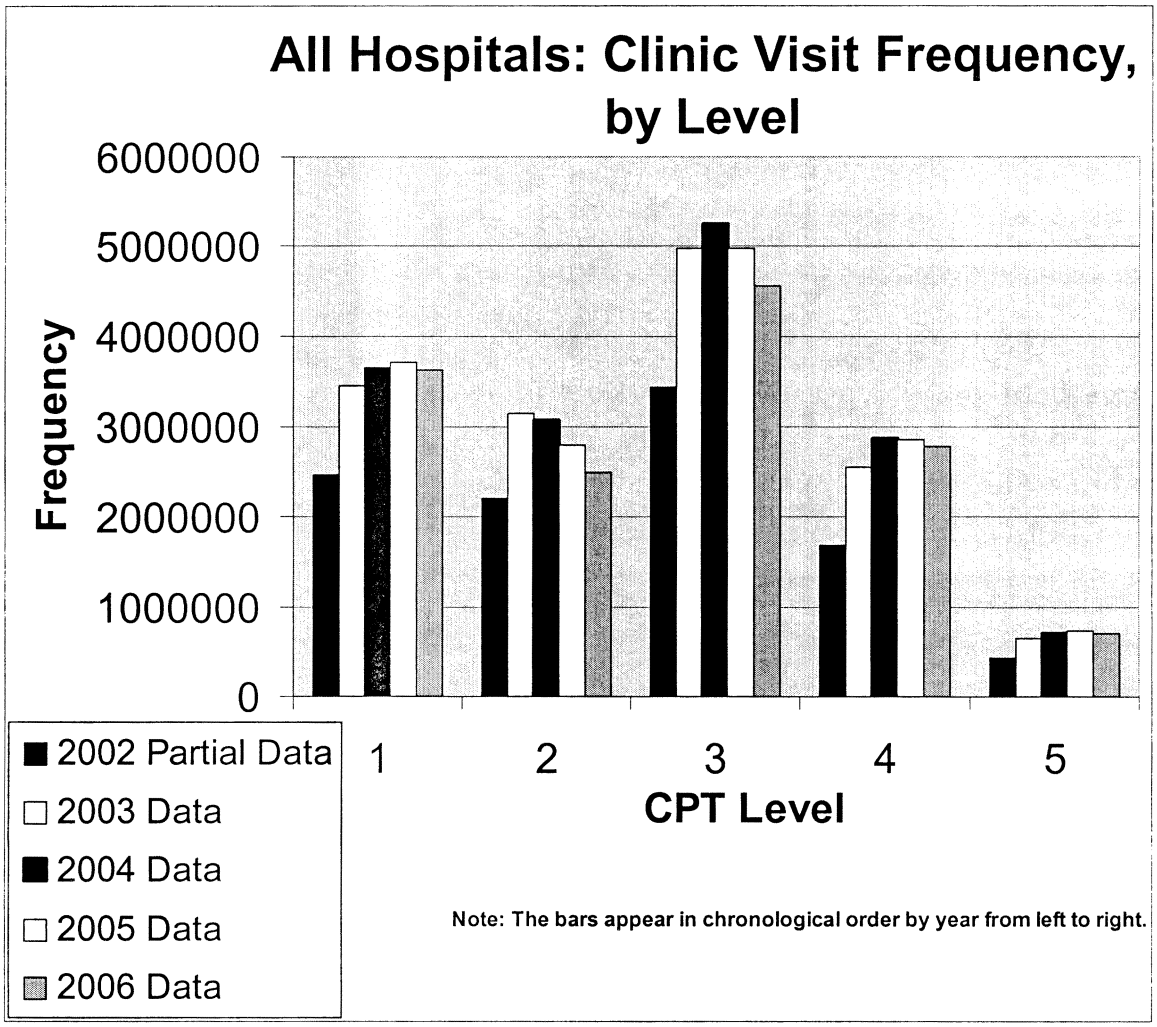
3. Proposed Visit Guidelines

We performed data analyses with the goal of studying the current distribution of each level of clinic and emergency department visit codes billed nationally, as well as the distribution among various classes of hospitals. We analyzed frequency data from claims with dates of service from March 1, 2002, through December 31, 2006, including those claims that were processed through December 31, 2006. To determine the national clinic visit distribution, we reviewed frequency data for each level of new patient visits, established patient visits, and consultation codes. To determine the national emergency department visit distribution, we reviewed frequency data for the five CPT emergency department visit codes. We did not include the five G-codes that describe Type B emergency departments because they became effective January 1, 2007, and we do not yet have a full year of frequency data for those codes.

The clinic visit data, displayed below in Figure 1, revealed a fairly normal national distribution of clinic visits, with the curve somewhat skewed to the left, consistent with our previous analysis of these data in CY 2002 (67 FR 66791). In addition, the visit distributions have been quite stable over the past 5 years.

BILLING CODE 4120–01–P

Figure 1.--Frequency Distribution of New and Established Patient Clinic Visits, by Level of Code



The graph shown in Figure 1 indicates that hospitals, on average, are billing all five levels of visit codes with varying frequency, in a consistent pattern over time. It is striking to note how similar the annual distributions appear from CY 2002 through CY 2006. We are not surprised that hospitals report a relatively high proportion of low level visits, given the typical clinical care provided in HOPDs during these visits. Many Medicare patients are evaluated regularly in clinics by hospitals' clinical staff to determine the status of their chronic medical

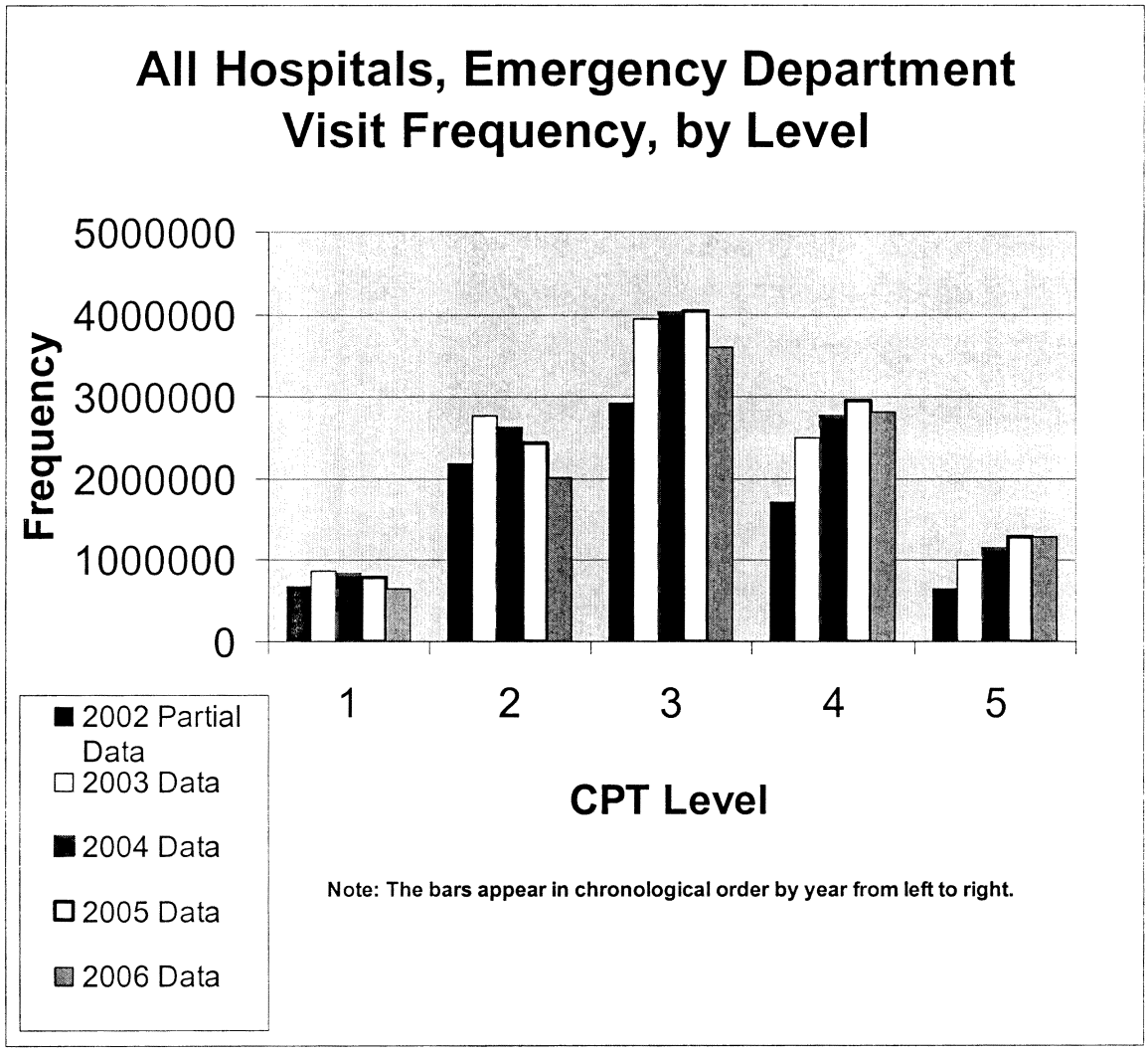
conditions and determine adjustments to treatment plans, and those visits may frequently be reported as a low level visit if that is consistent with the hospital's internal guidelines and fiscal intermediary instructions. Some patients may receive minor services during low level visits that are not described by more specific HCPCS codes. We note that, in general, billing a visit in addition to another service merely because the patient interacted with hospital staff or spent time in a room for that service is inappropriate. If a visit and another service are both billed, such as chemotherapy, a diagnostic test, or a surgical procedure, the visit must be separately identifiable from the other service because the resources used to provide nonvisit services, including staff time, equipment, supplies, among others, are captured in the line item for that service. We believe that hospitals by and large are abiding by this guidance because more than 90 percent of the CY 2006 claims for Level 1 established patient visits available for this proposed rule are single claims.

We also examined the billing patterns for various classes of hospitals, grouped by the hospital categories shown in the impact table (Table 67) in section XXII.B. of this proposed rule, to see how the clinic visit distributions of levels billed for these various categories compared to the national distribution of clinic visit levels. For these subcategories, we specifically focused on the number of established patient visits billed at each level. Generally, the distribution for major teaching hospitals, minor teaching hospitals, and nonteaching hospitals looked remarkably similar to the national distribution of established patient visits. Nonteaching hospitals tended to bill a greater proportion of Level 1 and 2 patient visits as compared to major teaching hospitals, as would be expected if their general patient acuity was slightly lower. Nonteaching hospitals include many community hospitals that treat a wide variety of patients, likely including a larger proportion of patients with minor ailments. Major teaching hospitals reported a slightly higher proportion of Level 4 and 5 visits. This too correlates well with our knowledge of the patient case-mix of large teaching hospitals, which tend to treat a higher proportion of very sick patients than nonteaching hospitals. The distributions for urban and rural hospitals also closely resembled the national distribution, including the rural SCH visit level distribution. The smallest rural hospitals predictably reported a higher proportion of Level 1 and 2 visit codes and a lower proportion of higher level visit codes, as compared to the national average, consistent with their generally lower case-mix severity.

The national emergency department visit data, displayed below in Figure 2, similarly revealed a normal national distribution of emergency department visit levels that was even more symmetrical than the national clinic visit distribution. The national distributions have been stable over the past 5 years as well.

BILLING CODE 4120–01–P

Figure 2.--Frequency Distribution of Emergency Department Visits, by Level of Code



BILLING CODE 4120–01–C

We also looked at various classes of hospitals, grouped by the hospital categories that we show in the impact table (Table 67) in section XXII. of this proposed rule to see how the emergency department visit distributions of levels billed by hospitals in each of these various categories compared to the national distribution of emergency department visit levels. The emergency department visit distributions for major teaching hospitals, minor teaching hospitals, and nonteaching hospitals were almost identical to the national distribution of emergency department visits. No significant differences were noted. The emergency department visit distributions for urban and rural hospitals also closely resembled the national distribution of emergency department visits. Rural hospitals in the aggregate reported slightly higher proportions of Level 2 and 3 emergency department visits than the national average and slightly fewer Level 4 and 5 visits. When subdividing rural hospitals into groupings based on size, the distribution for small, medium, and large rural hospitals closely mirrored the national average distribution. Large rural hospitals tended to report higher level emergency department visits than smaller rural hospitals. All of these observations regarding the patterns of reporting for rural hospitals are consistent with our expectations for care delivery of those hospitals.

Overall, both the clinic and emergency department visit distributions indicate that hospitals are billing consistently over time and in a manner that distinguishes between visit levels, resulting in relatively normal distributions nationally for the OPPS, as well as for smaller classes of hospitals. These analyses are generally consistent with our understanding of the clinical and resource characteristics of different levels of hospital outpatient clinic and emergency department visits.

We specifically are inviting public comment as to whether a pressing need for national guidelines continues 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 is currently more practical and appropriately flexible for hospitals. Although we have reiterated our goal since CY 2000 of creating national guidelines, this complex undertaking for these important and common hospital services is proving more challenging than we initially thought as we receive new and expanded information from the public on current hospital reporting practices that lead to appropriate

payment for the hospital resources associated with clinic and emergency department visits. Many hospitals have worked diligently and carefully to develop and implement their own internal guidelines that reflect the scope and types of services they provide throughout the hospital outpatient system. Based on public comments, as well as our own knowledge of how clinics operate, it seems 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 indicates that hospitals, both nationally in the aggregate and grouped by specific hospital classes, are generally billing in an appropriate and consistent manner as we would expect in a system that accurately distinguishes among different levels of service based on the associated hospital resources.

Therefore, while we continue to evaluate the information and input we have received from the public during CY 2007, as well as invite comments on this proposed rule regarding the necessity and feasibility of implementing different types of national guidelines, we are not proposing to implement national visit guidelines for clinic or emergency department visits for CY 2008. Instead, hospitals will continue to report visits during CY 2008 according to their own internal hospital guidelines.

In the absence of national guidelines, we would 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. In addition, we expect that hospitals' internal guidelines will comport with the principles listed below.

- The coding guidelines should follow the intent of the CPT code descriptor in that the guidelines should be designed to reasonably relate the intensity of hospital resources to the different levels of effort represented by the code (65 FR 18451).
- The coding guidelines should be based on hospital facility resources. The guidelines should not be based on physician resources (67 FR 66792).
- The coding guidelines should be clear to facilitate accurate payments and be usable for compliance purposes and audits (67 FR 66792).
- The coding guidelines should meet the HIPAA requirements (67 FR 66792).
- The coding guidelines should only require documentation that is clinically necessary for patient care (67 FR 66792).
- The coding guidelines should not facilitate upcoding or gaming (67 FR 66792)

We also are proposing the following five additional principles that should apply to hospital specific guidelines, based on our evolving understanding of the important issues addressed by many hospitals in developing their internal guidelines that now have been used for a number of years. We believe it is reasonable at this time to elaborate upon the standards for hospitals' internal guidelines that we are proposing to apply in CY 2008, based on our knowledge of hospitals' experiences to date with guidelines for visits.

- The coding guidelines should be written or recorded, well-documented and provide the basis for selection of a specific code.
- The coding guidelines should be applied consistently across patients in the clinic or emergency department to which they apply.
- The coding guidelines should not change with great frequency.
- The coding guidelines should be readily available for fiscal intermediary (or, if applicable, MAC) review.
- The coding guidelines should result in coding decisions that could be verified by other hospital staff, as well as outside sources.

We are inviting comment on these principles, specifically, whether hospitals' guidelines currently meet these principles, how difficult it would be for hospitals' guidelines to meet these principles if they do not meet them already, and whether hospitals believe that certain standards should be added or removed. We considered stating that a hospital must use one set of emergency department visit guidelines for all emergency departments in the hospital, but thought that some departments that might be considered emergency departments, such as the obstetrics department, may find it more practical and appropriate to use a different set of guidelines than the general emergency department. Similarly, we find it possible that various specialty clinics in a hospital could have their own set of guidelines, specific to the services offered in those specialty clinics. However, if different guidelines are implemented for different clinics, hospitals should ensure that these guidelines reflect comparable resource use at each level to the other clinic guidelines that the hospital may apply.

We appreciate all the comments we have received in the past from the public on visit guidelines, and we encourage continued submission of comments at any time that will 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. We would not expect individual hospitals to necessarily experience a normal distribution of visit levels across their claims, although we would expect a normal distribution across all hospitals as observed currently and as we would expect if national guidelines were implemented. We understand that, based on different patterns of care, we could expect that a small community hospital might provide more low level services than high level services, while an academic medical center or trauma center might provide more high level services than low level services. We would also expect national guidelines to provide for five levels of coding, to parallel the five payment levels that currently exist.

We hope to receive additional input from stakeholders over the upcoming months to address whether there is a definite contemporary need for national guidelines, given their potential to redistribute payment under the OPPS and the currently reassuring observed patterns of OPPS visit services. While we understand the interest of some hospitals in our moving quickly to promulgate national guidelines that will ensure standardized reporting of outpatient hospital visit levels, we believe that the issues identified both by us and others that may arise are important and require serious consideration prior to the implementation of national guidelines. Because of our commitment to provide hospitals with 6–12 months notice prior to implementation of national guidelines, we would not implement national guidelines prior to CY 2009. 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. Proposed OPPS Payment for Blood and Blood Products

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

A. Background

Since the implementation of the OPPS in August 2000, separate payments have been made for blood and blood products through APCs rather than packaging them into payments for the procedures with which they were administered. Hospital payments for the costs of blood and blood products, as well as the costs of collecting, processing, and storing blood and blood products, are made through the OPPS payments for specific blood product APCs. On April 12, 2001, CMS issued the original billing guidance for blood products to hospitals (Program Transmittal A–01–50). In response to requests for clarification of these instructions, CMS issued Program Transmittal 496 on March 4, 2005. The comprehensive billing guidelines in Program Transmittal 496 also addressed specific concerns and issues related to billing for blood-related services, which the public had brought to our attention.

In the CY 2000 OPPS, payments for blood and blood products were established based on external data provided by commenters due to limited Medicare claims data. From the CY 2000 OPPS to the CY 2002 OPPS, payment rates for blood and blood products were updated for inflation. For the CY 2003 OPPS, as described in the November 1, 2002 final rule with comment period (67 FR 66773), we applied a special adjustment methodology to blood and blood products that had significant reductions in payment rates from the CY 2002 OPPS to the CY 2003 OPPS, when median costs were first calculated from hospital claims. Using the adjustment methodology, we limited the decrease in payment rates for blood and blood products to approximately 15 percent. For the CY 2004 OPPS, as recommended by the APC Panel, we froze payment rates for blood and blood products at CY 2003 levels as we studied concerns raised by commenters and presenters at the August 2003 and February 2004 APC Panel meetings.

For the CY 2005 OPPS, we established new APCs that allowed each blood product to be assigned to its own separate APC, as several of the previous blood product APCs contained multiple blood products with no clinical homogeneity or whose product specific median costs may not have been similar. Some of the blood product HCPCS codes were reassigned to the new APCs (Table 34 of the November 15, 2004 final rule with comment period (69 FR 65819)).

We also noted in the November 15, 2004 final rule with comment period that public comments on previous OPPS rules had stated that the CCRs that were used to adjust charges to costs for blood products in past years were too low. Past commenters indicated that this approach resulted in an underestimation of the true hospital costs for blood and blood products. In response to these comments and the APC Panel recommendations from its February 2004 and September 2004 meetings, we conducted a thorough analysis of the CY 2003 claims (used to calculate the CY 2005 APC payment rates) to compare CCRs between those hospitals reporting a blood-specific cost center and those hospitals defaulting to the overall hospital CCR in the conversion of their blood product charges to costs. As a result of this analysis, we observed a significant difference in CCRs utilized for conversion of blood product charges to costs for those hospitals with and without blood-specific cost centers. The median hospital blood-specific CCR was almost two times the median overall hospital CCR. As discussed in the November 15, 2004 final rule with comment period, we applied a special methodology for hospitals not reporting a blood-specific cost center, which simulated a blood-specific CCR for each hospital that we then used to convert charges to costs for blood products. Thus, we developed simulated medians for all blood and blood products based on CY 2003 hospital claims data (69 FR 65816).

For the CY 2005 OPPS, we also identified a subset of blood products that had less than 1,000 units billed in CY 2003. For these low-volume blood products, we based the CY 2005 OPPS payment rate on a 50/50 blend of the CY 2004 OPPS product-specific OPPS median costs and the CY 2005 OPPS simulated medians based on the application of blood-specific CCRs to all claims. We were concerned that, given the low frequency in which these products were billed, a few occurrences of coding or billing errors may have led to significant variability in the median calculation. The claims data may not have captured the complete costs of these products to hospitals as fully as possible. This low-volume adjustment methodology also allowed us to further study the issues raised by commenters and by presenters at the September 2004 APC Panel meeting, without putting beneficiary access to these low volume blood products at risk. We have adopted the use of this modified CCR process for calculating unadjusted median costs for blood and blood products each year since the CY 2005 OPPS.

Overall, median costs from CY 2003 (used for the CY 2005 OPPS) to CY 2004 (used for the CY 2006 OPPS) were relatively stable, with a few significant increases and decreases from the CY 2005 adjusted median costs for some specific blood products. For the CY 2006 OPPS, we adopted a payment adjustment policy that limited significant decreases in APC payment rates for blood and blood products from the CY 2005 OPPS to the CY 2006 OPPS to not more than 5 percent. We applied this adjustment to 11 blood and blood product APCs for the CY 2006 OPPS, which we identified in Table 33 of the CY 2006 OPPS final rule with comment period (70 FR 68687). For the CY 2006 OPPS, we set the final median costs for blood and blood products at the greater of: (1) The simulated median costs calculated from the CY 2004 claims data; or (2) 95 percent of the CY 2005 OPPS adjusted median costs for these products, as reflected in Table 33 published in the CY 2006 OPPS final rule with comment period.

In the CY 2007 OPPS, we established payment rates for blood and blood products by using the same simulation methodology described in the November 15, 2004 final rule with comment period (69 FR 65816), which utilizes hospital-specific actual or simulated CCRs for blood cost centers to convert hospital charges for blood and blood products to costs. However, we provided a payment transition for those blood products for which the difference between their CY 2006 adjusted median cost and their CY 2007 simulated median cost was greater than 25 percent. Specifically, we set the CY 2007 median costs upon which payments for blood and blood products are based at the higher of the CY 2007 unadjusted simulated median cost or 75 percent of the CY 2006 adjusted median cost on which the CY 2006 payment is based.

B. Proposed Payment for Blood and Blood Products

We are proposing to set the payment rates for blood and blood products for CY 2008 at the unadjusted median cost for these products, calculated using the hospital specific simulated blood CCR for each hospital that does not have a blood cost center. For this proposed rule, we calculated median costs for blood and blood products using claims for services furnished on or after January 1, 2006, and before January 1, 2007, and using the actual or simulated CCRs from the most recently available hospital cost reports. The median costs derived from this data process are relatively stable compared to the median costs on which payment is based for CY 2007. (See Table 55 below.) Of the 34 blood and blood products, median costs increase for 24

products and decline for 10 products compared to the adjusted medians on which payment is based in CY 2007. Products with the largest declines are, like the products with the greatest increases, mostly those products with low volume use in the hospital outpatient setting. The products whose costs decline more than 5 percent account for less than 1 percent of the total volume of blood and blood products in the claims used to calculate the proposed rates. No product's median cost declines by more than 18 percent in the proposed rule data, and thus no product shows a decline that would have resulted in an adjustment under the final policy in place for CY 2007. The products whose median costs increase account for 79 percent of the total volume of blood and blood products in the claims used to calculate the proposed rates. We note that CY 2006 claims are the first OPPS claims that represent a full year of hospitals' reporting consistent with our detailed blood billing guidelines issued in CY 2005. We are reassured by the relatively stable or slightly increasing median costs from CY 2005 to CY 2006 claims data for most blood products, a pattern that we believe may reflect more accurate and complete hospital reporting and charging practices for these products. Consistent with our billing guidelines, hospitals may now be taking into consideration all appropriate costs associated with providing blood and blood products in charging for those products under the OPPS.

As we indicated in the CY 2007 OPPS/ASC final rule with comment period (71 FR 68147), we believe that the simulated CCR methodology results in accurate reflections of the relative estimated costs of these products for hospitals without blood cost centers and, therefore, for these products in general. Our 1-year adjustment to the median costs for CY 2007, where the median costs for blood and blood products decreased by more than 25 percent from the CY 2006 adjusted median costs, was intended to provide a reasonable transition to use of the simulated median costs for payment of blood and blood products under the OPPS without further adjustment. The medians that result from the use of the simulated CCR process and the CY 2006 claims generally result in median costs that we believe provide an appropriate basis for the relative weights on which the CY 2008 payments for blood and blood products would be based. Therefore, we are proposing to use the median costs derived from the application of blood cost center CCRs for those hospitals that have blood cost centers or simulated blood cost center CCRs for those hospitals that do not have blood cost centers as the basis for the CY 2008 payments for blood and blood products without further adjustment.

TABLE 55.—PROPOSED CY 2008 MEDIAN COSTS FOR BLOOD AND BLOOD PRODUCTS

HCPCS code*	Short descriptor	Proposed CY 2008 units	Proposed CY 2008 simulated CCR median unit cost	CY 2007 payment median: higher of CY 2007 OPPS simulated CCR median unit cost or 75% of CY 2006 adjusted median unit cost	Difference between proposed CY 2008 simulated CCR median unit cost and CY 2007 adjusted simulated CCR median unit cost (percent)
P9010	Whole blood for transfusion	2,467	$279.14	$131.21	112.74%
P9011	Blood split unit	288	133.59	136.42	−2.07
P9012	Cryoprecipitate each unit	4,941	43.05	48.31	−10.89
P9016	RBC leukocytes reduced	558,488	186.14	174.71	6.54
P9017	Plasma 1 donor frz w/in 8 hr	40,750	68.58	69.80	−1.75
P9019	Platelets, each unit	18,466	68.15	58.61	16.28
P9020*	Plaelet rich plasma unit	708	338.08	208.07	62.49
P9021	Red blood cells unit	139,030	127.97	128.78	−0.63
P9022	Washed red blood cells unit	2,220	264.78	209.79	26.21
P9023*	Frozen plasma, pooled, sd	343	75.37	57.11	31.97
P9031	Platelets leukocytes reduced	16,471	108.24	94.53	14.50
P9032	Platelets, irradiated	8,889	130.48	128.81	1.30
P9033	Platelets leukoreduced irrad	4,401	127.57	124.60	2.38
P9034	Platelets, pheresis	8,844	442.89	450.29	−1.64
P9035	Platelet pheres leukoreduced	44,607	502.95	485.89	3.51
P9036	Platelet pheresis irradiated	1,263	440.81	416.08	5.94
P9037	Plate pheres leukoredu irrad	22,378	631.62	613.39	2.97
P9038	RBC irradiated	4,967	209.22	195.85	6.83
P9039	RBC deglycerolized	831	364.46	356.22	2.31
P9040	RBC leukoreduced irradiated	69,722	240.24	216.29	11.07
P9043*	Plasma protein fract, 5%, 50ml	21	90.53	50.96	77.67
P9044	Cryoprecipitate reduced plasma	4,352	82.60	81.91	0.84
P9048*	Plasmaprotein fract, 5%, 250ml	508	245.39	236.78	3.64
P9050*	Granulocytes, pheresis unit	12	978.29	745.98	31.14
P9051*	Blood, l/r, cmv-neg	3,377	150.12	155.79	−3.64
P9052	Platelets, hla-m, l/r, unit	1,618	608.71	667.70	−8.83
P9053	Plt, pher, l/r cmv-neg, irr	1,437	678.13	701.26	−3.30
P9054	Blood, l/r, froz/degly/wash	584	210.86	209.82	0.50
P9055*	Plt, aph/pher, l/r, cmv-neg	789	490.13	394.50	24.24
P9056	Blood, l/r, irradiated	3,634	153.31	143.44	6.88
P9057	RBC, frz/deg/wsh, l/r, irrad	112	406.96	493.32	−17.51
P9058	RBC, l/r, cmv-neg, irrad	3,151	291.16	260.65	11.71
P9059	Plasma, frz between 8–24hour	2,820	78.35	76.32	2.66
P9060	Fr frz plasma donor retested	192	73.17	74.06	−1.20

*Indicates payment median for CY 2007 at 75 percent of the CY 2006 adjusted median.

XI. Proposed OPPS Payment for Observation Services

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

Observation care is a well-defined set of specific, clinically appropriate services that include ongoing short-term treatment, assessment, and reassessment before a decision can be made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital. Observation status is commonly assigned to patients with unexpectedly prolonged recovery after surgery and to patients who present to the emergency department and who then require a significant period of treatment or monitoring before a decision is made concerning their next placement.

Payment for all observation care under the OPPS was packaged prior to CY 2002. Since CY 2002, separate payment of a single unit of an observation APC for an episode of observation care has been provided in limited circumstances. Effective for services furnished on or after April 1, 2002, separate payment for observation was made if the beneficiary had chest pain, asthma, or congestive heart failure and met additional criteria for diagnostic testing, minimum and maximum limits to observation care time, physician care, and documentation in the medical record (66 FR 59879). Payment for observation care that did not meet these specified criteria was packaged. Between CY 2003 and CY 2006, several more changes were made to the OPPS policy regarding separate payment for observation care, such as: clarification that observation is not separately payable when billed with ''T'' status procedures on the day of or day before observation care; development of specific Level II HCPCS codes for hospital observation care and direct admission to observation care; and removal of the initially established diagnostic testing requirements for separately payable observation (67 FR 66794, 69 FR 65828, and 70 FR 68688). Throughout this time period, we maintained separate payment for observation care only for the three specified medical conditions, and OPPS payment for observation for all other clinical conditions remained packaged.

Since January 1, 2006, hospitals have reported observation services based on an hourly unit of care using HCPCS code G0378 (Hospital observation services, per hour). This code has a status indicator of ''Q'' under the CY 2007 OPPS, meaning that the OPPS claims processing logic determines whether the observation is packaged or separately payable. The OCE's current logic determines whether observation services billed under HCPCS code G0378 is separately payable through APC 0339 (Observation), or whether payment for observation services will be packaged into the payment for other separately payable services provided by the hospital in the same encounter based on criteria discussed below. Also since January 1, 2006, hospitals have reported HCPCS code G0379 (Direct admission of patient for hospital observation care) for a direct admission of a patient to observation care. The OPPS pays separately for that direct admission reported under HCPCS code G0379 in situations where payment for the actual observation services reported under HCPCS G0378 are packaged and where the direct admission meets certain other criteria. The OCE logic determines when HCPCS code G0379 is separately payable under the OPPS.

For CY 2007, we continued to apply the criteria for separate payment for observation care and the coding and payment methodology for observation care that were implemented in CY 2006. Observation care is reported using HCPCS code G0378 and observation that meets the criteria for separate payment maps to APC 0339 (Observation). The current criteria for separate payment for observation (APC 0339) are:

A. Diagnosis Requirements

1. The beneficiary must have one of three medical conditions: congestive heart failure (CHF), chest pain, or asthma.

2. Qualifying ICD–9–CM diagnosis codes must be reported in Form Locator (FL) 76, Patient Reason for Visit, or FL 67, principal diagnosis, or both in order for the hospital to receive separate payment for APC 0339. If a qualifying ICD–9–CM diagnosis code(s) is reported in the secondary diagnosis field, but is not reported in either the Patient Reason for Visit field (FL 76) or in the principal diagnosis field (FL 67), separate payment for APC 0339 is not allowed.

B. Observation Time

1. Observation time must be documented in the medical record.

2. A beneficiary's time in observation (and hospital billing) begins with the beneficiary's admission to an observation bed.

3. A beneficiary's time in observation (and hospital billing) ends when all clinical or medical interventions have been completed, including followup care furnished by hospital staff and physicians that may take place after a physician has ordered the patient be released or admitted as an inpatient.

4. The number of units reported with HCPCS code G0378 must equal or exceed 8 hours.

C. Additional Hospital Services

1. The claim for observation services must include one of the following services in addition to the reported observation services. The additional services listed below must have a line item date of service on the same day or the day before the date reported for observation:

- An emergency department visit (APC 0609, 0613, 0614, 0615, or 0616); or
- A clinic visit (APC 0604, 0605, 0606, 0607, or 0608); or
- Critical care (APC 0617); or
- Direct admission to observation reported with HCPCS code G0379 (APC 0604).

2. No procedure with a ''T'' status indicator can be reported on the same day or day before observation care is provided.

D. Physician Evaluation

1. The beneficiary must be in the care of a physician during the period of observation, as documented in the medical record by admission, discharge, and other appropriate progress notes that are timed, written, and signed by the physician.

2. The medical record must include documentation that the physician explicitly assessed patient risk to determine that the beneficiary would benefit from observation care.

The CY 2007 list of diagnoses eligible as a criterion for separate payment for observation services may be found in Table 44 of the CY 2007 OPPS/ASC final rule with comment period (71 FR 68152).

For CY 2007, we made one minor change in payment for direct admission to observation. As part of the changes in APC assignments and payments for clinic and emergency department visits, low level clinic visits were moved from APC 0600 (Low Level Clinic Visits) to APC 0604 (Level 1 Clinic Visits), with a CY 2007 payment rate of $50.66. Under the circumstances where direct admission to observation is separately payable, we finalized our CY 2007 assignment of HCPCS code G0379 to APC 0604, consistent with its CY 2006 placement in the APC for Low Level Clinic Visits.

During the APC Panel's August 2006 meeting, the Observation Subcommittee made several recommendations regarding observation services. The first

of these was that CMS should consider adding syncope and dehydration as diagnoses for which observation services would qualify for separate payment. Second, the Observation Subcommittee recommended that CMS perform claims analyses and present data that would allow CMS to consider revising criteria for separately payable observation care when certain procedures that are assigned status indicator ''T,'' for example, insertion of a bladder catheter or laceration repair, are reported on the same claim with an emergency department visit and observation care, and all other criteria for separate observation payment (for example, qualifying diagnosis code, number of hours) are met. The Panel also voted to change the name of the Observation Subcommittee to the Observation and Visit Subcommittee, based on the Panel's interest in expanding the scope of that subcommittee's work.

In response to August 2006 APC Panel recommendations and public comments to the CY 2007 proposed rule, we stated in the CY 2007 OPPS/ASC final rule with comment period that we intended to perform a series of analyses over the upcoming year to explore the potential effects of adding syncope and dehydration as qualifying diagnoses for separately payable observation care, as well as the possibility of allowing separate observation payment for claims for observation care that also include specific minor or routine procedures that have ''T'' status indicators (71 FR 68150).

At the March 2007 meeting of the APC Panel, we discussed with the Observation and Visit Subcommittee and the full Panel the results of the requested data analyses regarding syncope and dehydration, as well as the occurrences of claims for observation care that also include specific minor or routine procedures that have ''T'' status indicators. With respect to the diagnosis analyses, the data presented to the Subcommittee and Panel (consisting of partial year 2006 claims data that are less complete than the claims data available for this proposed rule) showed that there were 136,977 claims for separately payable observation services for the currently eligible conditions of chest pain, asthma, and congestive heart failure, with a median cost of $453. The frequency of claims for observation services for the diagnoses of syncope and dehydration, when all other criteria for separate payment of observation services (other than diagnosis) were met, was 46,961 claims, with a somewhat lower median cost of $416. The effect of adding both syncope and dehydration to the current diagnoses eligible for separate payment would be to lower the median for APC 0339 slightly to $443, using the early partial 2006 data presented to the Subcommittee and Panel. For the study of ''T'' status procedures in relation to observation, we identified relatively few instances (5,162) where observation met all of the criteria for separate payment, including the current three conditions of CHF, asthma, chest pain, except for the presence of a ''T'' status procedure. Of these claims, very few had any significant frequency. The most common procedures are those relating to heart catheterization, angioplasty procedures, and endoscopies. As we have stated in the past, we believe that the observation services in these cases may be related to these procedures and we have no way of discerning from our data whether the procedure happened before or after the observation services.

The APC Panel made three recommendations related to these topics. First, the Panel recommended that CMS add syncope and dehydration to the list of clinical conditions eligible for separate observation payment. Second, the Panel recommended that CMS continue to evaluate the types of diagnostic conditions that might qualify for separate observation payment in the future. Third, the Panel recommended that CMS make no changes to the criteria for separate observation payment related to the performance of ''T'' status procedures. However, the Panel added that if CMS added syncope and dehydration to the list of conditions eligible for separate observation payment, the Panel requested that CMS reexamine the claims data once CMS collects a year of observation claims data, including the additional conditions, so the Panel could reconsider this recommendation at a future meeting.

We have also taken into consideration the June 2006 IOM Report entitled, ''Hospital-Based Emergency Care: At the Breaking Point.'' This report encourages hospitals to apply tools to improve the flow of patients through emergency departments, especially through the use of observation units (clinical decision units). The IOM report also recommends that separate OPPS payment should be made for all conditions for which observation is indicated.

We appreciate the continued work and dedication of the Observation and Visit Subcommittee and the APC Panel, along with the findings and recommendations of the IOM. However, in light of the broader CY 2008 OPPS proposal to move toward expanded packaging of payment for supportive, dependent HOPD services, we are not accepting the Panel's recommendation related to adding syncope and dehydration to the list of diagnoses eligible for separate payment or to consider other clinical conditions for separate payment for observation care. We are proposing to package all observation services (reported with HCPCS code G0378) as part of the proposed changes to packaged services discussed previously in section II.A.4. of this proposed rule. Because we are proposing to package payment for all observation services, we are not proposing to adopt the Panel's recommendation to study claims data for separately payable observation care (including claims for observation for syncope and dehydration) that also include specific minor or routine procedures that have ''T'' status indicators. We agree with the APC Panel and the IOM that there is currently no compelling rationale for a different OPPS payment approach for observation care for only three specific clinical conditions. We recognize that observation care may play an important role in the treatment of many Medicare beneficiaries in the HOPD, decreasing the need for short inpatient admissions and ensuring safe discharges of patients to their homes. Therefore, we believe that our proposed CY 2008 payment policy that would package payment for all observation services consistently for Medicare beneficiaries regardless of their diagnoses is the most appropriate approach in every case of observation care. This proposed methodology encourages hospital efficiency and provides a consistent payment policy that allows hospitals to thoughtfully plan for the role of observation services in the emergency and postsurgical care of patients with many different clinical conditions.

As discussed in section II.A.4. of this proposed rule, observation care is one of seven categories of services for which we are proposing to make packaged payment in CY 2008. In view of the recent rapid growth in HOPD services, we are proposing to move toward larger payment packages and bundles under the OPPS because we believe that packaging creates incentives for providers to furnish services in the most efficient way by maximizing their flexibility to manage their resources, thereby encouraging cost containment. A detailed discussion of this proposal and our rationale for packaging observation care may be found in the section referenced above.

We are proposing to package observation care reported with HCPCS code G0378 for CY 2008 because the

facility portion of observation care is supportive and ancillary to other primary services being furnished in the HOPD. Payment for observation will be made as part of the payment for the separately payable independent services with which it is billed. As part of this proposal, we would change the status indicator for HCPCS code G0378 from ''Q'' to ''N.'' Although we would discontinue recognizing the criteria for separate payment related to hospital visits and qualifying conditions, we would retain as general reporting requirements the criteria related to physician evaluation, documentation and observation beginning and ending time because those are more general requirements that help to ensure proper reporting of observation on hospital claims. The criteria for reporting of observation services under HCPCS code G0378 that we are proposing to retain are:

A. Observation Time

1. Observation time must be documented in the medical record.
2. A beneficiary's time in observation (and hospital billing) begins with the beneficiary's admission to an observation bed.
3. A beneficiary's time in observation (and hospital billing) ends when all clinical or medical interventions have been completed, including followup care furnished by hospital staff and physicians that may take place after a physician has ordered the patient be released or admitted as an inpatient.

B. Physician Evaluation

1. The beneficiary must be in the care of a physician during the period of observation, as documented in the medical record by admission, discharge, and other appropriate progress notes that are timed, written, and signed by the physician.
2. The medical record must include documentation that the physician explicitly assessed patient risk to determine that the beneficiary would benefit from observation care.

We refer readers to section II.A.4. of this proposed rule for further detailed background on our proposal to package these seven categories of services and for a specific discussion of observation services.

Direct admission to observation (HCPCS code G0379, Direct admission of patient for hospital observation care) is assigned to APC 0604 (Level 1 Hospital Clinic Visits) when the criteria are met for separate payment. For CY 2008, the proposed median cost of APC 0604 is $52.58. We are proposing to continue the current coding and payment methodology for direct admission to observation, with the exception of the prior requirement that HCPCS code G0379 is only eligible for separate payment if observation care reported with HCPCS code G0378 does not qualify for separate payment. That requirement would no longer be applicable, given our CY 2008 proposal to provide packaged payment for all observation care. Hospitals report HCPCS code G0379 when a patient is admitted directly to observation care after being seen by a physician in the community. Thus, for CY 2008, we are proposing that in order to receive separate payment for a direct admission into observation (APC 00604), the claim must show:

1. Both HCPCS codes G0378 (Hospital observation services, per hr) and G0379 (Direct admission of patient for hospital observation care) with the same date of service.
2. That no services with a status indicator ''T'' or ''V'' or Critical Care (APC 0617) were provided on the same day of service as HCPCS code G0379.

Even though we are proposing to package payment for all observation services reported by HCPCS code G0378, we believe it is necessary to continue the OCE claims processing logic in order to make appropriate payment for direct admission.

In summary, we are proposing to package payment for observation care reported with HCPCS code G0378 for CY 2008. Payment for observation would be made as part of the payment for the separately payable independent services with which it is billed. As part of this proposal, we would change the status indicator for HCPCS Code G0378 from ''Q'' to ''N.'' In addition, we would discontinue recognizing the criteria for separate payment related to hospital visits and ''T'' status procedures, minimum number of hours, and qualifying diagnoses. However, we would retain as general requirements the criteria related to physician evaluation, documentation, and observation beginning and ending time. Those are more general requirements that ensure the proper reporting of observation care on correctly coded hospital claims that reflect the charges associated with all hospital resources utilized to provide the reported services. We are proposing to continue the coding and payment methodology for direct admission to observation status, as reported using HCPCS code G0379, with the exception of the prior requirement that HCPCS code G0379 is only eligible for separate payment if observation care reported under HCPCS code G0378 does not qualify for separate payment (since this requirement would no longer be applicable).

XII. Proposed Procedures That Will Be Paid Only as Inpatient Procedures

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

A. Background

Section 1833(t)(1)(B)(i) of the Act gives the Secretary broad authority to determine the services to be covered and paid for under the OPPS. Before implementation of the OPPS in August 2000, Medicare paid reasonable costs for services provided in the outpatient department. The claims submitted were subject to medical review by the fiscal intermediaries to determine the appropriateness of providing certain services in the outpatient setting. We did not specify in regulations those services that were appropriate to provide only in the inpatient setting and that, therefore, should be payable only when provided in that setting.

In the April 7, 2000 final rule with comment period, we identified procedures that are typically provided only in an inpatient setting and, therefore, would not be paid by Medicare under the OPPS (65 FR 18455). These procedures comprise what is referred to as the ''inpatient list.'' The inpatient list specifies those services that are only paid when provided in an inpatient setting because of the nature of the procedure, the need for at least 24 hours of postoperative recovery time or monitoring before the patient can be safely discharged, or the underlying physical condition of the patient. As we discussed in the April 7, 2000 final rule with comment period (65 FR 18455) and the November 30, 2001 final rule (66 FR 59856), we use the following criteria when reviewing procedures to determine whether or not they should be moved from the inpatient list and assigned to an APC group for payment under the OPPS:

- Most outpatient departments are equipped to provide the services to the Medicare population.
- The simplest procedure described by the code may be performed in most outpatient departments.
- The procedure is related to codes that we have already removed from the inpatient list.

In the November 1, 2002 final rule with comment period (67 FR 66741), we added the following criteria for use in reviewing procedures to determine whether they should be removed from the inpatient list and assigned to an

APC group for payment under the OPPS:

- We have determined that the procedure is being performed in numerous hospitals on an outpatient basis; or
- We have determined that the procedure can be appropriately and safely performed in an ASC and is on the list of approved ASC procedures or proposed by us for addition to the ASC list.

We believe that these additional criteria help us to identify procedures that are appropriate for removal from the inpatient list.

B. Proposed Changes to the Inpatient List

For the CY 2008 OPPS, we used the same methodology as described in the November 15, 2004 final rule with comment period (69 FR 65835) to identify a subset of procedures currently on the inpatient list that are being widely performed on an outpatient basis. These procedures were then clinically reviewed for possible removal from the inpatient list. We solicited input from the APC Panel on the appropriateness of removing 14 procedures from the OPPS inpatient list at its March 2007 meeting. Prior to publishing this OPPS proposed rule, we received one other candidate HCPCS code for removal from the OPPS inpatient list based on a recommendation from the public that was presented to the APC Panel during its meeting on March 8, 2007. The APC Panel recommended that 13 of the 14 procedures that CMS identified for possible removal be removed from the OPPS inpatient list. It also recommended that CMS obtain additional utilization data about 1 of the 14 procedures identified for possible removal from the OPPS inpatient list, specifically CPT code 64818 (Sympathectomy, lumbar); and for another procedure presented for possible removal from the OPPS inpatient list by the public, specifically, CPT code 20660 (Application of cranial tongs caliper, or stereotactic frame, including removal (separate procedure)). The APC Panel requested that CMS provide that additional information to the APC Panel at its next meeting.

Therefore, we are proposing to accept the APC Panel's recommendation to remove the 13 procedures from the OPPS inpatient list for CY 2008 and to assign them to clinically appropriate APCs as shown in Table 56. We also are accepting the recommendation from the APC Panel to gather additional utilization information for CPT codes 20660 and 64818, which we will provide to the APC Panel at its next meeting.

TABLE 56.—PROPOSED HCPCS CODES FOR REMOVAL FROM INPATIENT LIST AND THEIR PROPOSED APC ASSIGNMENTS FOR CY 2008

HCPCS code	Long descriptor	Proposed CY 2008 APC	Proposed CY 2008 SI
21360	Open treatment of depressed malar fracture, including zygomatic arch and malar tripod	0254	T
21365	Open treatment of complicated (eg, comminuted or involving cranial nerve foramina) fracture(s) of malar area, including zygomatic arch and malar tripod; with internal fixation and multiple surgical approaches.	0256	T
21385	Open treatment of orbital floor blowout fracture; transantral approach (Caldwell-Luc type operation)	0256	T
25931	Transmetacarpal amputation; re-amputation	0049	T
27006	Tenotomy, abductors and/or extensor(s) of hip, open (separate procedure)	0050	T
27720	Repair of nonunion or malunion, tibia; without graft, (eg, compression technique)	0063	T
27722	Repair of nonunion or malunion, tibia; with sliding graft	0064	T
50580	Renal endoscopy through nephrotomy or pyelotomy, with or without irrigation, instillation or ureteropyelography, exclusive of radiologic service; with removal of foreign body or calculus.	0161	T
51535	Cystotomy for excision, incision, or repair of ureterocele	0162	T
58805	Drainage of ovarian cyst(s), unilateral or bilateral, (separate procedure); abdominal approach	0195	T
60271	Thyroidectomy, including substernal thyroid; cervical approach	0256	T
61770	Stereotactic localization, including burr hole(s), with insertion of catheter(s) or probe(s) for placement of radiation source.	0221	T
69970	Removal of tumor, temporal bone	0256	T

XIII. Proposed Nonrecurring Technical and Policy Changes

A. Outpatient Hospital Services and Supplies Incident to a Physician Service

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

We are proposing to make a technical change to §§ 410.27(a)(1)(iii) and (f) of the regulations relating to outpatient hospital services and supplies incident to a physician service to remove an outdated reference to ''designation of a department of a provider'' by CMS and replace it with language that conforms to current policy under the provider based rules as stated in § 413.65 of the regulations. We are proposing to remove from both paragraphs (a)(1)(iii) and (f) the phrase ''at a location (other than an RHC or an FQHC) that CMS designates as a department of a provider under § 413.65 of this chapter'' and replace it with ''at a department of a provider, as defined in § 413.65(a)(2) of this subchapter, that has provider-based status in relation to a hospital under § 413.65 of this subchapter.''

Section 410.27 was codified in the April 7, 2000 OPPS final rule with comment period. The provider based rules at § 413.65 were also codified in the April 7, 2000 rule, but were subsequently amended in the August 1, 2002 IPPS final rule (67 FR 50078 through 50096 and 50114 through 50118). This proposed deletion of the reference in §§ 410.27(a)(1)(iii) and (f) to CMS ''designating'' a department of a provider under § 413.65 would make those sections consistent with the 2002 amendments to the provider-based rules, in that under the amended provider-based rules, a main provider is no longer required to ask CMS to make a determination that a facility or organization is provider-based before the main provider can bill for services of the facility as if the facility were provider-based, or before the main provider can include the costs of those services in its cost report.

We also remind hospitals of the requirements of § 410.27 concerning

services and supplies furnished incident to a physician's service to hospital outpatients. Section 410.27 applies to all ''incident to'' services covered under section 1861(s)(2)(B) of the Act. This provision does not apply to services covered under other benefit categories, such as clinical diagnostic laboratory services covered under section 1833(h)(1) of the Act or diagnostic services covered under section 1861(s)(2)(C) of the Act. Section 410.27(a)(1) currently states that Medicare Part B pays for hospital services and supplies furnished incident to a physician service to outpatients, including drugs and biologicals that cannot be self-administered, if they are furnished by or under arrangements made by a participating hospital, except in the case of a resident of a skilled nursing facility as provided in § 411.15(p); as an integral though incidental part of a physician's services; and in the hospital or at a location (other than a rural health clinic or a Federally qualified health center) that CMS designates as a department of a provider under § 413.65.

We recognize that hospitals consider a variety of business models in their efforts to supply efficient and high quality health care services to Medicare beneficiaries and the general public, and we support such efforts to the extent that they comply with all applicable laws and regulations, including, but not limited to, the Stark law and other anti-kickback laws. Recently, we have received an increasing number of questions about a number of hypothetical business arrangements between hospitals and other entities, including ASCs. We remind hospitals contemplating various business models that involve ''incident to'' services provided to hospital outpatients to consider the requirements of § 410.27. Under § 410.27, ''incident to'' services that are provided to hospital outpatients must be furnished in the hospital or at a department of a provider as described in more detail earlier in our proposed technical update to §§ 410.27(a)(1)(iii) and (f).

With regard to potential for ASCs to provide ''incident to'' services under arrangements with HOPDs, we note that the provider-based rules set forth at § 413.65 do not apply to ASCs. In addition, our longstanding policy codified at § 416.30(f) for ASCs operated by hospitals requires that ''the ASC participates and is paid only as an ASC, without the option of converting to or being paid as a hospital outpatient department, unless CMS determines there is good cause to do otherwise.'' We do not believe good cause exists such that a Medicare-certified ASC would be able to provide ''incident to'' services under arrangement to hospital outpatients under § 410.27. Section 410.27 contains longstanding policy codified in the CY 2000 OPPS final rule with comment period and applies to all ''incident to'' services covered under section1861(s)(2)(B) of the Act. While the hypothetical example we discussed above involves ASCs providing services under arrangement to an HOPD, the provision of § 410.27 applies more broadly to all ''incident to'' services provided either directly or under arrangements made by the hospital with another entity.

B. Interrupted Procedures

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

Currently, when a procedure is interrupted after its initiation or the administration of anesthesia, hospitals append modifier 74 (Discontinued outpatient procedure after anesthesia administration) to the interrupted procedure, and the full OPPS payment for the procedure is made. In addition, when a procedure requiring anesthesia is discontinued after the beneficiary is prepared for the procedure and taken to the room where the procedure is to be performed, but before the administration of anesthesia, hospitals currently append modifier 73 (Discontinued outpatient procedure prior to anesthesia administration) to the discontinued procedure and receive 50 percent of the OPPS payment for the planned procedure. Hospitals also report modifier 52 to signify that a service that did not require anesthesia was partially reduced or discontinued at the physician's discretion. Modifier 52 is reported under the OPPS for a variety of types of interrupted services, such as radiology services. Under the OPPS, we apply a 50-percent reduction to the facility payment for interrupted procedures and services reported with modifier 52.

We are proposing to amend § 419.44 (Payment reductions for surgical procedures) to more accurately reflect the current OPPS payment policy for interrupted procedures. First, we are proposing to make a technical conforming change to the title of § 419.44 by removing the word ''surgical,'' in order to encompass all the procedures performed in HOPDs. Second, we are proposing to change the heading of § 419.44(b) from ''Terminated procedures'' to ''Interrupted procedures.'' We are proposing to make further technical conforming changes to paragraphs (b)(1) and (b)(2) by removing the words ''surgical'' to encompass all the procedures performed in HOPDs. Finally, we are proposing to add a new paragraph (b)(3) to reflect the current policy of the application of a 50-percent reduction to the OPPS payment when a hospital reports modifier 52 for interrupted or discontinued services that do not require anesthesia.

C. Transitional Adjustments—Hold Harmless Provisions

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

Section 419.70(d) of the regulations relating to transitional adjustments to payments for covered outpatient services furnished by small rural hospitals and SCHs located in rural areas contains two outdated cross-references to § 412.63(b) (the definition of a hospital located in a ''rural area''). Several years ago, we made § 412.63 applicable from FY 1984 through FY 2004 and established a new § 412.64, effective for FY 2005 and subsequent fiscal years, to incorporate provisions to reflect our adoption of OMB's revised CBSAs as geographic area applicable under Medicare. We are proposing to make a technical correction to the regulations by replacing the cross-reference to § 412.63(b) in §§ 419.70(d)(1)(i), (d)(2)(i), and (d)(4)(ii) with the more current applicable cross-reference to § 412.64(b).

D. Reporting of Wound Care Services

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

Section 1834(k) of the Act, as added by section 4541 of the BBA, requires payment under a prospective payment system for all outpatient therapy services, that is, physical therapy services, speech-language pathology services, and occupational therapy services. As provided under section 1834(k)(5) of the Act, we created a therapy code list based on a uniform coding system (that is, the HCPCS) to identify and track these outpatient therapy services paid under the MPFS. We provide this list of therapy codes along with their respective designation in the Medicare Claims Processing Manual Pub. 100–04, Chapter 5, section 20. Two of the designations that we use in that manual denote whether the listed therapy code is an ''always therapy'' service or a ''sometimes therapy'' service. We define an ''always

therapy'' service as a service that must be performed by a qualified therapist under a certified therapy plan of care, and a ''sometimes therapy'' service as a service that may be performed by an individual outside of a certified therapy plan of care.

In the CY 2006 OPPS final rule with comment period (70 FR 68617), we stated that the following CPT codes were classified as ''sometimes therapy'' services that may be appropriately provided under either a certified therapy plan of care or without a certified therapy plan of care: 97597 (Removal of devitalized tissue from wound(s), selective debridement, without anesthesia (eg, high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps) with or without topical application(s) for ongoing care, may include use of a whirlpool, per session; total wound(s) surface area less than or equal to 20 square centimeters); 97598 (Removal of devitalized tissue from wound(s), selective debridement, without anesthesia (eg, high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps) with or without topical application(s) for ongoing care, may include use of a whirlpool, per session; total wound(s) surface area greater than 20 square centimeters); 97602 (Removal of revitalized tissue from wound(s), non-selective debridement, without anesthesia (eg, wet-to-moist dressings, enzymatic, abrasion) including topical application(s), wound assessment, and instruction(s) for ongoing care, per session), 97605 (Negative pressure wound therapy (eg, vacuum assisted drainage collection), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area less than or equal to 50 square centimeters); and 97606 (Negative pressure wound therapy (eg, vacuum assisted drainage collection), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area greater than 50 square centimeters). We further stated that hospitals would receive separate payment under the OPPS when they bill for wound care services described by CPT codes 97597, 97598, 97602, 97605, and 97606 that are furnished to hospital outpatients by individuals independent of a therapy plan of care. In contrast, when such services are performed by a qualified therapist under a certified therapy plan of care, providers should attach an appropriate therapy modifier (that is, GP for physical therapy, GO for occupational therapy, and GN for speech language pathology) or report their charges under a therapy revenue code (that is, 0420, 0430, or 0440), or both, to receive payment under the MPFS. The OCE logic assigns these services to the appropriate APC for payment under the OPPS if the services are not provided under a certified therapy plan of care, or will direct contractors to the MPFS established payment rates if the services are identified on hospital claims with a therapy modifier or therapy revenue code as therapy services.

For CY 2008, we are proposing to revise the list of therapy revenue codes that may be reported with CPT codes 97597, 97598, 97602, 97605, and 97606 to designate them as services that are performed by a qualified therapist under a certified therapy plan of care, and thus payable under the MPFS, to be consistent with the current billing practices of hospitals and to ensure that we are making separate payment under the OPPS only in appropriate situations. We are proposing to revise the list of therapy revenue codes for reporting these five CPT wound care codes as therapy services to include all revenue codes in the 042X series, which incorporates all revenue codes that begin with 042, such as 0420, 0421, 0422, 0423, 0424, and 0429; the 043X series, which includes all revenue codes that begin with 043, such as 0430, 0431, 0432, 0434, and 0439; and the 044X series, which includes all revenue codes that begin with 044, such as 0440, 0441, 0442, 0443, 0444, and 0449. Therefore, for CY 2008 we are proposing that when services reported with CPT codes 97597, 97598, 97602, 97605, and 97606 are performed by a qualified therapist under a certified therapy plan of care, providers should attach an appropriate therapy modifier (that is, GP for physical therapy, GO for occupational therapy, and GN for speech-language pathology) or report their charge under a therapy revenue code (that is, 042X, 043X, or 044X), or both, to receive payment under the MPFS. Under other circumstances, hospitals would receive separate payment under the OPPS when they bill for wound care services described by CPT codes 97597, 97598, 97602, 97605, and 97606 that are furnished to hospital outpatients by individuals independent of a certified therapy plan of care.

E. Reporting of Cardiac Rehabilitation Services

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

Since the initiation of the OPPS, Medicare has paid for cardiac rehabilitation services in HOPDs using CPT code 93797 (Physician services for outpatient cardiac rehabilitation, without continuous ECG monitoring (per session)) and CPT code 93798 (Physician services for outpatient cardiac rehabilitation, with continuous ECG monitoring (per session)). Both codes are assigned to status indicator ''S'' and are currently mapped to APC 0095 (Cardiac Rehabilitation) for payment.

For CY 2008, we are proposing to discontinue recognizing the current CPT codes for cardiac rehabilitation services and to establish two new Level II HCPCS codes that we believe are more appropriate for specifically reporting cardiac rehabilitation services under the OPPS. The proposed HCPCS codes are: GXXX1 (Physician services for outpatient cardiac rehabilitation; without continuous ECG monitoring (per hour)) and GXXX2 (Physician services for outpatient cardiac rehabilitation; with continuous ECG monitoring (per hour)). In contrast with the current CPT codes, we believe the descriptors of these proposed G-codes more specifically reflect the way cardiac rehabilitation services are provided in HOPDs so that reporting would be more straightforward for hospitals and would result in more accurate data for OPPS ratesetting in 2 years. Consistent with the current APC assignments of the cardiac rehabilitation CPT codes, we are proposing to assign these new HCPCS codes to APC 0095 for CY 2008, with a status indicator of ''S.'' Accordingly, we are proposing to change the status indicators for CPT codes 93797 and 93798 from ''S'' to ''B'' to indicate that alternative codes (GXXX1 and GXXX2) for cardiac rehabilitation services are recognized for payment under the OPPS.

F. Reporting of Bone Marrow and Stem Cell Processing Services

(If you choose to comment on issues in this section, please include the caption ''Bone Marrow and Stem Cell Processing Services'' at the beginning of your comment.)

The OPPS currently recognizes HCPCS code G0267 (Bone marrow or peripheral stem cell harvest, modification or treatment to eliminate cell type(s)) for depletion services for hematopoietic progenitor cells, instead of the more specific CPT codes that describe these services, including CPT codes 38210 (Transplant preparation of hematopoietic progenitor cells; specific

cell depletion within harvest, T-cell depletion); 38211 (Transplant preparation of hematopoietic progenitor cells; tumor cell depletion); 38212 (Transplant preparation of hematopoietic progenitor cells; red blood cell removal); 38213 (Transplant preparation of hematopoietic progenitor cells; platelet depletion); 38214 (Transplant preparation of hematopoietic progenitor cells; plasma (volume) depletion); and 38215 (Transplant preparation of hematopoietic progenitor cells; cell concentration in plasma, mononuclear, of buffy coat layer). These six CPT codes are currently assigned to status indicator ''B,'' while HCPCS code G0267 is assigned to APC 0110 (Transfusion) for payment, with a status indicator of ''S.''

For CY 2008, we are proposing to continue to assign the historical claims data for HCPCS code G0267 to APC 0110. In addition, we are proposing to discontinue recognizing HCPCS code G0267 for CY 2008, assigning it to status indicator ''B,'' and to recognize the six more specific CPT codes, which we are proposing to also assign to APC 0110 with a status indicator of ''S.'' Historically, under the OPPS we recognized the single G-code rather than the CPT codes for the individual transplant cell preparation services because we believed that the services would be uncommonly provided to Medicare beneficiaries in the outpatient setting and would likely require similar resources, so that distinguishing among the services would not be necessary to ensure appropriate OPPS payment. Stakeholders have brought to our attention that the current hospital resources associated with the six different bone marrow and stem cell processing procedures described by these CPT codes may vary widely. While we recognize that the services currently reported with G0267 under the OPPS are not common HOPD procedures, the total volume of these procedures has been increasing over the past several years. Therefore, we believe that recognizing these six CPT codes for bone marrow and stem cell processing services would yield more specific claims data and enable us to pay more appropriately for these services in the future. Consistent with our general OPPS practice, we are proposing to assign the newly recognized CPT codes to the clinical APC that is most appropriate based on historical claims data for the predecessor HCPCS code until we have more specific hospital resource data available to assess the specific CPT codes for possible reassignment.

In addition, we are proposing to discontinue recognition of HCPCS code G0265 (Cyropreservation, freezing and storage of cells for therapeutic use) and G0266 (Thawing and expansion of frozen cells for therapeutic use), currently assigned to status indicator ''A'' under the OPPS and paid according to the Medicare Clinical Laboratory Fee Schedule (CLFS), by assigning them to status indicator ''B'' for CY 2008. We are proposing to recognize, instead, CPT codes 38207 (Transplant preparation of hematopoietic progenitor cells; cryopreservation and storage); 38208 (Transplant preparation of hematopoietic progenitor cells; thawing of previously frozen harvest, without washing); and 38209 (Transplant preparation of hematopoietic progenitor cells; thawing of previously frozen harvest, with washing) for payment under the OPPS because we believe they are similar to blood processing services that are currently paid under the OPPS, not under the CLFS. We are proposing to assign the single cryopreservation and two thawing CPT codes to APC 0344 (Level IV Pathology) based on their clinical characteristics and resource costs from historical hospital claims data for HCPCS codes G0265 and G0266, which would have been assigned to the same clinical APC if they were paid under the OPPS. Although HCPCS code G0265 and G0266 have not historically been paid under the OPPS, we have a small number of HOPD single claims from CY 2006 for these two predecessor HCPCS codes (when they were paid off the CLFS), respectively, and similar laboratory tissue cryopreservation and thawing services also are proposed for assignment to APC 0344 under the CY 2008 OPPS. We believe this proposal would allow us to pay appropriately for all of these bone marrow and stem cell processing services and to collect more specific hospital resource data.

XIV. Proposed OPPS Payment Status and Comment Indicators

A. Proposed Payment Status Indicator Definitions

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

The OPPS payment status indicators (SIs) that we assign to HCPCS codes and APCs play an important role in determining payment for services under the OPPS. They indicate whether a service represented by a HCPCS code is payable under the OPPS or another payment system and also whether particular OPPS policies apply to the code. Our proposed CY 2008 status indicator assignments for APCs and HCPCS codes are shown in Addendum A and Addendum B, respectively, to this proposed rule. We are proposing to use the status indicators and definitions that are listed in Addendum D1, which we discuss below in greater detail.

1. Proposed Payment Status Indicators to Designate Services That Are Paid under the OPPS

Indicator	Item/code/service	OPPS payment status
G	Pass-Through Drugs and Biologicals	Paid under OPPS; Separate APC payment includes pass through amount.
H	Pass-Through Device Categories	Separate cost-based pass-through payment; Not subject to coinsurance.
K	(1) Non-Pass-Through Drugs and Biologicals	(1) Paid under OPPS; Separate APC payment.
	(2) Therapeutic Radiopharmaceuticals	(2) Paid under OPPS; Separate APC payment.
	(3) Brachytherapy Sources	(3) Paid under OPPS; Separate APC payment.
	(4) Blood and Blood Products	(4) Paid under OPPS; Separate APC payment.
N	Items and Services Packaged into APC Rates	Paid under OPPS; Payment is packaged into payment for other services, including outliers. Therefore, there is no separate APC payment.
P	Partial Hospitalization	Paid under OPPS; Per diem APC payment.

Indicator	Item/code/service	OPPS payment status
Q	Packaged Services Subject to Separate Payment Under OPPS Payment Criteria..	Paid under OPPS; Addendum B displays APC assignments when services are separately payable. (1) Separate APC payment based on OPPS payment criteria. (2) If criteria are not met, payment is packaged into payment for other services, including outliers. Therefore, there is no separate APC payment.
S	Significant Procedure, Not Discounted when Multiple.	Paid under OPPS; Separate APC payment.
T	Significant Procedure, Multiple Reduction Applies	Paid under OPPS; Separate APC payment.
V	Clinic or Emergency Department Visit	Paid under OPPS; Separate APC payment.
X	Ancillary Services	Paid under OPPS; Separate APC payment.

As stated in section VII.A. of this proposed rule, subsequent to the publication of the CY 2007 OPPS/ASC final rule with comment period, section 107(a) of the MIEA TRHCA extended the payment period for brachytherapy sources paid under the OPPS based on a hospital's charges adjusted to cost under section 1833(t)(16)(C) of the Act for one additional year. This requirement for cost-based payment ends after December 31, 2007. Therefore, we have continued the OPPS cost-based payment for brachytherapy sources through CY 2007, and have continued using status indicator ''H'' to designate nonpass-through brachytherapy sources paid on a cost basis.

As discussed in section VII.B. of this proposed rule, we are proposing to implement prospective payment for brachytherapy sources paid under the OPPS in CY 2008. In accordance with this proposal, we also are proposing to discontinue our use of payment status indicator ''H'' for APCs assigned to brachytherapy sources. As indicated in section VII.B. of this proposed rule for CY 2008, we are proposing to use payment status indicator ''K'' to designate all brachytherapy source APCs that will be paid under the OPPS.

As discussed in section V.B.3.a.(4) of this proposed rule, we are proposing to implement prospective payment for separately payable therapeutic radiopharmaceuticals under the OPPS in CY 2008. In accordance with this proposal, we also are proposing to discontinue our use of payment status indicator ''H'' for APCs assigned to separately payable therapeutic radiopharmaceuticals. For CY 2008, we are proposing to use payment status indicator ''K'' to designate separately payable therapeutic radiopharmaceuticals that will be paid under the OPPS.

2. Proposed Payment Status Indicators to Designate Services That Are Paid Under a Payment System Other Than the OPPS

Indicator	Item/code/service	OPPS Payment Status
A	Services furnished to a hospital outpatient that are paid under a fee schedule or payment system other than OPPS, for example: • Ambulance Services • Clinical Diagnostic Laboratory Services • Non-Implantable Prosthetic and Orthotic Devices • EPO for ESRD Patients • Physical, Occupational, and Speech Therapy • Routine Dialysis Services for ESRD Patients Provided in a Certified Dialysis Unit of a Hospital • Diagnostic Mammography • Screening Mammography	Not paid under OPPS. Paid by fiscal intermediaries under a fee schedule or payment system other than OPPS.
C	Inpatient Procedures	Not paid under OPPS. Admit patient. Bill as inpatient.
F	Corneal Tissue Acquisition; Certain CRNA Services; and Hepatitis B Vaccines.	Not paid under OPPS. Paid at reasonable cost.
L	Influenza Vaccine; Pneumococcal Pneumonia Vaccine	Not paid under OPPS. Paid at reasonable cost; Not subject to deductible or coinsurance.
M	Items and Services Not Billable to the Fiscal Intermediary	Not paid under OPPS.
Y	Non-Implantable Durable Medical Equipment	Not paid under OPPS. All institutional providers other than home health agencies bill to DMERC.

3. Proposed Payment Status Indicators to Designate Services That Are Not Recognized Under the OPPS But That May Be Recognized by Other Institutional Providers

Indicator	Item/code/service	OPPS Payment Status
B	Codes that are not recognized by OPPS when submitted on an outpatient hospital Part B bill type (12x and13x).	Not paid under OPPS. • May be paid by intermediaries when submitted on a different bill type, for example, 75x (CORF), but not paid under OPPS. • An alternate code that is recognized by OPPS when submitted on an outpatient hospital Part B bill type (12x and 13x) may be available.

4. Proposed Payment Status Indicators to Designate Services That Are Not Payable by Medicare

Indicator	Item/code/service	OPPS Payment Status
D	Discontinued Codes	Not paid under OPPS or any other Medicare payment system.
E	Items, Codes, and Services: ..... • That are not covered by Medicare based on statutory exclusion • That are not covered by Medicare for reasons other than statutory exclusion • That are not recognized by Medicare but for which an alternate code for the same item or service may be available • For which separate payment is not provided by Medicare	Not paid under OPPS or any other Medicare payment system.

To address providers' broader interests and to make the published Addendum B more convenient for public use, we are displaying in Addendum B to this proposed rule all active HCPCS codes that describe items or services that are: (1) Payable under the OPPS; (2) paid under a payment system other than the OPPS; (3) not recognized under the OPPS but that may be recognized by other institutional providers; and (4) not payable by Medicare. The status indicators that we are proposing for CY 2008 for these items and services are listed in the tables above.

A complete listing of HCPCS codes with proposed payment status indicators and APC assignments for CY 2008 is also available electronically on the CMS Web site at *http://www.cms.hhs.gov/HospitalOutpatientPPS/HORD/list.asp#TopOfPage.*

B. Proposed Comment Indicator Definitions

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

In the November 15, 2004 final rule with comment period (69 FR 65827 and 65828), we made final our policy to use two comment indicators to identify in an OPPS final rule the assignment status of a specific HCPCS code to an APC and the timeframe when comments on the HCPCS APC assignment would be accepted. These two comment indicators are listed below.

• ''NF''—New code, final APC assignment; Comments were accepted on a proposed APC assignment in the Proposed Rule; APC assignment is no longer open to comment.

• ''NI''—New code, interim APC assignment; Comments will be accepted on the interim APC assignment for the new code.

In the November 10, 2005 final rule with comment period (70 FR 68702 and 68703), we adopted a new comment indicator:

• ''CH''—Active HCPCS codes in current and next calendar year; status indicator and/or APC assignment have changed.

We implemented comment indicator ''CH'' to designate a change in payment status indicator and/or APC assignment for HCPCS codes in Addendum B of the CY 2006 final rule with comment period. We also stated that codes flagged with the ''CH'' indicator in that final rule would not be open to comment because the changes generally were previously subject to comment during the proposed rule comment period. For CY 2008, we are proposing to continue that policy in the CY 2008 OPPS/ASC final rule with comment period. When used in an OPPS final rule, the ''CH'' indicator is only intended to facilitate the public's review of changes made from one calendar year to another. We are proposing to use the ''CH'' indicator in the CY 2008 OPPS/ASC final rule with comment period to indicate HCPCS codes for which the status indicator or APC assignment, or both, would change in CY 2008 compared to their assignment as of December 31, 2007.

However, only HCPCS codes with comment indicator ''NI'' in the CY 2008 OPPS/ASC final rule with comment period would be subject to comment during the comment period for the final rule with comment period.

We are using the ''CH'' indicator in this proposed rule to call attention to proposed changes in the payment status indicator and/or APC assignment for HCPCS codes for CY 2008. The use of the comment indicator ''CH'' in association with a composite APC indicates that the configuration of the composite APC is proposed for change in this proposed rule.

In this proposed rule, the ''CH'' indicator is appended to HCPCS codes for which we have proposed changes in the payment status indicator and/or APC assignment for CY 2008 compared to their assignment as of June 30, 2007. We believe that using the ''CH'' indicator in this proposed rule will facilitate the public's review of the changes that we are proposing to make final in CY 2008. Use of the ''CH'' indicator in this proposed rule is significant because it highlights changes that are subject to comment during the proposed rule comment period.

We are proposing to terminate comment indicator ''NF'' because its use is no longer relevant in the final rule(s). The two comment indicators, ''NI'' and ''CH,'' that we are proposing to continue using in CY 2008 and their definitions are listed in Addendum D2 to this proposed rule.

XV. OPPS Policy and Payment Recommendations

A. MedPAC Recommendations

The MedPAC submits reports to Congress in March and June that summarize payment policy recommendations. The March 2007 MedPAC report included the following recommendation relating specifically to the hospital OPPS:

Recommendation 2A–1: The Congress should increase payment rates for the outpatient prospective payment system in 2008 by the projected rate-of-increase in the hospital market basket index, concurrent with the implementation of a quality incentive payment program.

CMS Response: We are proposing to increase the payment rates for the CY 2008 OPPS by the projected rate-of-increase in the hospital market basket index (as discussed in section II.C. of this proposed rule) and to implement, effective for CY 2009, the reduction in the annual update factor by 2.0 percentage points for subsection (d) hospitals that do not meet the outpatient hospital quality reporting required by section 1833(t)(17) of the Act, as added by section 109(b) of the MIEA-TRHCA. Our proposal for implementing the hospital quality reporting measures for the CY 2008 OPPS is discussed in detail in section XVII. of this proposed rule.

B. APC Panel Recommendations

Recommendations made by the APC Panel at its March 2007 meeting are discussed in sections of this proposed rule that correspond to topics addressed by the APC Panel. Minutes of the APC Panel's March 7–9, 2007 meeting are available on the CMS Web site at: *http://www.cms.hhs.gov/FACA/05_AdvisoryPanelonAmbulatoryPaymentClassification Groups.asp*.

XVI. Proposed Update of the Revised Ambulatory Surgical Center Payment System

A. Legislative and Regulatory Authority for the ASC Payment System

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

To establish the reasonable estimated allowances for ASC facility services, section 1833(i)(2)(A)(i) of the Act required us to take into account the audited costs incurred by ASCs to perform a procedure, in accordance with a survey. The ASC services benefit was enacted by Congress through the Omnibus Reconciliation Act of 1980 (Pub. L. 96 499). For a detailed discussion of the legislative history related to ASCs, we refer readers to the June 12, 1998 proposed rule (63 FR 32291).

Section 141(b) of the Social Security Act Amendments of 1994, Pub. L. 103–432, requires us to establish a process for reviewing the appropriateness of the payment amount provided under section 1833(i)(2)(A)(iii) of the Act for intraocular lenses (IOLs) that belong to a class of new technology intraocular lenses (NTIOLs). That process was the subject of a separate final rule entitled ''Adjustment in Payment Amounts for New Technology Intraocular Lenses Furnished by Ambulatory Surgical Centers,'' published on June 16, 1999, in the **Federal Register** (64 FR 32198).

Section 626(b) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. 108–173, repealed the requirement formerly found in section 1833(i)(2)(A) of the Act that the Secretary conduct a survey of ASC costs for purposes of updating ASC payment rates and required the Secretary to implement a revised ASC payment system, to be effective not later than January 1, 2008.

Section 5103 of the DRA, Pub. L. 109–171, amended section 1833(i)(2) of the Act by adding a new subparagraph (E) to place a limitation on payments for surgical procedures in ASCs. The amended language 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. This provision applies to surgical procedures furnished in ASCs on or after January 1, 2007, and before the effective date of the revised ASC payment system (see the final rule for the revised ASC payment system published elsewhere in this issue of the **Federal Register**).

Section 109(b) of the MIEA–TRHCA, Pub. L.109–432, amended section 1833(i) of the Act, in part, by adding new clause (iv) to paragraph (2)(D) and by also adding new paragraph (7)(A), which provides that the Secretary may reduce the annual ASC update by 2 percentage points if an ASC fails to submit data as required by the Secretary on selected measures of quality of care, including medication errors. Section 109(b) of MIEA–TRCHA requires that certain quality of care reporting requirements mandated for hospitals paid under the OPPS by section 109(a) of the MIEA–TRCHA be applied in a similar manner to ASCs unless otherwise specified by the Secretary. We refer readers to sections XVII.A. and H. of this proposed rule for further discussion of this provision and our plans for future ASC implementation

B. Rulemaking for the Revised ASC Payment System

On August 23, 2006, we proposed in the **Federal Register** (71 FR 49635) a revised payment system for ASCs to be implemented effective January 1, 2008, in accordance with section 626(b) of Pub. L. 108–173. The proposal included, among other things, revisions to the ASC list of covered surgical procedures for CY 2008 and the payment methodology for the items and services furnished by the ASC.

We are publishing elsewhere in this issue of the **Federal Register** the final rule for the revised ASC payment system, effective January 1, 2008, hereinafter referred to as the July 2007 final rule for the revised ASC payment system. In that final rule, we established that we would address two components of the ASC payment system annually as part of the OPPS rulemaking cycle. Section 1833(i)(1) of the Act requires us to specify, in consultation with appropriate medical organizations, surgical procedures that are appropriately performed on an inpatient basis in a hospital but that can be safely performed in an ASC, CAH, or an HOPD and to review and update the list of ASC procedures at least every 2 years.

In the July 2007 final rule for the revised ASC payment system, we also adopted the method we will use to set payment rates for ASC services furnished in association with covered surgical procedures. Updating 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 rates will be used as the basis for the payment of most covered surgical

procedures and covered ancillary services under the revised ASC payment system. This joint update process will ensure that the ASC updates occur in a regular, predictable, and timely manner. The final rule included applicable regulatory changes to 42 CFR Parts 410 and 416.

In this CY 2008 OPPS/ASC proposed rule, we are proposing to update the revised ASC payment system for CY 2008, along with the OPPS. We are also proposing to revise the regulations to make practice expense payment to physicians who perform noncovered ASC procedures in ASCs based on the facility practice expense (PE) relative value units (RVUs) and 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.

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

1. Covered Surgical Procedures Under the Revised ASC Payment System

a. Definition of Surgical Procedure

In order to delineate the scope of procedures that constitute ''outpatient surgical procedures'' for payment under the revised ASC payment system, in the July 2007 final rule for the revised ASC payment system, we clarified what we consider to be a ''surgical'' procedure. Under the ASC payment system existing through CY 2007, we define a surgical procedure as any procedure described within the range of Category I CPT codes that the CPT Editorial Panel of the AMA defines as ''surgery'' (CPT codes 10000 through 69999). Under the revised payment system, we continue to define surgery using that standard. We also include within the scope of surgical procedures payable in an ASC those procedures that are described by Level II HCPCS codes or by Category III CPT codes that directly crosswalk or are clinically similar to procedures in the CPT surgical range that we have determined do not pose a significant safety risk and that we would not expect to require an overnight stay when performed in ASCs. Having established what we consider to be a ''surgical procedure,'' we defined criteria that enable us to identify procedures that could pose a significant safety risk when performed in an ASC or that we expect would require an overnight stay within the bounds of prevailing medical practice.

b. Identification of Surgical Procedures Eligible for Payment Under the Revised ASC Payment System

ASC ''covered surgical procedures'' are those surgical procedures for which payment is made under the revised ASC payment system. Our final policy for identifying surgical procedures eligible for ASC payment excludes those surgical procedures that are on the OPPS inpatient list, procedures that are packaged under the OPPS, CPT unlisted surgical procedure codes, and surgical procedures that are not recognized for payment under the OPPS. Further, we exclude from ASC payment any procedure for which standard medical practice dictates that the beneficiary would typically be expected to require active medical monitoring and care at midnight following the procedure (overnight stay), and all surgical procedures that could pose a significant safety risk to Medicare beneficiaries. The criteria used under the revised ASC payment system to identify procedures that could pose a significant safety risk when performed in an ASC include 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; or commonly require systemic thrombolytic therapy. These criteria for evaluating surgical procedures are set forth in § 416.166(c).

c. Payment for Covered Surgical Procedures Under the Revised ASC Payment System

(1) General Policies

To make payment for most covered surgical procedures, we utilize the OPPS APCs as a ''grouper'' and the APC relative payment weights as the basis for ASC relative payment weights and for calculating ASC payment rates under the revised payment system, by applying a uniform ASC conversion factor to the ASC payment weights. For the first year of the revised ASC payment system, we adopted the OPPS relative payment weights as the ASC relative payment weights for most covered surgical procedures.

For future years, we will update the ASC relative payment weights annually using the OPPS relative payment weights for that calendar year, as well as the practice expense payment amounts under the MPFS schedule for that calendar year, because some covered office-based surgical procedures and covered ancillary services will be paid according to MPFS amounts if those amounts are less than the rates calculated under the standard methodology of the revised ASC payment system.

Just as we scale the OPPS relative payment weights each year to ensure that the OPPS is budget neutral from one year to the next, we will rescale relative weights each year for the revised ASC payment system. The purpose of scaling the relative weights is to ensure that the estimated aggregate payments under the ASC payment system for an upcoming year would be neither greater than nor less than the aggregate payments that would be made in the prior year, taking into consideration any changes or recalibrations for the upcoming year. Rescaling enables us to compensate for the effects of changes in the OPPS relative payment weights from year to year for services that are not performed in ASCs (for example, due to sudden increases or decreases in the costs of hospital outpatient emergency department visits) that could inappropriately cause the estimated ASC expenditures to increase or decrease as a function of those changes.

To establish the budget neutrality adjustment for the revised ASC payment system, we used a model that accounts for the migration of surgical procedures between ASCs, physicians' offices, and HOPDs as discussed in the July 2007 final rule for the revised ASC payment system. The budget neutrality adjustment for CY 2008 is based on updated proposed CY 2008 OPPS and MPFS rates, along with updated utilization data. The estimated ASC CY 2008 budget neutrality adjustment factor is multiplied by the proposed OPPS conversion factor to establish the proposed ASC conversion factor. The standard ASC payment for most of the covered surgical procedures displayed in Addendum AA of this proposed rule is calculated as the product of that proposed ASC conversion factor multiplied by the proposed OPPS relative payment weight for each separately payable procedure. A more detailed discussion of the methodology is provided in section XVI.L. of this proposed rule.

Beginning in CY 2010, we will update the ASC conversion factor for the revised ASC payment system by the percentage increase in the CPI–U (U.S. city average), as estimated for the 12-month period ending with the midpoint of the year involved. At the same time, we recognize that we continue to have flexibility under the statute to employ a different update mechanism under the revised ASC payment system. As one example, we do not intend for the revised ASC payment system to result in additional Medicare expenditures over

time. We will be monitoring this issue closely in the coming years. Consequently, we will reconsider the ASC update if expenditures increase inappropriately in future years.

(2) Office-Based Procedures

Among the procedures newly identified as covered surgical procedures for payment in ASCs beginning in CY 2008 are many procedures that are performed most of the time in physicians' offices. These procedures neither pose a significant safety risk nor are they expected to require an overnight stay when performed in ASCs, and they generally require a lower level of resource intensity than do most other ASC covered surgical procedures. For those reasons, in the July 2007 final rule for the revised ASC payment system, we adopted a policy to include them as covered surgical procedures but to ensure that payment for the facility resources associated with the procedures identified as ''office-based'' would not be greater when provided in ASCs than when furnished in physicians' offices.

Under the revised ASC payment system, we cap payment for office-based surgical procedures for which ASC payment would first be allowed beginning in CY 2008 or later years at the lesser of the MPFS nonfacility practice PE RVU amount or the ASC rate developed according to the standard methodology of the revised ASC payment system. For those office-based procedures for which there is no available MPFS nonfacility PE RVU amount, we will implement the cap, as appropriate, once a MPFS nonfacility PE RVU amount is available. Once procedures are finalized as being office-based procedures, they remain designated as office-based. We may propose that additional HCPCS codes be classified as office-based in a proposed rule for an annual ASC update after review of the most recent available utilization data. We consider for additional designation as office-based those procedures newly paid in ASCs in CY 2008 or later years that our review concludes are performed predominantly (more than 50 percent of the time) in physicians' offices, based on our consideration of volume and site of service utilization data for the procedures, as well as clinical information and comparable data for related procedures, if appropriate.

Procedures designated as office-based for CY 2008 are identified in Addendum AA to this proposed rule and assigned payment indicators ''P2'' (Office-based surgical procedures added to ASC list in CY 2008 or later with MPFS nonfacility PE RVUs; payment based on OPPS relative payment weight); ''P3'' (Office-based surgical procedure added to ASC list in CY 2008 or later with MPFS nonfacility PE RVUs; payment based on MPFS nonfacility PE RVUs); and ''R2'' (Office-based surgical procedure added to ASC list in CY 2008 or later without MPFS nonfacility PE RVUs; payment based on OPPS relative payment weight). Those procedures for which the designation as office-based is newly proposed for CY 2008 are identified in Addendum AA with comment indicator ''CH'' and those for which the payment indicator is a temporary designation are marked by an asterisk. The temporary designation means that the office-based payment indicator (''P2,'' '' P3,'' or ''R2'') assigned to the procedure is temporary because the code is a new HCPCS code for which we have insufficient data upon which to base a proposal for a final decision regarding the code's office-based status. The temporary designation will be reevaluated by CMS when there are data upon which to base a proposal for a final payment indicator. The remainder of the office-based procedure designations was finalized in the July 2007 final rule for the revised ASC payment system.

(3) Device-Intensive Procedures

Under the final policy of the revised ASC payment system, we use a modified payment methodology to establish the ASC payment rates for device-intensive procedures. We identify device-intensive procedures as covered surgical procedures that, under the OPPS, are assigned to those device-dependent APCs for which the ''device offset percentage'' is greater than 50 percent of the APC's median cost. The device offset percentage is our best estimate of the percentage of device cost that is included in an APC payment under the OPPS. The CY 2008 proposed device-dependent APCs and device offset percentages are discussed in section IV.A. of this proposed rule.

According to the final ASC policy, payment for implantable devices is packaged into payment for the covered surgical procedures, but we utilize a modified ASC methodology based on OPPS data to establish payment rates for the device-intensive procedures under the revised ASC payment system. According to that modified payment methodology, we apply the OPPS device offset percentage to the OPPS national unadjusted payment to determine the device cost included in the OPPS payment rate for a device-intensive ASC covered surgical procedure, which we then set as equal to the device portion of the national unadjusted ASC payment rate for the procedure. We then calculate the service portion of the ASC payment for device-intensive procedures by applying the uniform ASC conversion factor to the service (nondevice) portion of the OPPS relative payment weight for the device-intensive procedure. Finally, we sum the ASC device portion and ASC service portion to establish the full payment for the device-intensive procedure under the revised ASC payment system. For example, if the OPPS device offset percentage for the procedure is 80 percent and the OPPS national unadjusted payment is $100, the device cost included in that payment is $80. Under the ASC payment system, we also would pay $80 for the device portion of the procedure but the service portion of the OPPS payment, $20, would be adjusted by the budget neutrality adjustment factor (for example, using the proposed budget neutrality factor, the calculation would be: $20 x 0.65 = $13) and, if it is subject to the transition (as set forth in section XVI.C.1.c.(5) of this proposed rule), it would also be adjusted accordingly. If the procedure in the example is not subject to the transition, its CY 2008 payment would be equal to $93 ($80 + $13). This example illustrates the contributions of the device and service payment amounts to the national unadjusted ASC payment rate; payment to an ASC for the device-intensive service would be subject to the 50 percent geographic adjustment.

We also reduce the amount of payment made to ASCs for device-intensive procedures assigned to certain OPPS APCs in those cases in which the necessary device is furnished without cost to the ASC or the beneficiary, or with a full credit for the cost of the device being replaced. A full discussion of that policy may be found in section XVI.F. of this proposed rule.

(4) Multiple and Interrupted Procedure Discounting

Under the revised ASC payment system, we discount payment for certain multiple and interrupted procedures performed in ASCs. While most covered surgical procedures will be subject to a 50-percent reduction in ASC payment for the lower paying procedure when more than one procedure is performed in a single operative session, those covered surgical procedures that we are proposing to exempt from the multiple procedure reduction in ASCs because they are proposed to not be subject to this reduction under the OPPS are identified in Addendum AA to this

proposed rule. Procedures requiring anesthesia that are terminated after the patient has been prepared for surgery and taken to the operating room but before the administration of anesthesia will be reported with modifier 73, and the ASC payment for the covered surgical procedure will be reduced by 50 percent. Procedures requiring anesthesia that are terminated after administration of anesthesia or initiation of the procedure will be reported with modifier 74, and the ASC payment for the covered surgical procedure will be made at 100 percent of the established payment rate. Procedures and services not requiring anesthesia that are partially reduced or discontinued at the physician's discretion are reported with modifier 52, and the ASC payment for the covered surgical procedure or covered ancillary service is reduced by 50 percent.

(5) Transition to Revised ASC Payment Rates

Under the revised ASC payment system, we are providing a payment transition of 4 years for all services on the CY 2007 ASC list of covered surgical procedures. Beginning in CY 2008, the contribution of CY 2007 ASC payment rates to the blended transitional rates will decrease by 25 percentage point increments each year of transitional payment, until CY 2011, when we will fully implement the revised ASC payment rates calculated under the final methodology of the revised payment system. While we do not subject the device payment portion of the total ASC payment for a device-intensive procedure to the transition policy, we transition the service payment portion of the total ASC payment for the procedure over the 4 year phase-in period. Procedures new to ASC payment for CY 2008 or later calendar years receive payments determined according to the final methodology of the revised ASC payment system, without a transition.

ASC covered surgical procedures listed in Addendum AA to this proposed rule that are subject to the transition are assigned payment indicators ''A2'' (Surgical procedure on ASC list in CY 2007; payment based on OPPS relative payment weight) and ''H8'' (Device-intensive procedure on ASC list in CY 2007; paid at adjusted rate). ASC covered surgical procedures listed in Addendum AA to this proposed rule that are not subject to the transition are assigned payment indicators ''G2'' (Nonoffice-based surgical procedure added to ASC list in CY 2008 or later; payment based on OPPS relative payment weight); ''J8'' (Device-intensive procedure added to ASC list in CY 2008 or later; paid at adjusted rate); ''P2'' (Office-based surgical procedure added to ASC list in CY 2008 or later with MPFS nonfacility PE RVUs; payment based on OPPS relative payment weight); ''P3'' (Office-based surgical procedure added to ASC list in CY 2008 or later with MPFS nonfacility PE RVUs; payment based on MPFS nonfacility PE RVUs); and ''R2'' (Office-based surgical procedure added to ASC list in CY 2008 or later without MPFS nonfacility PE RVUs; payment based on OPPS relative payment weight).

2. Covered Ancillary Services Under the Revised ASC Payment System

a. General Policies

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

Under the final policy of the revised ASC payment system, covered ancillary services are allowed separate payment. Covered ancillary services are defined at § 416.164(b) as follows: brachytherapy sources; certain implantable items that have pass-through status under the OPPS; certain items and services that we designate as contractor-priced (payment rate is determined by the Medicare contractor) including, but not limited to, the procurement of corneal tissue; certain drugs and biologicals for which separate payment is allowed under the OPPS; and certain radiology services for which separate payment is allowed under the OPPS.

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

b. Payment Policies for Specific Items and Services

(1) Radiology Services

Under the revised ASC payment system, we make separate payment to ASCs for ancillary radiology services designated as separately payable under the OPPS, when those radiology services are provided in the ASC integral to the performance of a covered surgical procedure provided on the same day. ASC payment for those ancillary services is at the lower of the rate developed according to the standard methodology of the revised ASC payment system or the MPFS nonfacility PE RVU amount (specifically for the technical component (TC) if the service is assigned a TC under the MPFS). No separate payment is made for those ancillary services that are designated as packaged under the OPPS. We specify that a radiology service is integral to the performance of a covered surgical procedure if it is required for the successful performance of the surgery and is performed in the ASC immediately preceding, during, or immediately following the covered surgical procedure. Payment under the revised ASC payment system for these ancillary radiology services is subject to geographic adjustment, like payment for ASC surgical procedures. Only the ASC can receive payment for the facility resources required to provide the ancillary radiology services, and ASCs are no longer able to bill as independent diagnostic testing facility (IDTF) suppliers to receive payment for ancillary radiology services that are integral to the performance of a covered surgical procedure for which the ASC is billing Medicare. Because the packaging status of radiology services under the revised ASC payment system parallels the OPPS, any changes to the packaging of radiology services under the OPPS would also occur under the revised ASC payment system.

Radiology services include all Category I CPT codes in the radiology range established by CPT, from 70000 to 79999, and Category III CPT codes and Level II HCPCS codes that describe radiology services that crosswalk or are clinically similar to procedures in the radiology range established by CPT. This revised ASC payment system policy for each calendar year applies to all radiology services that are separately

payable under the OPPS in that same calendar year. A listing that includes all radiology services that we are proposing for separate payment under the CY 2008 ASC payment system because they would be separately payable under the proposed CY 2008 OPPS may be found in Addendum BB to this proposed rule. Separately paid radiology services 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) or ''Z3'' (Radiology service paid separately when provided integral to a surgical procedure on ASC list; payment based on MPFS nonfacility PE RVUs). Payment for ancillary radiology services that are packaged under the OPPS is packaged under the revised ASC payment system, and these services are identified in Addendum BB to this proposed rule with payment indicator ''N1'' (Packaged service/item; no separate payment made). ASC payment for these radiology services is not subject to the 4-year transition.

(2) Brachytherapy Sources

Under the revised ASC payment system, we provide separate payment to ASCs for brachytherapy sources as covered ancillary services when they are implanted in conjunction with covered surgical procedures billed by ASCs. The application of the brachytherapy sources is integrally related to the surgical procedures for insertion of brachytherapy needles and catheters. There is a statutory requirement that the OPPS establish separate payment groups for brachytherapy sources related to their number, radioisotope, and radioactive intensity, as well as for stranded and non-stranded sources as of July 1, 2007. OPPS procedure payments specifically do not include payment for brachytherapy sources. The ASC brachytherapy source payment rate for a given calendar year is the same as the OPPS payment rate for that year, without application of the ASC budget neutrality adjustment or, if specific OPPS prospective payment rates are unavailable, ASC payments for brachytherapy sources are contractor-priced. In addition, consistent with the payment of brachytherapy sources under the OPPS, the ASC payment rates for brachytherapy sources are not adjusted for geographic wage differences. Some Level II HCPCS codes and their proposed payment rates for brachytherapy sources for the CY 2008 revised ASC payment system, the same as those proposed for the CY 2008 OPPS, are included in Addendum BB to this proposed rule. Brachytherapy sources are assigned payment indicator ''H2'' (Brachytherapy source paid separately when provided integral to a surgical procedure on ASC list; payment based on OPPS rate). We note that the brachytherapy source payment indicator has changed for this proposed rule from the July 2007 final rule for the revised ASC payment system, in which sources were designated with payment indicator H4, defined as ''Brachytherapy source paid separately when provided integral to a surgical procedure on ASC list; payment contractor-priced.'' During CY 2007, brachytherapy source payment is made under the OPPS, according to the statute, at charges adjusted to cost. In order to be consistent with that OPPS policy under the revised ASC payment system, our policy is to pay for brachytherapy sources under the revised ASC payment system using contractor-based pricing because we have no CCR data for ASCs that would enable us to pay at charges adjusted to cost like we do under the OPPS. However, the CY 2008 proposal for OPPS payment of brachytherapy sources, as described in section VII. of this proposed rule, proposes payment at prospective rates calculated from historical claims data and, therefore, the proposed ASC payment for brachytherapy sources would be at those same rates. The HCPCS codes for all brachytherapy sources and their proposed ASC payment amounts and ASC payment indicators are listed in Table 57 below.

TABLE 57.—PROPOSED CY 2008 PAYMENTS FOR BRACHYTHERAPY SOURCES PROVIDED IN ASCS

HCPCS code	Short descriptor	ASC payment indicator	Proposed CY 2008 ASC payment rate
A9527	Iodine I–125 sodium iodide	H2	$28.62
C1716	Brachytx, non-str, Gold-198	H2	31.95
C1717	Brachytx, non-str, HDR Ir-192	H2	173.40
C1719	Brachytx, NS, Non-HDR Ir-192	H2	57.40
C2616	Brachytx, non-str,Yttrium-90	H2	11,943.79
C2634	Brachytx, non-str, HA, I–125	H2	29.93
C2635	Brachytx, non-str, HA, P–103	H2	47.06
C2636	Brachy linear, non-str, P–103	H2	37.09
C2638	Brachytx, stranded, I–125	H2	42.86
C2639	Brachytx, non-stranded, I–125	H2	31.91
C2640	Brachytx, stranded, P–103	H2	62.24
C2641	Brachytx, non-stranded, P–103	H2	45.29
C2642	Brachytx, stranded, C–131	H2	97.72
C2643	Brachytx, non-stranded, C–131	H2	51.35
C2698	Brachytx, stranded, NOS	H2	42.46
C2699	Brachytx, non-stranded, NOS	H2	29.93

The brachytherapy source HCPCS codes listed in Table 57 are not all included in Addendum BB to this proposed rule because they were new in July 2007, and Addendum BB reflects only those codes available for the April 2007 update to the OPPS. Although the proposed ASC payment rates for the new brachytherapy source HCPCS codes implemented under the OPPS in July 2007 are not displayed in Addendum BB to this proposed rule, they will be included in Addendum BB to the CY 2008 OPPS/ASC final rule with comment period and their final payment will be effective under the revised ASC payment system, beginning January 1, 2008.

(3) Drugs and Biologicals

Under the revised ASC payment system, we pay separately for all drugs and biologicals that are separately paid under the OPPS, when they are provided integral to a covered surgical procedure that is billed by the ASC to Medicare. We specify that a drug or biological is integral to a covered

surgical procedure if it is required for the successful performance of the surgery and is provided to the beneficiary in the ASC immediately preceding, during, or immediately following the covered surgical procedure. Payments for separately payable drugs and biologicals under the revised ASC payment system for a calendar year are equal to the OPPS payment rates for that same year, without application of the ASC budget neutrality adjustment. In addition, consistent with the payment of drugs and biologicals under the OPPS, the ASC payment rates for these items are not adjusted for geographic wage differences.

A list of the drugs and biologicals that we are proposing for separate payment under the CY 2008 revised ASC payment system and their proposed payment rates are included in Addendum BB to the proposed rule. Separately paid drugs and biologicals are assigned payment indicator ''K2'' (Drugs and biologicals paid separately when provided integral to a surgical procedure on ASC list; payment based on OPPS rate). Drugs and biologicals for which we are proposing to package payment into the ASC payment for the covered surgical procedure in CY 2008 because we are proposing to package under the OPPS for CY 2008, are also listed in Addendum BB, where they are assigned payment indicator ''N1'' (Packaged service/item; no separate payment made).

(4) Implantable Devices with Pass-Through Status under the OPPS

Under the revised ASC payment system, we provide separate payment at contractor-priced rates for devices that are included in device categories with pass-through status under the OPPS when the devices are an integral part of a covered surgical procedure. As we have specified for drugs, biologicals, and ancillary radiology services, a pass-through device would be considered integral to the covered surgical procedure when it is required for the successful performance of the procedure; is provided in the ASC immediately before, during, or immediately following the covered surgical procedure; and is billed by the ASC on the same day as the covered surgical procedure.

In the future, new device categories may be established that will have OPPS pass through status during all or a portion of any calendar year. For CY 2008, there are two device categories with OPPS pass-through status that are proposed to continue in that status under the OPPS for CY 2008, specifically HCPCS code C1821 (Interspinous process distraction device (implantable)), and HCPCS code L8690 (Auditory osseointegrated device, includes all internal and external components). We note that only the surgical procedures associated with the implantation of HCPCS code L8690 are ASC covered surgical procedures for CY 2008. As under the OPPS, ASC payment for pass-through devices is not subject to the geographic wage adjustment.

The proposed pass-through device category HCPCS codes are included in Addendum BB to this proposed rule and are assigned payment indicator ''J7'' (OPPS pass-through device paid separately when provided integral to a surgical procedure on ASC list; payment contractor-priced). Implantable devices that receive packaged payment because they do not have OPPS pass-through status are also listed in Addendum BB to this proposed rule, where they are assigned payment indicator ''N1'' (Packaged service/item; no separate payment made).

The associated non-device facility resources for the device implantation procedures are paid through the ASC surgical procedure service payment, based upon the payment weight for the non-device portion of the related OPPS APC payment weight.

(5) Corneal Tissue Acquisition

Under the revised ASC payment system, we pay separately for corneal tissue procurement provided integral to the performance of an ASC covered surgical procedure based on invoice costs. The HCPCS code for corneal tissue acquisition, V2785 (Processing, preserving and transporting corneal tissue), is listed in Addendum BB to this proposed rule, and it is assigned payment indicator ''F4'' (Corneal tissue processing; paid at reasonable cost).

3. General Payment Policies

a. Geographic Adjustment

Under the revised ASC payment system policy, we utilize 50 percent as the labor related share. Fifty percent is significantly higher than the labor-related share used for the ASC payment system through CY 2007 (34.45 percent) but is also lower than the OPPS labor-related share of 60 percent, a differential we believe is appropriate given the broader range of labor-intensive services provided in the HOPD setting.

Consistent with the OPPS, we apply to ASC payments the IPPS pre reclassification wage index values associated with the June 2003 OMB geographic localities, as recognized under the IPPS and OPPS, in order to adjust the labor-related portion of the national ASC payment rates for geographic wage differences. b. Beneficiary Coinsurance

Under the revised ASC payment system, beneficiary coinsurance remains at 20 percent for ASC services, except for screening flexible sigmoidoscopy and screening colonoscopy procedures. The coinsurance for screening colonoscopies and screening flexible sigmoidoscopies is 25 percent, as required by section 1834(d) of the Act, with no deductible for those services under the revised ASC payment system.

D. Proposed Treatment of New HCPCS Codes

1. Treatment of New CY 2008 Category I and III CPT Codes and Level II HCPCS Codes

We finalized a policy in the July 2007 final rule for the revised ASC payment system to evaluate each year all new HCPCS codes that describe surgical procedures to make preliminary determinations regarding whether or not they meet the criteria for payment in the ASC setting and, if so, whether they are office-based procedures. In the absence of claims data that indicate where procedures described by new codes are being performed and reflect the facility resources required to perform them, we decided to use other available information to make our interim decisions regarding assignment of payment indicators for the new codes. The other data available to us include our clinical advisors' judgment, data regarding predecessor and related HCPCS codes, information submitted by representatives of specialty societies and professional associations, and information submitted by commenters during the public comment period following publication of the final rule with comment period in the **Federal Register**. We will publish in the annual OPPS/ASC payment update final rule the interim ASC determinations for the new codes to be effective January 1 of the update year. The interim payment indicators assigned to new codes under the revised ASC payment system will be subject to comment in that final rule. We will respond to those comments in the OPPS/ASC update final rule for the following calendar year, just as we currently respond to OPPS comments about APC and status indicator assignments for new procedure codes in the OPPS update final rule for the year following publication of the code's interim OPPS treatment.

After our review of public comments and in the absence of physicians' claims data, our determination that a new code

is an office based procedure and is, thereby, subject to the payment limitation, would remain temporary and subject to review, until there are adequate data available to assess the procedure's predominant sites of service. Using those data, if we confirm our determination that the new code is office-based after taking into account the most recent available volume and utilization data for the procedure code and/or, if appropriate, the clinical characteristics, utilization, and volume of related codes, the code would be assigned permanently to the list of office-based procedures subject to the ASC payment limitation.

New HCPCS codes for ASC implementation on January 1, 2008, will be designated in Addenda AA and BB to the OPPS/ASC final rule with comment period with comment indicator ''NI.'' The ''NI'' comment indicator is used to identify those HCPCS codes for which the assigned ASC payment indicator is subject to public comment. (We refer readers to section XVI.J. of this proposed rule for discussion of ASC payment and comment indicators.)

2. Proposed Treatment of New Mid-Year Category III CPT Codes

Twice each year, the AMA issues Category III CPT codes, which the AMA defines as temporary codes for emerging technology, services, and procedures. The AMA established Category III CPT codes to allow collection of data specific to the service described by the code which otherwise could only be reported using a Category I CPT unlisted code. The AMA releases Category III CPT codes in January, for implementation beginning the following July, and in July, for implementation beginning the following January.

CMS provides a predictable quarterly update for the OPPS occurring throughout each calendar year (January, April, July, and October), and the final payment policies of the revised ASC payment system parallel, in many cases, the OPPS treatment of HCPCS codes. As discussed in the July 2007 final rule for the revised ASC payment system, we will provide a quarterly ASC update for each calendar quarter to recognize newly created HCPCS codes for ASC payment and to update the payment rates for separately paid drugs and biologicals based on the most recently submitted ASP data.

Under the OPPS and MPFS, CMS allows Category III CPT codes that are released by the AMA in January to be effective beginning July of the same calendar year in which they are issued, rather than deferring implementation of those codes to the following calendar year update of the payment systems, as is the case for the Category III codes that are released in July by the AMA for implementation in January of the upcoming calendar year. Therefore, in contrast to the Category I CPT codes that are issued only once annually and that CMS recognizes as effective under the MPFS and OPPS each January for the new calendar year, new Category III CPT codes are made effective under the MPFS and OPPS biannually. In order to be consistent in this regard across the three payment systems, we are proposing to adopt that same policy under the revised ASC payment system.

Some of the new Category III CPT codes may describe services that our medical advisors determine directly crosswalk or are clinically similar to HCPCS codes that describe ASC covered surgical procedures. In those instances, we may allow ASC payment for the new Category III CPT code as a covered surgical procedure. Similarly, the new code may represent an ancillary service that directly crosswalks or is clinically similar to those for which separate ASC payment is allowed when it is performed integral to a covered surgical procedure, and the new code also may be determined to be eligible for ASC payment as a covered ancillary service.

Therefore, beginning in CY 2008, we are proposing to include in the July update to the ASC payment system, the ASC payment indicators for new Category III CPT codes that the AMA releases in January, and that we determine are appropriate ASC covered surgical procedures or covered ancillary services for implementation, as payable in ASCs beginning in July of the same year. Likewise, as described above, we would implement annually for payment in the January update of the ASC payment system any of the Category III CPT codes that the AMA released the previous July, along with new Category I CPT codes that are determined to be appropriate for ASC payment. Interim ASC payment indicators will be assigned to those new mid-year Category III CPT codes that are released in January for implementation in July of a given calendar year, and the interim ASC indicators will be open to comment in the OPPS/ASC proposed rule for the following calendar year and their status will be made final in the update year's final rule.

Of the Category III CPT codes the AMA released January 1, 2007, we have determined that only one is appropriate for payment in ASCs as a covered ancillary radiology service. The new CPT code is 0182T (High dose rate electronic brachytherapy, per fraction), and we are proposing to assign it to the list of covered ancillary services with payment indicator ''Z2'' as noted in Table 58 below for payment in ASCs beginning January 1, 2008. This service has no MPFS nonfacility PE RVUs assigned to it. Therefore, we are proposing that its CY 2008 ASC payment be calculated according to the standard ASC payment system methodology, based on the code's OPPS relative payment weight.

We do not believe that any of the other Category III CPT codes released in January 2007 for implementation in July 2007 meet the criteria for inclusion on the ASC list of covered surgical procedures or covered ancillary services because they do not directly crosswalk and are not clinically similar to established covered ASC services.

TABLE 58.—CATEGORY III CPT CODE IMPLEMENTED IN JULY 2007AND PROPOSED FOR CY 2008 ASC PAYMENT

HCPCS code	Long descriptor	Proposed CY 2008 ASC Payment Indicator
0182T	High dose rate electronic brachytherapy, per fraction	Z2

3. Proposed Treatment of Level II HCPCS Codes Released on a Quarterly Basis

In addition to the Category III CPT codes that are released twice each year, new Level II HCPCS codes may be created more frequently and are implemented for the MPFS and OPPS on a quarterly basis. Level II HCPCS codes are most commonly created for the purpose of reporting new drugs and biologicals but also are created for reporting some surgical procedures and other services for which payment may be made under the revised ASC payment system, as it is under the OPPS.

We base the ASC payment policies for covered surgical procedures, drugs, biologicals, and certain other covered ancillary services integral to ASC covered surgical procedures on the OPPS and, therefore, we are proposing to update the coding and payment for the services in ASCs at the same time that the OPPS is updated. In order to maintain consistency across the OPPS and ASC payment systems, as discussed in the July 2007 final rule for the revised ASC payment system, we are proposing to recognize newly created Level II HCPCS codes under the revised ASC payment system for payment on a quarterly basis, consistent with the quarterly updates to the OPPS. CMS provides a predictable quarterly update for the OPPS occurring throughout each calendar year (January, April, July, and October). As discussed in the July 2007 final rule for the revised ASC payment system, we will provide a quarterly ASC update for each calendar quarter to recognize newly created Level II HCPCS codes for ASC payment and to update the payment rates for separately paid drugs and biologicals based on the most recently submitted ASP data.

We are proposing to update the lists of covered surgical procedures and ancillary services that qualify for separate payment in ASCs in CY 2008 by adding 8 new Level II HCPCS codes that were implemented in the OPPS in July 2007 and that were not addressed in the CY 2007 OPPS/ASC final rule with comment period. Because of the timing of this proposed rule, the new Level II HCPCS codes implemented through the July 2007 OPPS update are not included in Addendum BB to this proposed rule and there were no Level II HCPCS codes included in the April OPPS update that were eligible for payment under the OPPS. The new CY 2007 Level II HCPCS codes we are proposing for ASC payment beginning in January 2008 are listed in Table 59. Beginning in CY 2008, with implementation of the revised ASC payment system, the Level II HCPCS codes describing new procedures, drugs and biologicals would be made payable in ASCs in the same calendar quarter as they are initially paid under the OPPS.

We are proposing to assign payment indicator K2 to the 7 new codes for drugs to indicate that separate payment would be made for those drugs when they are provided to beneficiaries in ASCs integral to covered surgical procedures. We are proposing to include new Level II HCPCS code C9728 (Placement of interstitial device(s) for radiation/surgery guidance (e.g., fiducial markers, dosimeter), other than prostate (any approach), single or multiple) as a covered surgical procedure with payment indicator ''R2'' because it is clinically similar to CPT code 55876 (Placement of interstitial device(s) for radiation therapy guidance (e.g., fiducial markers, dosimeter), prostate (via needle, any approach), single or multiple) that we have included on the list of covered surgical procedures with payment indicator of ''P3.'' While we believe both procedures are office-based, there are currently no nonfacility PE RVUs available for the Level II HCPCS code C9728, which was initially established in response to a New Technology APC application under the OPPS, and, therefore, its payment indicator is ''R2.''

TABLE 59.—LEVEL II HCPCS CODES IMPLEMENTED UNDER THE OPPS IN APRIL OR JULY 2007 AND PROPOSED FOR CY 2008 ASC PAYMENT

HCPCS code	Short descriptor	Proposed CY 2008 ASC payment indicator
C9728	Place device/marker, non prostate	R2
Q4087	Octagam injection	K2
Q4088	Gammagard liquid injection	K2
Q4089	Rhophylac injection	K2
Q4090	HepaGam B IM injection	K2
Q4091	Flebogamma injection	K2
Q4092	Gamunex injection	K2
Q4095	Reclast injection	K2

In summary, beginning in CY 2008 with implementation of the revised ASC payment system, we are proposing to implement new Level II HCPCS codes for ASC payment on a quarterly basis each year and new Category III CPT codes on a semi annual basis, to parallel the policies under the MPFS and OPPS for the recognition of those codes. Also, consistent with the MPFS and OPPS policies, our final policy with regard to Category I CPT codes is to publish the new codes and interim payment indicators annually in the OPPS/ASC final rule with comment period.

E. Proposed Updates to Covered Surgical Procedures and Covered Ancillary Services

1. Identification of Covered Surgical Procedures

a. General Policies

We published Addendum AA to the July 2007 final rule for the revised ASC payment system as an illustrative list of covered surgical procedures and payment rates for the revised ASC payment system to be implemented January 1, 2008. The final rule established our policies for determining which procedures are eligible to be considered ASC covered surgical procedures and, of those, which are excluded from ASC payment because they pose a significant risk to beneficiary safety or would be expected to require an overnight stay. We adopted a definition of surgical procedure for the revised ASC payment system as those procedures described by all Category I CPT codes in the surgical range from 10000 through 69999 except unlisted procedure codes, as well as those Category III CPT codes and Level II

HCPCS codes that crosswalk or are clinically similar to ASC covered surgical procedures.

Section 1833(i)(1) of the Act requires us to review and update the list of ASC procedures at least every 2 years. We finalized our policy to update the ASC list of covered surgical procedures annually, in conjunction with annual proposed and final rulemaking to update the OPPS and ASC payment systems. Each year we undertake a review of excluded procedures, new procedures, and procedures for which there is revised coding to identify any that we believe are appropriate for coverage in ASCs because they do not pose significant risks to beneficiary safety and would not be expected to require overnight stays.

In the July 2007 final rule for the revised ASC payment system, we finalized the addition of 793 new covered surgical procedures for payment under the revised ASC payment system beginning in CY 2008. We are proposing to remove 13 procedures from the OPPS inpatient list and, of those 13, we believe that 3 are safe for performance in ASCs. Therefore, at this time, we are proposing to add these three additional new surgical procedures to the ASC list of covered surgical procedures eligible for Medicare ASC payment in CY 2008. The proposed procedures and their ASC payment indicators are displayed in Table 60.

TABLE 60.—PROCEDURES PROPOSED AS NEW ASC COVERED SURGICAL PROCEDURES FOR CY 2008

HCPCS code	Short descriptor	Proposed ASC payment indicator
25931	Amputation follow-up surgery	G2
50580	Kidney endoscopy & treatment	G2
58805	Drainage of ovarian cyst(s)	G2

In this proposed rule, we are soliciting commenters' recommendations regarding additional surgical procedures that they believe should not be excluded from ASC payment beginning in CY 2008. We specifically encourage commenters to provide evidence, to the extent possible, to support their recommendations regarding procedures and services they believe should not be excluded from ASC payment.

b. Proposed Change in Designation of Covered Surgical Procedures as Office-Based

According to our final policy for the revised ASC payment system, we designate as office-based 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 code and/or, if appropriate, the clinical characteristics, utilization, and volume of related codes.

The list of codes that we identified as office-based in the July 2007 final rule for the revised ASC payment system took into account the most recent available CY 2005 volume and utilization data for each individual procedure code or related codes. In that rule, we finalized our policy to apply the office-based designation only to procedures that would no longer be excluded from ASC payment beginning in CY 2008 or later years and to exempt all procedures on the CY 2007 ASC list from application of the office based classification. We believe that the resulting list accurately reflected Medicare practice patterns and was clinically consistent. In Addendum AA to the July 2007 final rule for the revised ASC payment system, each of the office-based procedures is identified by payment indicator ''P2,'' ''P3,'' or ''R2,'' 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 nonfacility PE RVU amount.

Consistent with our final ASC policy to review and update annually the surgical procedures for which ASC payment is made and to identify new procedures that may be appropriate for ASC payment, in developing this proposed rule we reviewed the CY 2006 utilization data for all those surgical procedures newly added for ASC payment in CY 2008 that were assigned payment indicator ''G2'' as nonoffice-based additions in the July 2007 final rule for the revised ASC payment system. We based our evaluation of the potential designation of a procedure as office-based on the most recent available volume and utilization data for each individual procedure code and/or, as appropriate, the clinical characteristics, utilization, and volume of related codes. As a result of that review, we identified 19 procedures assigned payment indicator ''G2'' in the July 2007 final rule for the revised ASC payment system that we are proposing to assign to the office-based procedure list with payment indicator ''P2,'' ''P3,'' or ''R2,'' as appropriate. We refer readers to Addendum DD1 to this proposed rule for the definitions of the ASC payment indicators.

We will consider comments submitted timely on the proposed designation of these 19 new procedures as office-based for CY 2008. For example, in the July 2007 final rule for the revised ASC payment system, payment indicator ''G2'' was assigned to CPT code 64650 (Chemodenervation of eccrine glands; both axillae). After reviewing more recent CY 2006 data, we discovered that the procedure is performed predominantly in physicians' offices and we believe the procedure should be designated as an office-based procedure. Therefore, we are proposing to assign payment indicator ''P3'' to CPT code 64650, effective for CY 2008. In this proposed rule, we are proposing to assign an office-based payment indicator for CPT code 64650 and 18 other procedures, as displayed in Table 61.

TABLE 61.—PROPOSED CY 2008 NEW DESIGNATIONS OF ASC COVERED SURGICAL PROCEDURES AS OFFICE-BASED

HCPCS code	Short descriptor	ASC Payment Indicator in July 2007 ASC Final Rule	Proposed CY 2008 ASC payment indicator
24640	Treat elbow dislocation	G2	P3
26641	Treat thumb dislocation	G2	P2
26670	Treat hand dislocation	G2	P2
26700	Treat knuckle dislocation	G2	P2
26775	Treat finger dislocation	G2	P3
28630	Treat toe dislocation	G2	P3
28660	Treat toe dislocation	G2	P3
28890	High energy eswt, plantar fascia	G2	P3
29035	Application of body cast	G2	P2
29305	Application of hip cast	G2	P2
29325	Application of hip casts	G2	P2
29505	Application, long leg splint	G2	P3
29515	Application lower leg splint	G2	P3
36469	Injection(s), spider veins	G2	R2
46505	Chemodenervation anal misc	G2	P3
62292	Injection into disk lesion	G2	R2
64447	Nblock inj fem, single	G2	R2
64650	Chemodenerv, eccrine glands	G2	P3
64653	Chemodenerv, eccrine glands	G2	P3

We also reviewed the five procedures that were assigned temporary office-based payment indicators in the July 2007 final rule for the revised ASC payment system. Those codes are listed in Table 62 below. Using the most recent data available, we believe there are adequate claims data for two of the procedures upon which to base assignment of permanent office-based payment indicators. Table 62 shows that we are proposing to assign CPT code 36598 (Contrast injection(s) for radioisotope evaluation of existing central venous access device, including fluoroscopy, image documentation and report) permanently to the office-based list and assign it to payment indicator ''P3'' for CY 2008. In accordance with the CY 2008 OPPS proposal to package payment for CPT code 58110 (Endometrial sampling (biopsy) performed in conjunction with colposcopy), we are also proposing to package payment for this procedure under the ASC payment system and assign it payment indicator ''N1'' as indicated in Table 62.

We are proposing to maintain the temporary office-based payment indicator assignments for the other three procedures listed in Table 62. We have only a few claims for CPT code 0099T (Implantation of intrastromal corneal ring segments) and no claims for 0124T (Conjunctival incision with posterior juxtascleral placement of pharmacological agent (does not include supply of medication)) or CPT code 55876 (Placement of interstitial device(s) for radiation therapy guidance (e.g., fiduciary markers, dosimeter), prostate (via needle, any approach), single or multiple). We continue to believe these procedures are predominantly office-based. Therefore, we are not proposing to make any change to the temporary office-based designation of these procedures at this time.

TABLE 62.—PROPOSED PAYMENT INDICATORS FOR PROCEDURES ASSIGNED TEMPORARY OFFICE-BASED PAYMENT INDICATORS IN THE JULY 2007 ASC FINAL RULE

HCPCS Code	Short descriptor	Temporary Office Based Payment Indicator in July 2007 ASC Final Rule	Proposed Final CY 2008 ASC Payment Indicator (or * if HCPCS code will continue with temporary office-based assignment for CY 2008)
0099T	Implant corneal ring	R2	*
0124T	Conjunctival drug placement	R2	*
36598	Inj w/fluor, eval cv device	P2	P3
55876	Place rt device/marker, pros	P3	*
58110	Bx done w/colposcopy add-on	P3	N1

c. Proposed Changes to Designation of Covered Surgical Procedures as Device-Intensive

As explained in section XVI.C. of this proposed rule, we adopted a modified payment methodology for calculating the ASC payment rates for ASC covered surgical procedures that are assigned to the subset of device-dependent APCs under the OPPS with a device offset percentage greater than 50 percent under the OPPS to ensure that payment for the procedure is adequate to provide packaged payment for the high-cost implantable devices used in those procedures. In the July 2007 final rule for the revised ASC payment system, we identified 24 procedures that were on the CY 2007 ASC list of covered surgical procedures that would be subject to this policy, as well as 15 new ASC covered surgical procedures for CY 2008 to which we expected the final policy to apply.

As a result of the proposed CY 2008 reconfiguration of several device-dependent APCs under the OPPS and the proposed updated APC device offset percentages, we are proposing to designate as device-intensive for ASC payment in CY 2008 an additional 10 ASC covered surgical procedures. We are also proposing to remove 4 procedures from their estimated designation as device-intensive because we are proposing to recognize CPT codes instead of Level II HCPCS codes for ICD implantation.procedures as discussed in section III.D.7. of this proposed rule. In the July 2007 final rule for the revised ASC payment system, either payment indicator ''H8'' or ''J8'' was assigned to the procedures that we estimated would be designated as device-intensive procedures for CY 2008. As displayed in Table 63 below, we are proposing to assign payment indicators ''H8'' or ''J8,'' as appropriate, to the covered surgical procedures included in the table so that the payment for these surgical procedures would be made consistent with our final revised ASC payment system payment policy for device-intensive procedures that are identified according to their APC assignments under the OPPS.

TABLE 63.—PROPOSED ASC COVERED SURGICAL PROCEDURES PROPOSED FOR DESIGNATION AS DEVICE-INTENSIVE FOR CY 2008

HCPCS code	Short descriptor	Proposed CY 2008 OPPS APC	Proposed CY 2008 device-dependent APC offset percentage
33206	Insertion of heart pacemaker	0089	74.02
33207	Insertion of heart pacemaker	0089	74.02
33208	Insertion of heart pacemaker	0655	74.59
33210	Insertion of heart electrode	0106	57.20
33211	Insertion of heart electrode	0106	57.20
33212	Insertion of pulse generator	0090	75.54
33213	Insertion of pulse generator	0654	75.86
33214	Upgrade of pacemaker system	0655	74.59
33216	Insert lead pace-defib, one	0106	57.20
33217	Insert lead pace-defib, dual	0106	57.20
33224	Insert pacing lead & connect	0418	81.38
33225	Lventric pacing lead add-on	0418	81.38
33240	Insert pulse generator	0107	89.43
33249	Eltrd/insert pace-defib	0108	89.26
33282	Implant pat-active ht record	0680	72.14
36566	Insert tunneled cv cath	0625	62.63
53440	Male sling procedure	0385	51.67
53444	Insert tandem cuff	0385	51.67
53445	Insert uro/ves nck sphincter	0386	61.98
53447	Remove/replace ur sphincter	0386	61.98
54400	Insert semi-rigid prosthesis	0385	51.67
54401	Insert self-contd prosthesis	0386	61.98
54405	Insert multi-comp penis pros	0386	61.98
54410	Remove/replace penis prosth	0386	61.98
54416	Remv/repl penis contain pros	0386	61.98
55873	Cryoablate prostate	0674	59.34
61885	Insrt/redo neurostim 1 array	0039	82.15
61886	Implant neurostim arrays	0315	86.23
62361	Implant spine infusion pump	0227	79.69
62362	Implant spine infusion pump	0227	79.69
63650	Implant neuroelectrodes	0040	55.93
63655	Implant neuroelectrodes	0061	59.32
63685	Insrt/redo spine n generator	0222	83.29
64553	Implant neuroelectrodes	0225	80.84
64555	Implant neuroelectrodes	0040	55.93
64560	Implant neuroelectrodes	0040	55.93
64561	Implant neuroelectrodes	0040	55.93
64565	Implant neuroelectrodes	0040	55.93
64573	Implant neuroelectrodes	0225	80.84
64575	Implant neuroelectrodes	0061	59.32
64577	Implant neuroelectrodes	0061	59.32
64580	Implant neuroelectrodes	0061	59.32
64581	Implant neuroelectrodes	0061	59.32
64590	Insrt/redo pn/gastr stimul	0222	83.29
69930	Implant cochlear device	0259	83.03

2. Proposed Changes for Identification of Covered Ancillary Services

In the July 2007 final rule for the revised ASC payment system, we set forth our policy to make separate ASC payments for certain ancillary services, for which separate payment is made under the OPPS, when they are provided integral to ASC covered surgical procedures. Under the revised ASC payment system, we exclude from the scope of ASC facility services, for which payment is packaged into the ASC payment for the covered surgical procedure, the following ancillary services that are integral to a covered surgical procedure: 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 fall within the scope of ASC services, so they are eligible for separate ASC payment.

In this proposed rule, we are proposing to make changes to the list of covered ancillary services eligible for separate ASC payment, as proposed in Addendum BB to this proposed rule, to comport with their proposed treatment under the OPPS according to the final payment policies of the revised ASC payment system, and to add new Category III CPT code 0182T (High dose rate electronic brachytherapy, per fraction), as discussed in section XVI.D.2 of this proposed rule.

F. Proposed Payment for Covered Surgical Procedures and Covered Ancillary Services

1. Proposed Payment for Covered Surgical Procedures

a. Proposed Update to Payment Rates

Our final payment policy for covered surgical procedures under the revised ASC payment system is described in section XVI.C. of this proposed rule. For CY 2008, payment for procedures with payment indicator ''G2'' will be calculated by multiplying the ASC relative payment weight for the procedure by the final ASC conversion factor. For those procedures with payment indicator ''A2,'' a blended rate will be used that is comprised of 25 percent of the revised ASC payment rate added to 75 percent of the CY 2007 payment rate. Special payment policies apply to covered surgical procedures identified as office-based or device-intensive.

The payment amounts provided in Addendum AA to the July 2007 final rule for the revised ASC payment system were illustrative only, and we are proposing to update them in this proposed rule. We are not proposing to make any changes to the final policies established in the July 2007 final rule for the revised ASC payment system related to the methodology for developing the relative payment weights and rates. The differences in the payment rates for covered surgical procedures with ''G2'' and ''A2'' payment indicators, reflected in Addendum AA to this proposed rule, compared with the July 2007 final rule for the revised ASC payment system are due to our use of updated CY 2006 utilization data, proposed payment policy changes for the CY 2008 OPPS, including APC reassignments and changes to packaged services, and the proposed OPPS update factor.

We also are proposing to update the payment amounts for the office-based procedures in this rule. Using the most recent available MPFS and OPPS data, including the proposed CY 2008 rates, we compared the estimated CY 2008 rate for each of the office-based procedures calculated according to the standard methodology of the revised ASC payment system and to the MPFS nonfacility PE RVUs to determine which is the lower payment amount that, therefore, is the rate we are proposing for payment of the procedure according to the final policy of the revised ASC payment system. The proposed update to the rates results in changes to the payment indicators, as well as the rates, for several of the office-based procedures. For example, a procedure with payment indicator ''P2'' in the July 2007 final rule for the revised ASC payment system may be assigned payment indicator ''P3'' in this proposed rule, depending on the outcome of that rate comparison.

In addition, we are proposing to update the payment amounts for the device intensive procedures in this rule, based on the CY 2008 OPPS proposal and updated OPPS claims data.

b. Payment Policies When Devices Are Replaced at No Cost or With Credit

(1) Policy When Devices Are Replaced at No Cost or With Full Credit

Our final ASC policy with regard to payment for costly devices implanted in ASCs is fully consistent with the current OPPS policy. The ASC policy includes adoption of the OPPS policy for payment to providers when a device is replaced without cost or with full credit for the cost of the device being replaced, for those ASC covered surgical procedures that are assigned to APCs under the OPPS to which this policy applies. In the case of no cost or full credit cases under the OPPS, we reduce the APC payment to the hospital by the device offset amount that we estimate represents the cost of the device. Therefore, in accordance with the OPPS policy implemented in CY 2007, and the ASC policy as finalized in the July 2007 final rule for the revised ASC payment system, beginning in CY 2008, we reduce the amount of payment made to ASCs for certain covered surgical procedures when the necessary device is furnished without cost to the ASC or the beneficiary or with a full credit for the cost of the device being replaced. We provide the same amount of payment reduction based on the device offset amount in ASCs that would apply under the OPPS for performance of those procedures under the same circumstances. Specifically, when a procedure that is listed in Table 64 below is performed in an ASC and the case involves implantation of a no cost or full credit device listed in Table 65, the ASC must report the HCPCS ''FB'' modifier on the line with the covered surgical procedure code to indicate that an implantable device in Table 65 was furnished without cost. The devices listed in Table 65 are the same proposed devices to which the policy applies under the OPPS, and the procedures listed in Table 64 are those ASC covered surgical procedures assigned to proposed APCs under the OPPS to which the policy applies.

As finalized in the July 2007 final rule for the revised ASC payment system, when the ''FB'' modifier is reported with a procedure code that is listed in Table 64, the contractor reduces the ASC payment by the amount of payment that we attributed to the device when the ASC payment rate was calculated. The reduction of ASC payment in this circumstance is necessary to pay appropriately for the covered surgical procedure being furnished by the ASC.

(2) Proposed Policy When Implantable Devices Are Replaced With Partial Credit

Consistent with our CY 2008 OPPS proposal discussed in section IV.A.3. of this proposed rule, we are proposing to reduce the ASC payment by one half of the device offset amount for certain surgical procedures into which the device cost is packaged, when an ASC receives a partial credit toward replacement of an implantable device.

This partial payment reduction would apply to covered surgical procedures in which the amount of the device credit is greater than or equal to 20 percent of the cost of the new replacement device being implanted.

We also are proposing to base the beneficiary's coinsurance on the reduced ASC payment rate so that the beneficiary shares the benefit of the ASC's reduced costs. This proposed policy is set forth in proposed new § 416.179(b)(2).

We have no OPPS data to empirically determine by how much we should reduce the payment for ASC surgical procedures into which the costs of these devices are packaged. Device manufacturers and hospitals have told us that a common scenario is that, if a device fails 3 years after implantation, the hospital would receive a 50 percent credit towards a replacement device. We do not believe that hospitals reduce their device charges to reflect the credits that may have been received, so the lower facility costs associated with these partial credit scenarios would likely not be reflected in our proposed OPPS rates for these device-dependent procedures. Therefore, we are proposing under the OPPS to reduce the payment for the relevant device-dependent APCs and, under the revised ASC payment system, to reduce the payment for those ASC covered surgical procedures assigned to those APCs under the OPPS by half of the reduction that applies when the hospital or ASC receives a device without cost or receives a full credit for a device being replaced. That is, we are proposing to reduce the payments by half of the offset amount that represents the cost of the device packaged into the procedure payment. In the absence of OPPS claims data on which to base a reduction factor, but taking into consideration what we have been told is common industry practice, we believe that reducing the amount of payment for the device-dependent APC and the related ASC covered surgical procedure by half of the estimated cost of the device packaging represents a reasonable reduction in these cases.

Moreover, we are proposing to take this reduction only when the credit is for 20 percent or more of the cost of the new replacement device, so that the reduction is not taken in cases in which more than 80 percent of the cost of the replacement device has been incurred by the facility. If the partial credit is less than 20 percent of the cost of the new replacement device, we believe that reducing the payment for the device implantation procedure by 50 percent of the packaged device cost would provide too low a payment for necessary device replacement procedures. This proposed policy is discussed in section IV.A. of this proposed rule for the OPPS and is fully consistent with the proposed FY 2008 Medicare payment policy for hospital inpatient services and the proposed CY 2008 policy for hospital outpatient services.

Therefore, we are proposing that the new HCPCS partial credit modifier would be reported and the partial credit reduction would be taken only in cases in which the device credit is equal to or greater than 20 percent of the cost of the new replacement device. The partial credit reduction modifier would be reported in all cases in which the ASC receives a partial credit toward the replacement of a medical device listed in Table 65 when used in a surgical procedure listed in Table 64. The proposed policy related to partial device credits applies to the same devices and procedures to which our policy governing payment when the device is furnished to the ASC without cost or with full credit applies. We selected these devices because they have substantial costs and because each device is implanted in one beneficiary at least temporarily and, therefore, can be associated with an individual beneficiary. Moreover, we believe that this policy is a logical extension of our established policy regarding reduction of the ASC payment in cases in which the facility furnishes the device without cost or with a full credit to the ASC and ensures that beneficiary and Medicare payments are appropriate and consistent with costs incurred by ASCs.

This partial device credit policy that we are proposing would enhance our ability to track the replacement of these implantable medical devices and may enable us to identify patterns of device failure or limited longevity early in their natural history so that appropriate strategies to reduce future problems for our beneficiaries may be developed. We also are mindful of the opportunity to use our claims history data to promote high quality medical care with regard to the devices and the services in which they are used. Collecting data on a wider set of device replacements under full and partial credit situations in all sites of outpatient surgery, including ASCs, would assist in developing comprehensive summary data, not just a subset of data related to devices replaced without cost or with a full credit to facilities.

TABLE 64.—PROPOSED ADJUSTMENTS TO PAYMENTS FOR ASC COVERED SURGICAL PROCEDURES IN CY 2008 IN CASES OF DEVICES REPORTED WITHOUT COST OR FOR WHICH FULL OR PARTIAL CREDIT IS RECEIVED

HCPCS code	Short descriptor	Proposed CY 2008 OPPS APC	APC title	Proposed CY 2008 OPPS offset percentage	50 Percent of proposed CY 2008 OPPS offset percentage
61885	Insrt/redo neurostim 1 array	0039	Level I Implantation of Neurostimulator	82.15	41.07
63560	Implant neuroelectrodes	0040	Percutaneous Implantation of Neurostimulator Electrodes, Excluding Cranial Nerve.	55.93	27.97
64555	Implant neuroelectrodes				
64560	Implant neuroelectrodes				
64561	Implant neuroelectrodes				
63655	Implant neuroelectrodes	0061	Laminectomy or Incision for Implantation of Neurostimulator Electrodes, Excluding Cranial Nerve.	59.32	29.66
64575	Implant neuroelectrodes				
64577	Implant neuroelectrodes				
64580	Implant neuroelectrodes				
64581	Implant neuroelectrodes				
33206	Insertion of heart pacemaker	089	Insertion/Replacement of Permanent Pacemaker and Electrodes.	74.02	37.01
33207	Insertion of heart pacemaker				
33212	Insertion of pulse generator	0090	Insertion/Replacement of Pacemaker Pulse Generator.	75.54	37.77

TABLE 64.—PROPOSED ADJUSTMENTS TO PAYMENTS FOR ASC COVERED SURGICAL PROCEDURES IN CY 2008 IN CASES OF DEVICES REPORTED WITHOUT COST OR FOR WHICH FULL OR PARTIAL CREDIT IS RECEIVED—Continued

HCPCS code	Short descriptor	Proposed CY 2008 OPPS APC	APC title	Proposed CY 2008 OPPS offset percentage	50 Percent of proposed CY 2008 OPPS offset percentage
33210	Insertion of heart electrode	0106	Insertion/Replacement/Repair of Pacemaker and/or Electrodes.	57.20	28.60
33211	Insertion of heart electrode				
33216	Insert lead pace-defib, one				
33217	Insert lead pace-defib, dual				
33240	Insert pulse generator	0107	Insertion of Cardioverter-Defibrillator	89.43	44.72
33249	Eltrd/insert pace-defib	0108	Insertion/Replacement/Repair of Cardioverter-Defibrillator Leads.	89.26	44.63
63685	Insrt/redo spine n generator	0222	Implantation of Neurological Device	83.29	41.64
64590	Insrt/redo perph n generator				
64553	Implant neuroelectrodes	0225	Implantation of Neurostimulator Electrodes, Cranial Nerve.	80.84	40.42
64573	Implant neuroelectrodes				
62361	Implant spine infusion pump	0227	Implantation of Drug Infusion Device	79.69	39.85
62362	Implant spine infusion pump				
69930	Implant cochlear device	0259	Level VI ENT Procedures	83.03	41.52
61886	Implant neurostim arrays	0315	Level II Implantation of Neurostimulator	86.23	43.12
53440	Male sling procedure	0385	Level I Prosthetic Urological Procedures	51.67	25.83
53444	Insert tandem cuff				
54400	Insert semi-rigid prosthesis				
53445	Insert uro/ves nck sphincter	0386	Level II Prosthetic Urological Procedures	61.98	30.99
53447	Remove/replace ur sphincter				
54401	Insert self-contd prosthesis				
54405	Insert multi-comp penis pros				
54410	Remove/replace penis prosth				
54416	Remv/repl penis contain pros				
33224	Insert pacing lead & connect	0418	Insertion of Left Ventricular Pacing Elect	81.38	40.69
33225	L ventric pacing lead add-on				
36566	Insert tunneled cv cath	0625	Level IV Vascular Access Procedures	62.63	32.32
33213	Insertion of pulse generator	0654	Insertion/Replacement of a permanent dual chamber pacemaker.	75.86	37.93
33214	Upgrade of pacemaker system	0655	Insertion/Replacement/Conversion of a permanent dual chamber pacemaker.	74.59	37.30
33208	Insertion of heart pacemaker				
33282	Implant pat-active ht record	0680	Insertion of Patient Activated Event Recorders.	72.14	36.07

TABLE 65.—PROPOSED DEVICES FOR WHICH THE "FB" OR NEW HCPCS MODIFIER MUST BE REPORTED WITH THE PROCEDURE CODE WHEN FURNISHED WITHOUT COST OR FOR WHICH FULL OR PARTIAL CREDIT IS RECEIVED

Device HCPCS code	Short descriptor
C1721	AICD, dual chamber.
C1722	AICD, single chamber.
C1764	Event recorder, cardiac.
C1767	Generator, neurostim, imp.
C1771	Rep dev, urinary, w/sling.
C1772	Infusion pump, programmable.
C1776	Joint device (implantable).
C1777	Lead, AICD, endo single coil.
C1778	Lead, neurostimulators.
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.

TABLE 65.—PROPOSED DEVICES FOR WHICH THE "FB" OR NEW HCPCS MODIFIER MUST BE REPORTED WITH THE PROCEDURE CODE WHEN FURNISHED WITHOUT COST OR FOR WHICH FULL OR PARTIAL CREDIT IS RECEIVED—Continued

Device HCPCS code	Short descriptor
C1895	Lead, AICD, endo dual coil.
C1896	Lead, AICD, non sing/dual.
C1897	Lead, neurostim, test kit.
C1898	Lead, pmkr, other than trans.
C1899	Lead, pmkr/AICD combination.
C1900	Lead coronary venous.
C2619	Pmkr, dual, non rate-resp.
C2620	Pmkr, single, non rate-resp.
C2621	Pmkr, other than sing/dual.
C2622	Prosthesis, penile, non-inf.
C2626	Infusion pump, non-prog, temp.
C2631	Rep dev, urinary, w/o sling.
L8614	Cochlear device/system.

2. Proposed Payment for Covered Ancillary Services

Our final CY 2008 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 for separate ASC payment for certain ancillary services integrally related to the provision of ASC covered surgical procedures if those services are paid separately under the OPPS. Thus, we established a policy to align ASC payment bundles with those under the OPPS. Specifically, our final ASC payment policies would provide separate ASC payment for brachytherapy sources and drugs and biologicals that are separately paid under the OPPS at the OPPS rates, while we would pay for radiology services at the lower of the MPFS nonfacility PE RVU (or technical component) amount or the rate calculated according to the standard methodology of the revised ASC payment system based on the

OPPS relative payment weight for the service.

As evidenced by our final policies for the CY 2008 revised ASC payment system, our intention is to maintain consistent payment and packaging policies across HOPD and ASC settings for covered ancillary services that are integral to covered surgical procedures performed in ASCs. Therefore, consistent with our policy to pay separately only for those ancillary services that are paid separately under the OPPS, we also are proposing to package into the ASC payment for covered surgical procedures the costs of those ancillary services that are proposed to be packaged under the OPPS for CY 2008. Certain covered ancillary services that we are proposing to package for the CY 2008 OPPS were assigned payment indicator ''Z2'' or ''Z3'' in the July 2007 final rule for the revised ASC payment system, but they are assigned payment indicator ''N1'' in Addendum BB to this proposed rule. We refer readers to section II.A.4 of this proposed rule for a description of the CY 2008 OPPS packaging approach that we also are proposing to adopt in ASCs and that would package ASC payment for certain covered ancillary services. In addition, proposed OPPS payments for brachytherapy sources and separately payable drugs and biologicals are discussed in sections VII.B. and V. of this proposed rule, respectively. Other separately paid covered ancillary services in ASCs, specifically corneal tissue acquisition and devices with OPPS pass-through status, do not have prospectively established ASC payment rates according to the final policies of the revised ASC payment system. Payments for devices with pass-through status under the OPPS, for which separate payment would be made to ASCs at contractor-priced rates, are discussed in detail in section VI. of this proposed rule.

G. Physician Payment for Procedures and Services Provided in ASCs

If you choose to comment on issues in this section, please include the caption ''Physician Payment for Procedures and Services Provided in ASCs'' at the beginning of your comment.)

Under current policy, when physicians perform surgical procedures in ASCs that are included on the ASC list of covered surgical procedures, they are paid under the MPFS for the PE component using the facility PE RVUs. This is appropriate because the surgical procedures are those for which Medicare allows facility payment to ASCs. However, when physicians perform surgical procedures in ASCs that are not included on the ASC list of covered surgical procedures and for which Medicare does not allow facility payments to ASCs, physicians are paid for the PE component at the higher nonfacility PE RVUs (unless a nonfacility rate does not exist, in which case Medicare pays the physician at the facility rate). These policies are set forth in § 414.22(b)(5)(i)(A) and (B), respectively. Furthermore, physician payment for nonsurgical services provided in ASCs, for which no facility payment is made to ASCs under the existing ASC payment system, varies based on local Medicare contractor policy. Some contractors pay physicians only for the professional component (PC) of the service and others make payment to the physician for the technical component (TC) as well. Under the current policy, as described in the CY 2002 Physician Fee Schedule final rule with comment period (66 FR 55264), Medicare payment to the physician for a noncovered surgical procedure performed in an ASC constitutes payment in full.This is so even if the physician is paid the facility rate (because there is no nonfacility rate). In this case, there is no beneficiary liability other than the deductible and copayment for the physician's services.

According to the policy adopted in the July 2007 final rule for the revised ASC payment system, Medicare will make facility payments to ASCs for all covered surgical procedures except those that could pose a significant risk to beneficiary safety or would be expected to require active medical monitoring and care at midnight following the procedure (that is, an overnight stay). The revised policy will result in a significant expansion in the number and type of surgical procedures for which Medicare will make an ASC facility payment. The final payment policy for the revised ASC payment system also allows separate payments to ASCs for certain covered ancillary services (for example, some drugs, brachytherapy sources, and certain radiology services) that are provided integral to an ASC covered surgical procedure. According to the final policy, when covered ancillary services are integral to the successful performance of a covered surgical procedure and are performed on the same day as the covered surgery, immediately before, during or following the procedure, Medicare will allow separate ASC payment for those services.

The revised ASC payment system is based on the APC groups and payment weights of the OPPS. We believe ASCs are facilities that are similar, insofar as the delivery of surgical and related nonsurgical services, to HOPDs. Specifically, when services are provided in ASCs, the ASC, not the physician, bears responsibility for the facility costs associated with the service. This situation parallels the hospital facility resource responsibility for hospital outpatient services. Therefore, we believe it would be more appropriate for physicians to be paid for all services furnished in ASCs just as they would be paid for all services furnished in the hospital outpatient setting. In addition, because we have adopted a final policy for the revised ASC payment system that identifies and excludes from ASC payment only those procedures that could pose a significant risk to beneficiary safety or would be expected to require an overnight stay, we believe that it would be incongruous with the revised ASC payment system methodology to continue to pay the higher nonfacility rate to physicians who furnish excluded ASC procedures. Because these excluded procedures have been specifically identified by CMS as procedures that could pose a significant risk to beneficiary safety or would be expected to require an overnight stay, we do not believe it would be appropriate to provide payment based on the higher nonfacility PE RVUs to physicians who furnish them. In fact, we do not expect that the excluded procedures will be performed in ASCs after the revised ASC payment system is implemented on January 1, 2008. Therefore, we are proposing to revise § 414.22(b)(5)(i)(A) and (B) to reflect this proposed policy.

We believe that the proposed revised policy would provide appropriate payment to physicians for services provided in the ASC facility setting and would encourage the most appropriate utilization of ASCs. For procedures that are not excluded from coverage under the revised ASC payment system, the ASC would be paid for the covered surgical procedure and associated covered ancillary services, and the physician would be paid for the professional work and facility PE associated with performing the procedure. In the case of noncovered surgical procedures or other noncovered services provided in ASCs, Medicare would make no payment to the ASC under the revised ASC payment system and no payment to the physician under the MPFS for the facility resources associated with providing those services. Although the current MPFS payment policy provides payment to the physician for some facility costs as if the service were being furnished in a

physician's office, according to the final policy of the revised payment system, these services would not be covered ASC services. These services have been excluded from ASC payment for safety reasons, because they are expected to require an overnight stay, or because they are not surgical procedures, and they would not be covered by Medicare either directly, under the ASC payment system, or indirectly, through PE payments to the physicians who perform them.

In summary, under the proposed policy, physicians would receive payment for all surgical and nonsurgical services furnished in ASCs based on the facility PE RVUs and excluding the TC payment, if applicable, consistent with physician payment for HOPD services. Medicare would make no payment for facility services to ASCs or physicians for procedures or services that are performed in ASCs but that are excluded from the list of covered ASC surgical procedures or that are not covered ancillary services. While physicians would be paid for these services based on the facility PE RVUs, physicians would no longer receive the additional payment for the associated facility resources.

Consistent with the current OPPS payment policy that prohibits facility payments to the hospital for noncovered services (such as those surgical procedures on the OPPS inpatient list) and makes the beneficiary liable for those charges, this proposed policy would make beneficiaries responsible for the ASC charges for noncovered services furnished to them in ASCs.

H. Proposed Changes to Definitions of ''Radiology and Certain Other Imaging Services'' and ''Outpatient Prescription Drugs

In section 1877(h)(6) of the Act, the Congress defined the ''designated health services'' (DHS) that are subject to the physician self-referral prohibition to include 11 broad categories of services. In our regulations at § 411.351, we define each of the 11 DHS categories, including ''radiology and certain other imaging services.'' In addition, we have clarified that the term ''designated health services'' excludes ''services that are reimbursed by Medicare as part of a composite rate (for example, ASC services or SNF Part A services)'' except to the extent that the DHS categories are themselves payable through a composite rate. In the definition of ''radiology and certain other imaging services'' at § 411.351, we exclude x-ray, fluoroscopy, or ultrasound procedures that require the insertion of a needle, catheter, tube, or probe through the skin or into a body orifice because we do not believe that a physician would inappropriately subject a Medicare patient to such a procedure. In addition, the definition of ''radiology and certain other imaging services'' excludes radiology services that are integral to the performance of a nonradiological medical procedure and performed during the nonradiological medical procedure or immediately following the nonradiological medical procedure when necessary to confirm placement of an item placed during the nonradiological medical procedure. Radiology and certain other imaging services performed *before* a nonradiological medical procedure are DHS subject to the physician self-referral prohibition.

Taken together, these provisions effectively exclude from the physician self-referral prohibition referrals for radiology services that are paid through the ASC composite payment rate, as well as any other radiology services that are integral to the performance of an ASC covered surgical procedure, that are paid separately, and that are performed in the ASC during the surgical procedure or immediately after the surgical procedure if required to confirm placement of an item placed during the nonradiological medical procedure. (For physician self-referral purposes, we have considered radiology services that are performed while the patient is still in the operating room to confirm that ASC surgery is effective to be performed during the surgical procedure.)

Through CY 2007, most radiology services performed as integral to ASC surgical procedures were either included in the ASC payment rate or were provided and billed by a separate entity. Effective beginning CY 2008, the revised ASC payment system will cover a greater variety of surgical procedures performed in an ASC and make separate payments (outside the ASC composite rate) for certain radiology services performed in an ASC that are integral to a covered surgical procedure and performed immediately before, during, or immediately after surgery. Consequently, under the revised ASC payment system, we expect that more radiology procedures would be performed in ASCs, and more of those services would be subject to the physician self-referral prohibition to the extent that those services are paid outside the ASC composite rate and are performed either immediately before an ASC procedure or during or immediately after an ASC procedure for a purpose other than to confirm placement of an item inserted during the ASC procedure.

We are proposing to revise the physician self-referral definition of ''radiology and certain other imaging services'' at § 411.351 to exclude those radiology and imaging services that are ''covered ancillary services'' (as defined at new § 416.164(b)) for which separate payment is made under the revised ASC payment system. That is, we propose that those radiology and imaging procedures that are integral to a covered ASC surgical procedure and that are performed immediately before, during, or immediately following the surgical procedure shall not constitute ''radiology and certain other imaging procedures'' for purposes of the physician self-referral law. If we do not revise the definition of radiology and certain other imaging services for physician self-referral purposes to exclude such radiological procedures, the physician self-referral law would prohibit an ASC from billing Medicare for such separately payable radiology services rendered to patients who had been referred by a physician with an ownership or investment interest in, or compensation relationship with, the ASC, unless an exception applies. Although there are a number of compensation exceptions that may be applicable, there are very few applicable ownership or investment exceptions. Thus, many physicians would not be able to refer Medicare patients to ASCs in which they have an ownership interest. We believe that this outcome would be burdensome to our beneficiaries and contrary to Medicare policies that support appropriate surgery in ASCs, and we further believe that our proposed revision to the definition of ''radiology and certain other imaging services'' would not pose a risk of program or patient abuse.

Under our proposal, the DHS category of ''radiology and certain other imaging services'' would continue to include those radiology and imaging services that are not paid for under the revised ASC payment system (that is, those radiology and imaging services that are ''excluded services'' as defined at new § 416.164(c)). For example, radiology and imaging services that are necessary for the performance of a covered surgical procedure, but are not integral to, a covered surgical procedure, such as preoperative studies not performed immediately before surgery, would be paid for under Part 414 of our regulations and would continue to be considered DHS.

For the reasons that we believe warrant our revising the definition of ''radiology and certain other imaging

services'' at § 411.351, we also propose to exclude from the definition of ''outpatient prescription drugs'' at § 411.351, drugs that are ''covered ancillary services'' as defined at new § 416.164(b) under the revised ASC payment system. These drugs are furnished, for example, during the immediate postoperative recovery period to a patient to reduce suffering from nausea or pain. Under the revised ASC payment system, an ASC would be permitted to furnish and bill separately for such outpatient prescription drugs, as appropriate. Under our proposal, such drugs would not constitute DHS. However, the physician self-referral provisions would continue to prohibit an ASC from furnishing outpatient prescription drugs for use in the patient's home.

For clarity, we would also make a technical correction to paragraph (2) of the definition of ''radiology and certain other imaging services'' at § 411.351. This paragraph currently excludes ''radiology procedures'' that are integral to the performance of a ''nonradiological procedure.'' We would revise paragraph (2) to exclude ''radiology and certain other imaging services'' that are integral to the performance of ''a medical procedure that is not identified on the List of CPT/HCPCS Codes as a 'radiology or certain other imaging service.' '' We would revise the language of paragraph (2) because we believe that, neither radiology services, nor certain other imaging services should constitute DHS if they are integral to the performance of a medical procedure that is neither a radiology service nor a certain other imaging service. We believe that this change would not result in any risk of program or patient abuse.

I. New Technology Intraocular Lenses

1. Background

At the inception of the ASC benefit on September 7, 1982, Medicare paid 80 percent of the reasonable charge for IOLs supplied for insertion concurrent with or following cataract surgery performed in an ASC (47 FR 34082, August 5, 1982). Section 4063(b) of OBRA 1987, Public Law 100–203, amended the Act to mandate that we include payment for an IOL furnished by an ASC for insertion during or following cataract surgery as part of the ASC facility fee for insertion of the IOL, and that the facility fee include payment that is reasonable and related to the cost of acquiring the class of lens involved in the procedure.

Section 4151(c)(3) of the Omnibus Budget Reconciliation Act of 1990 (OBRA 1990), Public Law 101–508, froze the IOL payment amount at $200 for IOLs furnished by ASCs in conjunction with surgery performed during the period beginning November 5, 1990 and ending December 31, 1992. We continued paying an IOL allowance of $200 from January 1, 1993, through December 31, 1993.

Section 13533 of the Omnibus Budget Reconciliation Act of 1993 (OBRA 1993), Public Law 103–66, mandated that payment for an IOL furnished by an ASC be equal to $150 beginning January 1, 1994, through December 31, 1998. Section 141(b)(1) of the Social Security Act Amendments of 1994 (SSAA 1994), Public Law 103 432, required us to develop and implement a process under which interested parties may request a review of the appropriateness of the payment amount for insertion of an IOL, to ensure that the facility fee for the procedure includes payment that is reasonable and related to the cost of acquiring a lens that belongs to a class of NTIOLs.

In the February 8, 1990 **Federal Register** (55 FR 4526), we published a final notice entitled ''Revision of Ambulatory Surgery Center Payment Rate Methodology,'' which implemented Medicare payment for an IOL furnished at an ASC as part of the ASC facility fee for insertion of the IOL. In the June 16, 1999 **Federal Register** (64 FR 32198), we published a final rule entitled ''Adjustment in Payment Amounts for New Technology Intraocular Lenses Furnished by Ambulatory Surgical Centers,'' to add Subpart F (§§ 416.180 through 416.200) to 42 CFR Part 416, which established a process for adjusting payment amounts for insertion of a class of NTIOLs furnished by ASCs.

Since June 16, 1999, we have issued a series of **Federal Register** notices to list lenses for which we received requests for an NTIOL payment adjustment and to solicit comments on those requests, or to announce the lenses that we have determined meet the criteria and definition of NTIOLs. We last published a **Federal Register** notice pertaining specifically to NTIOLs on April 28, 2006 (71 FR 25176).

2. Changes to the NTIOL Determination Process Finalized for CY 2008

In the CY 2007 OPPS/ASC final rule with comment period, we finalized our proposal to update and streamline the process for recognizing IOLs inserted during or subsequent to cataract extraction as belonging to a new, active NTIOL class that is qualified for a payment adjustment. The following is a summary of the changes beginning for CY 2008 that were finalized in the CY 2007 OPPS/ASC final rule with comment period (71 FR 68176 through 68181).

We modified the historical process of using separate **Federal Register** notices to notify the public of requests to review lenses for membership in new NTIOL classes, to solicit public comment on requests, and to notify the public of CMS' determinations concerning lenses assigned to classes of NTIOLs for which an ASC payment adjustment would be made. In the CY 2007 OPPS/ASC final rule with comment period (71 FR 68176), we specified that these NTIOL–related notifications would be fully integrated into the annual notice and comment rulemaking cycle for updating the ASC payment rates, the specific payment system in which NTIOL payment adjustments are made. Our final policy for updating the revised ASC payment system to be implemented in January 2008 will utilize an annual update process in coordination with notice and comment rulemaking for the OPPS. Aligning the NTIOL process with this annual update will promote coordination and efficiency, thereby streamlining and expediting the NTIOL notification, comment, and review process.

Specifically, we established the following process:

- We will announce annually in the **Federal Register** document that proposes the update of ASC payment rates for the following calendar year, a list of all requests to establish new NTIOL classes accepted for review during the calendar year in which the proposal is published and the deadline for submission of public comments regarding those requests. The deadline for receipt of public comments will be 30 days following publication of the list of requests.
- In the **Federal Register** document that finalizes the update of ASC payment rates for the following calendar year, we will—
  + Provide a list of determinations made as a result of our review of all requests and public comments; and
  + Publish the deadline for submitting requests for review in the following calendar year.

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. In the CY 2007 final rule, we finalized our proposal to base our determinations on consideration of the following factors:

• The IOL must have been approved by the FDA and claims of specific clinical benefits and/or lens characteristics with established clinical relevance in comparison with currently available IOLs must have been approved by the FDA for use in labeling and advertising.

• The IOL is not described by an active or expired NTIOL class; that is, it does not share the predominant, class-defining characteristic associated with improved clinical outcomes with designated members of an active or expired NTIOL class.

• Evidence 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 would be considered include the following:

+ Reduced risk of intraoperative or postoperative complication or trauma;

+ Accelerated postoperative recovery;

+ Reduced induced astigmatism;

+ Improved postoperative visual acuity;

+ More stable postoperative vision;

+ Other comparable clinical advantages, such as—

++ Reduced dependence on other eyewear (for example, spectacles, contact lenses, and reading glasses);

++ Decreased rate of subsequent diagnostic or therapeutic interventions, such as the need for YAG laser treatment;

++ Decreased incidence of subsequent IOL exchange;

++ Decreased blurred vision, glare, other quantifiable symptom or vision deficiency.

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://cms.hhs.gov/ASCPayment/05_NTIOLs.asp#TopOfPage.*

As 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 determination of a new NTIOL class. As appropriate, for each completed request for a candidate IOL that is received by the established deadline, one of the following determinations would be announced annually in the final rule updating the ASC payment rates for the next calendar year:

• The request for a payment adjustment is approved for the IOL for 5 full years as a member of a new NTIOL class described by a new HCPCS code.

• The request for a payment adjustment is approved for the IOL for the balance of time remaining as a member of an active NTIOL class.

• The request for a payment adjustment is not approved.

We also discussed our plan to summarize briefly in the final rule the evidence that was reviewed, the public comments, and the basis for our determinations. We established that when a new NTIOL class is created, we would identify the predominant characteristic of NTIOLs in that class that sets them apart from other IOLs (including those previously approved as members of other expired or active NTIOL classes) and is associated with improved clinical outcomes. The date of implementation of a payment adjustment in the case of approval of an IOL as a member of a new NTIOL class would be set prospectively as of 30 days after publication of the ASC payment update final rule, consistent with the statutory requirement. The date of implementation of a payment adjustment in the case of approval of a lens as a member of an active NTIOL class would be set prospectively as of the publication date of the ASC payment update final rule.

3. NTIOL Application Process for CY 2008 Payment Adjustment

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, in the winter of CY 2007 we posted the guidance document to the CMS Web site regarding such requests as described above. We did not receive any review requests by the deadline of April 1, 2007 in response to the announcement made in the CY 2007 OPPS/ASC final rule with comment period (71 FR 68181) soliciting CY 2008 requests for review of the appropriateness of the payment amount for new classes of NTIOLs furnished in ASCs.

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.hhs.gov/ASCPayment/05_NTIOLs.asp.*

This 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. CMS accepts 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 would complete the review of such a request within 90 days of receipt, and upon completion of our review, we would 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.

4. Classes of NTIOLs Approved for Payment Adjustment

Since implementation of the process for adjustment of payment amounts for NTIOLs that was established in the June 16, 1999 **Federal Register**, we have approved three classes of NTIOLs, as shown in the following table:

NTIOL category	HCPCS code	$50 approved for services furnished on or after	NTIOL characteristic	IOLs eligible for adjustment
1	Q1001	May 18, 2000, through May 18, 2005.	Multifocal	Allergan AMO Array Multifocal lens, model SA40N.

NTIOL category	HCPCS code	$50 approved for services furnished on or after	NTIOL characteristic	IOLs eligible for adjustment
2	Q1002	May 18, 2000, through May 18, 2005.	Reduction in Preexisting Astigmatism.	STAAR Surgical Elastic Ultraviolet-Absorbing Silicone Posterior Chamber IOL with Toric Optic, models AA4203T, AA4203TF, and AA4203TL.
3	Q1003	February 27, 2006, through February 26, 2011.	Reduced Spherical Aberration.	Advanced Medical Optics (AMO) Tecnis® IOL models Z9000, Z9001, Z9002, and ZA9003; Alcon Acrysof® IQ Model SN60WF; Bausch & Lomb Sofport AO models LI61AOV, and LI61AOV.

5. 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 will be made and how an NTIOL will be paid after expiration of the payment adjustment, as well as made minor editorial changes to § 416.200(d). For CY 2008, we are not proposing to revise the current payment adjustment amount, but we reiterate our intention, as stated in the CY 2007 final rule, to reevaluate whether or not the ASC payment rates established for cataract surgery with IOL insertion are appropriate when a lens determined to be an NTIOL is furnished after we have implemented the revised ASC payment system in CY 2008.

6. Proposed CY 2008 ASC Payment for Insertion of IOLs

In accordance with the final policies of the revised ASC payment system for CY 2008, payment for IOL insertion services will be established according to the standard payment methodology of the revised payment system, which applies the ASC budget neutrality adjustment to the OPPS conversion factor to calculate an ASC conversion factor that is then multiplied by the ASC payment weight for the surgical procedure to implant the IOL. CY 2008 ASC payment for the cost of a conventional lens will be packaged into the payment for the associated covered surgical procedure performed by the ASC. The proposed CY 2008 ASC payment rates for IOL insertion procedures are included in Table 66.

TABLE 66.—INSERTION OF IOL PROCEDURES AND THEIR PROPOSED CY 2008 ASC PAYMENT RATES

HCPCS code	Long descriptor	Proposed CY 2008 ASC payment
66983	Intracapsular cataract extraction with insertion of intraocular lens prosthesis (one stage procedure)	$980.43
66984	Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification).	980.43
66985	Insertion of intraocular lens prosthesis (secondary implant), not associated with concurrent cataract removal	870.18
66986	Exchange of intraocular lens	870.18

J. Proposed ASC Payment and Comment Indicators

In addition to the payment indicators that we introduced in the July 2007 final rule for the revised ASC payment system, we also are introducing comment indicators for the ASC payment system in this proposed rule. We created Addendum DD1 to define ASC payment indicators that we will use in Addenda AA and BB to provide payment information regarding covered surgical procedures and covered ancillary services, respectively, under the revised ASC payment system. Analogous to the OPPS payment status indicators that we define in Addendum D1 to the annual OPPS proposed and final rules, the ASC payment indicators in Addendum DD1 are intended to capture policy-relevant characteristics of HCPCS codes that may receive packaged or separate payment in ASCs, including: their ASC payment status prior to CY 2008; their designations as device-intensive; their designations as office-based and the corresponding ASC payment methodology; and their classifications as separately payable radiology services, brachytherapy sources, OPPS pass-through devices, corneal tissue acquisition services, drugs or biologicals, or NTIOLs.

We have also created new Addendum DD2 to this proposed rule that lists the ASC comment indicators. Like the comment indicators used in the OPPS, the ASC comment indicators to be used in Addenda AA and BB to the OPPS/ASC final rule with comment period will 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 would be accepted. The comment indicator ''NI'' will be used in the final rule to indicate new HCPCS codes for which the interim payment indicator assigned is subject to comment in the final rule.

The changes for CY 2008 that we are proposing to the payment indicators assigned to HCPCS codes for procedures and services in the July 2007 final rule for the revised ASC payment system are identified with a ''CH'' in Addenda AA and BB to this proposed rule and are subject to comment during the 60-day comment period provided for this proposed rule. ''CH'' will be used in Addenda AA and BB to the CY 2008 OPPS/ASC final rule with comment period to indicate that a new payment indicator (in comparison with that in the July 2007 final rule for the revised ASC payment system) has been assigned to an active HCPCS code in the current and next calendar year; that an active HCPCS code has been added to the list of procedures or services payable in ASCs; or that an active HCPCS code will be deleted at the end of the current calendar year. These ''CH'' comment indicators that will be published in the CY 2008 OPPS/ASC final rule with comment period will be provided to alert our readers that a change has been made since the July 2007 final rule for the revised ASC payment system, but do not indicate that the change is subject to comment. The full definitions for the comment indicators are provided in Addendum DD2 to this proposed rule.

K. ASC Policy and Payment Recommendations

The GAO published the statutorily mandated report entitled, ''Medicare: Payment for Ambulatory Surgical Centers Should Be Based on the Hospital Outpatient Payment System'' (GAO–07–86) on November 30, 2006. We considered the report's methodology, findings, and recommendations in the development of the July 2007 final rule for the revised ASC payment system. The GAO methodology, results, and recommendations are summarized below.

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

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

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

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

Based on its extensive analyses, the GAO determined that the APC groups in the OPPS accurately reflect the relative costs of the procedures performed in ASCs. The GAO's analysis of the cost ratios showed that the ASC-to-APC cost ratios were more tightly distributed around their median cost ratio than were the OPPS-to-APC cost ratios. The ASC-to-APC median cost ratio is a comparison of the median cost of each of the 20 surgical procedures with the highest ASC claims volume to the median cost of the APC group in which it would be placed under the OPPS, while the OPPS-to-APC cost ratio is a comparison of the median cost of each of those same procedures under the OPPS with the median cost of its assigned APC group. These patterns demonstrated that the APC groups reflect the relative costs of procedures performed by ASCs like they do for procedures performed in HOPDs and, therefore, that the APC groups could be used as the basis for an ASC payment system. The GAO determined, in fact, that there was less variation in the ASC setting between individual procedures' costs and the costs of their assigned APC groups than there is in the HOPD setting. It concluded that, as a group, the costs of procedures performed in ASCs have a relatively consistent relationship with the costs of the APC groups to which they are assigned under the OPPS. The GAO's analysis also found that procedures in the ASC setting had substantially lower costs than those same procedures in the HOPD. While ASC costs for individual procedures varied, in general, the median costs for procedures were lower in ASCs, relative to the median costs of their APC groups, than the median costs for the same procedures in the HOPD setting. The median cost ratio among all ASC procedures was 0.39 (0.84 when weighted by Medicare volume based on CY 2004 claims), whereas the median cost ratio among all OPPS procedures was 1.04.

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

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

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

L. Proposed Calculation of the ASC Conversion Factor and ASC Payment Rates

1. Overview

As discussed in section XVI.C. of this proposed rule, we finalized our policy to base ASC relative payment weights and payment rates under the revised ASC payment system on APC groups and relative payment weights established under the OPPS in the July 2007 final rule for the ASC revised payment system. In that rule, we made final our proposal to set the ASC relative payment weight for certain office-based surgical procedures so that the national unadjusted ASC payment rate does not exceed the MPFS unadjusted nonfacility PE RVU amount. Our final policy is to calculate ASC payment rates by multiplying the ASC relative payment weights by the ASC conversion factor. In the July 2007 final rule for the revised ASC payment system, our estimate of the CY 2008 budget neutral ASC conversion factor was $42.542. In this proposed rule, the proposed ASC conversion factor for CY 2008 is $41.400. This new estimate of the ASC conversion factor differs from the estimate in the July 2007 final rule for the revised ASC payment system for a number of reasons, including: (1) Use of the proposed OPPS relative payment weights for CY 2008; (2) use of the proposed MPFS nonfacility practice expense payment amounts for CY 2008; and (3) use of updated utilization data from CY 2006. Specific details regarding our final methodology for estimating the CY 2008 ASC conversion factor may be found in the July 2007 final rule for the revised ASC payment system.

We were not able to provide the final CY 2008 ASC conversion factor in the July 2007 final rule for the revised ASC payment system because the final CY 2008 conversion factor will be based on the final OPPS relative payment weights for CY 2008, the final MPFS nonfacility practice expense payment amounts for CY 2008, and updated and complete CY 2006 utilization data, all of which are unavailable at the time we are publishing the July 2007 final rule for the ASC revised payment system elsewhere in this issue of the **Federal Register**. In this proposed rule, we use the final methodology described in the July 2007 final rule for the revised ASC payment system to calculate the proposed CY 2008 ASC conversion factor and proposed ASC relative payment weights and rates that will be made final in the CY 2008 OPPS/ASC final rule with comment period.

2. Budget Neutrality Requirement

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

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

As discussed in the July 2007 final rule for the revised ASC payment system, the ASC conversion factor is

calculated so that estimated total Medicare payments under the revised ASC payment system would be budget neutral to estimated total Medicare payments under the current ASC payment system as required by the statute. That is, application of the ASC conversion factor is designed to result in aggregate expenditures under the revised ASC payment system in CY 2008 equal to aggregate expenditures that would have occurred in CY 2008 in the absence of the revised system, taking into consideration the cap on payments in CY 2007 as required under section 5103 of Pub. L. 109–171.

We note that we considered the term ''expenditures'' in the context of section 626(b) of the Pub. L. 108–173 budget neutrality requirement to mean expenditures from the Medicare Part B Trust Fund. We did not consider expenditures to include beneficiary coinsurance and copayments.

3. Calculation of the ASC Payment Rates for CY 2008

The following is a step-by-step illustration of the final budget neutrality adjustment calculation as finalized in the July 2007 final rule for the revised ASC payment system and as applied to updated data available for this proposed rule.

The final methodology for establishing budget neutrality under the revised ASC payment system takes into account a 4-year transition to full implementation of the revised payment rates and the effects of several assumptions regarding migration of services across ASCs, HOPDs, and physicians' offices. Payments during the 4-year transition to the fully implemented revised ASC payment rates will be based on a blend of the CY 2007 ASC payment rates and the revised ASC payment rates at 75/25 in CY 2008, 50/50 in CY 2009, and 25/75 in CY 2010, with payment at 100 percent of the revised ASC payment rates in 2011. The methodology assumes no net cost or savings to Medicare from the migration of existing ASC services among ASCs, HOPDs, and physicians' offices. It includes assumptions that 15 percent of physicians' office utilization for new ASC procedures, specifically those first added for ASC payment beginning in CY 2008, will migrate to ASCs over a 4-year period (3.75 percent each year) and that 25 percent of the new procedures' HOPD utilization will migrate over the first 2 years under the revised payment system (12.5 percent each year) and accounts for the Medicare costs and savings associated with that movement. A detailed explanation of the model may be found in section V.C. of the July 2007 final rule for the revised ASC payment system.

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

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

(a) We multiply the estimated CY 2008 HOPD utilization for each new ASC procedure by 0.125, consistent with our assumption that 25 percent of the HOPD utilization for new ASC procedures will migrate to the ASC over the first 2 years of the revised ASC payment system, only half of which would occur in CY 2008. In estimating HOPD utilization for CY 2008, we take into account the impact of the multiple procedure discount (as discussed in more detail in section V.C.3. the July 2007 final rule for the revised ASC payment system).

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

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

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

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

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

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

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

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

(a) We multiply the estimated CY 2008 ASC utilization for each HCPCS code on the CY 2007 ASC list by the estimated CY 2008 ASC payment rate for the HCPCS code under the existing ASC payment system, and then subtract beneficiary coinsurance for the procedure. The estimated CY 2008 ASC payment rates are based on the CY 2007 ASC payment rates, which were listed in Addendum AA to the CY 2007 OPPS/ASC final rule with comment period (71 FR 68243 through 68283) and take into account the OPPS cap on payment for ASC services as required by section 5103 of Pub. L. 109–171 and reflect the zero percent CY 2008 update for ASC services mandated by section 1833(i)(2)(C) of the Act. In estimating ASC utilization for CY 2008, we take into account the impact of the multiple procedure discount (as discussed in section V.C.3. of the July 2007 final rule for the revised ASC payment system).

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

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

Step 4: Sum the results of Steps 1–3.

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

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

This step is the same as Step 1, above.

Step 6: We identify new ASC procedures that are office-based (as discussed in section III.C. of the July 2007 final rule for the revised ASC payment system).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

c. Calculation of the Proposed CY 2008 Budget Neutrality Adjustment

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

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

The application of the above methodology to the data available for this proposed rule results in an estimated budget neutrality adjustment of 0.65. This number differs from the estimated budget neutrality adjustment of 0.67 for the July 2007 final rule for the revised ASC payment system that was based on CY 2005 utilization and CY 2007 OPPS and MPFS payment rates. The proposed budget neutrality adjustment for CY 2008 reflects updated data, including CY 2006 utilization and proposed CY 2008 OPPS and MPFS payment rates. The CY 2008 budget neutrality adjustment for the revised ASC payment system, calculated based on the methodology outlined above, will be finalized in the CY 2008 OPPS/ASC final rule with comment period.

d. Calculation of the Proposed CY 2008 ASC Payment Rates

After developing the proposed CY 2008 budget neutrality adjustment of 0.65 according to the policies established in the July 2007 final rule for the revised ASC payment system, to determine the proposed CY 2008 ASC conversion factor, we multiplied the proposed CY 2008 OPPS conversion factor by the proposed ASC budget neutrality adjustment. The proposed CY 2008 OPPS conversion factor is $63.693 and multiplying that by the 0.65 budget neutrality adjustment yields our proposed CY 2008 ASC conversion factor of $41.400. To determine the proposed fully implemented ASC payment rates for this proposed rule, including beneficiary coinsurance, according to the final payment methodology that applies to covered surgical procedures and covered ancillary radiology services under the revised ASC payment system, we multiplied the proposed ASC conversion factor by the proposed ASC relative payment weight for each procedure or service. As further discussed in section XVI.C. of this proposed rule, the ASC relative payment weights for certain office-based surgical procedures and covered ancillary radiology services are set so that the national unadjusted ASC payment rate does not exceed the MPFS unadjusted nonfacility practice expense amount. In addition, the ASC relative payment weights for device-intensive covered surgical procedures are set according to a modified payment methodology to ensure the same device payment under the revised ASC payment system as under the OPPS. We then calculated the proposed CY 2008 payment rate for procedures on the CY 2007 ASC list of covered surgical procedures using a blend of 75 percent of the final CY 2007 ASC payment rate and 25 percent of the proposed CY 2008 ASC payment rate developed according to the methodology of the revised ASC payment system, applying the special transition treatment to device-intensive procedures as discussed in section XVI.C of this proposed rule. See Addenda AA and BB to this proposed rule for the proposed CY 2008 ASC payment weights and payment rates for covered surgical procedures and covered ancillary services that are expected to be paid separately under the CY 2008 revised ASC payment system.

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

a. Updating the ASC Relative Payment Weights

In the July 2007 final rule for the revised ASC payment system, we finalized our policy to update the ASC relative payment weights in the revised ASC payment system each year using the national OPPS relative payment weights (and MPFS nonfacility PE RVU amounts, as applicable) for that same calendar year and to uniformly scale the ASC relative payment weights for each update year to make them budget neutral. For example, holding ASC utilization and the mix of services constant, for CY 2009, we will compare the total weight using the CY 2008 ASC relative payment weights under the 75/25 blend (of the CY 2007 payment rate and the revised payment rate) with the total weight using CY 2009 relative payment weights under the 50/50 blend (of the CY 2007 payment rate and the revised payment rate), taking into account the changes in the OPPS relative payment weights between CY 2008 and CY 2009. We will use the ratio of CY 2008 to CY 2009 total weight to scale the ASC relative payment weights for CY 2009. Scaling of ASC relative payment weights would apply to covered surgical procedures and covered ancillary radiology services whose payment rates are related to OPPS relative payment weights. Scaling would not apply in the case of ASC payment for other separately payable

covered ancillary services that have a predetermined national payment amount (that is, their national payment amounts are not based on OPPS relative payment weights) such as drugs and biologicals that are separately paid under the OPPS. Any service with a predetermined national payment amount would be included in the budget neutrality comparison, but scaling of the relative payment weights would not apply to those services that have a predetermined payment amount. The ASC payment weights for those services without predetermined national payment amounts (that is, their national payment amounts would be based on OPPS relative payment weights if a payment limitation did not apply) would be scaled to eliminate any difference in the total payment weight between the current year and the update year. As we noted in the July 2007 final rule for the revised ASC payment system, while we do not currently have a provider-level dataset of ASC utilization that accurately identifies unique ASCs and their geographic information that would allow us to compare changes in geographic adjustment over time for budget neutrality purposes, we intend to take these changes into account in maintaining budget neutrality for the revised ASC payment system as soon as our provider-level ASC data permit.

b. Updating the ASC Conversion Factor

Section 1833(i)(2)(C) of the Act requires that, if the Secretary has not updated the ASC payment amounts in a calendar year after CY 2009, the payment amounts shall be increased by the percentage increase in the CPI-U as estimated by the Secretary for the 12-month period ending with the midpoint of the year involved. Therefore, as discussed in the July 2007 final rule for the ASC revised payment system, we adopted a final policy to update the ASC conversion factor using the CPI-U in order to adjust ASC payment rates for inflation. We will implement the annual updates through an adjustment to the conversion factor under the revised ASC payment system, beginning in CY 2010 when the statutory requirement for a zero update no longer applies.

XVII. Reporting Quality Data for Annual Payment Rate Updates

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

A. Background

1. Reporting Hospital Outpatient Quality Data for Annual Payment Update

Section 109(a) of the MIEA–TRHCA (Pub. L. 109–432) amended section 1833(t) of the Act by adding a new subsection (17) that affects the payment rate update applicable to OPPS payments for services furnished by hospitals in outpatient settings on or after January 1, 2009. New 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 section 1833(t)(17)(B) of the Act will incur a reduction in their annual payment update factor by 2.0 percentage points. New 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. New sections 1833(t)(17)(C)(i) and (ii) of the Act require the Secretary to develop measures appropriate for the measurement of the quality of care (including medication errors) furnished by hospitals in outpatient settings and that these measures reflect consensus among affected parties and, to the extent feasible and practicable, include measures set forth by one or more national consensus building entities. The Secretary is not prevented from selecting 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 for the IPPS Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) program. New 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. New section 1833(t)(17)(E) of the Act, requires the Secretary to establish procedures for making data submitted available to the public. Such procedures must give hospitals the opportunity to review data before these data are released.

In the CY 2007 OPPS/ASC final rule with comment period (71 FR 68189), we indicated our intent to establish, in CY 2009, an OPPS RHQDAPU program modeled after the current IPPS RHQDAPU program in CY 2009. We stated our belief that the quality of hospital outpatient services would be most appropriately and fairly rewarded through the reporting of quality measures developed specifically for application in the hospital outpatient setting. We agreed with the commenters that assessment of hospital outpatient performance would ultimately be most appropriately based on reporting of hospital outpatient measures developed specifically for this purpose. We stated our intent to condition the full OPPS payment rate update beginning in CY 2009 based upon hospital reporting of quality data beginning in CY 2008, using effective measures of the quality of hospital outpatient care that have been carefully developed and evaluated, and endorsed as appropriate, with significant input from stakeholders.

The amendments to the Act made by section 109(a) of the MIEA–TRHCA are consistent with our intent and direction outlined in the CY 2007 OPPS/ASC final rule with comment period. Under these amendments, we are now statutorily required to establish a program under which hospitals will report data on the quality of hospital outpatient care using standardized measures of care to receive the full annual update to the OPPS payment rate, effective for payments beginning in CY 2009. We will refer to the program established under these amendments as the Hospital Outpatient Quality Data Reporting Program (HOP QDRP).

In reviewing the measures currently available for care in the hospital outpatient settings, we continue to believe that it would be most appropriate and desirable to use measures that have been specifically developed for application in the hospital outpatient setting. Although we still believe that hospitals generally function as integrated systems in inpatient and outpatient settings, we do not believe it is appropriate to use participation in the IPPS RHQDAPU program for the purpose of implementing section 1833(t)(17) of the Act in the hospital outpatient setting. Nonetheless, section 1833(t)(17)(C)(ii) of the Act indicates that the Secretary is not prevented ''from selecting measures that are the same as (or a subset of) the measures for which data are required to be submitted'' under the IPPS RHQDAPU program. In this proposed rule, we are proposing to establish a separate reporting program and proposing quality measures that are appropriate for measuring hospital outpatient quality of care, that reflect consensus among affected parties, and are set forth by one or more of the national consensus building entities.

2. Reporting ASC Quality Data for Annual Payment Increase

Section 109(b) of the MIEA–TRHCA, Pub. L. 109–432 amended section 1833(i) of the Act by adding new sections 1833(i)(2)(D)(iv) and 1833(i)(7) to the Act. These amendments may affect ASC payments for services furnished in ASC settings on or after January 1, 2009. New section 1833(i)(2)(D)(iv) of the Act authorizes the Secretary to implement the revised payment system for services furnished in ASCs (established under section 1833(i)(2)(D) of the Act), ''so as to provide for a reduction in any annual payment increase for failure to report on quality measures.''

New section 1833(i)(7)(A) of the Act authorizes the Secretary to 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 new section 1833(i)(7) of the Act will incur a reduction in any annual payment increase of 2.0 percentage points. New section 1833(i)(7)(A) of the Act also specifies that a reduction for one year cannot be taken into account in computing the ASC update for a subsequent year.

New section 1833(i)(7)(B) of the Act provides that, ''except as the Secretary may otherwise provide,'' the hospital outpatient quality data provisions of section 1833(t)(17)(B) through (E) of the Act, summarized above, shall apply to ASCs.

We refer readers to section XVII.H. of this proposed rule for a discussion of our intent to introduce implementation of this provision in a later rulemaking.

B. Proposed Hospital Outpatient Measures

For the initial implementation of the HOP QDRP, we have identified 10 quality measures that we believe are both applicable to care provided in hospital outpatient settings and likely to be sufficiently developed to permit data collection consistent with the timeframes defined by statute. 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 hospitals.

The first five of these measures capture the quality of outpatient care in hospital emergency departments (EDs), specifically for those adult patients with acute myocardial infarction (AMI) who are treated and then transferred to another facility for further care. These patients receive many of the same interventions as patients who are evaluated and admitted at the same facility, whose care is currently assessed in measures that are endorsed by the National Quality Forum (NQF). NQF is a voluntary consensus standard-setting organization established to standardize health care quality measurement and reporting through its consensus development process. Moreover, these are also inpatient AMI measures that have long been reported under the IPPS RHQDAPU program, and are published on the Hospital Compare Web site at: *http://www.HospitalCompare.hhs.gov.* Transferred AMI patients historically have not been included with the directly-admitted patients for purposes of the calculation of the inpatient AMI measures because of differences in data collection and reporting for the two groups. With the input of provider and practitioner experts in the field, we have developed specifications for related emergency department transfer measures that, while consistent with the measure specifications for the related hospital inpatient measures, reflect the unique operational and clinical aspects of care in hospital outpatient settings. The processes of care encompassed by these measures address care on arrival, the promptness of interventions, and discharge care for patients presenting to a hospital with an AMI.

In addition to the five ED–AMI measures, we have identified five quality measures that are directly related to conditions treated or interventions provided in hospital outpatient settings and that we believe are also appropriate and fully developed for use in the HOP QDRP. While currently specified in a form that assesses the care provided by physicians, these measures are also directly relevant to assessing care at the facility level. CMS is currently engaged in reviewing, and where appropriate, revising these measure specifications so that they explicitly assess care provided in hospital outpatient settings. The five measures include one measure related to treatment of heart failure, two measures related to surgical care improvement, one measure addressing treatment of community acquired pneumonia, and one measure related to diabetes care.

Specifically, in order for hospitals to receive the full OPPS payment update for services furnished in CY 2009, we are proposing to require that hospital outpatient settings submit data on the following 10 measures, effective with hospital outpatient services furnished on or after January 1, 2008:

- ED–AMI–1—Aspirin at Arrival
- ED–AMI–2—Median Time to Fibrinolysis
- ED–AMI–3—Fibrinolytic Therapy Received Within 30 Minutes of Arrival
- ED–AMI–4—Median Time to Electrocardiogram (ECG)
- ED–AMI–5—Median Time to Transfer for Primary PCI
- PQRI #5: Heart Failure: Angiotensin-Converting Enzyme (ACE) Inhibitor or
- Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)
- PQRI #20 Perioperative Care: Timing of Antibiotic Prophylaxis
- PQRI #21 Perioperative Care: Selection of Prophylactic Antibiotic
- PQRI #59: Empiric Antibiotic for Community-Acquired Pneumonia
- PQRI #1: Hemoglobin A1c Poor Control in Type 1 or 2 Diabetes Mellitus

As required by statute, consensus was reached by affected parties, as the measures were identified as appropriate for reporting on hospital outpatient care in collaboration with professionals and providers with experience in hospital outpatient settings as well as with the Hospital Quality Alliance (HQA), a hospital-industry led, public-private collaboration established to promote public reporting on hospital quality of care. CMS is currently finalizing the specifications for these 10 measures and expects to release these specifications to the public by Fall 2007. In addition, CMS expects to submit these measures for endorsement by the NQF.

Nine of the ten measures are process measures, while one measure—Hemoglobin A1c >9.0 percent—is an intermediate outcome measure that has not been risk-adjusted. While poor quality of care can lead to poor diabetes control and elevated A1c levels, CMS recognizes the importance of compliance with prescribed treatment regimen in improving diabetes control and A1c levels. Patients with comorbidities or diabetes complications may experience challenges controlling their diabetes and may have higher A1c levels. Therefore, CMS specifically requests comments on this intermediate outcome measure and how to balance the desire for improved quality of care with individual patient challenges that may affect results.

CMS believes that an A1c level higher than 9.0 percent represents a level of control that is sufficiently poor enough that it should not result in any unintended consequences. The scientific literature would suggest that an A1c level of 8.0 percent or less might represent the best control that could be expected for some patients: therefore, CMS believes that an A1c level of > 9.0

percent represents a level of control that is poor enough that risk-adjustment is not warranted. Additionally, this A1c measure has been endorsed by the National Quality Forum (NQF) in 2006. One of the criteria for evaluation of measures within the NQF process is ''scientific acceptability,'' which includes appropriate risk-adjustment. Some measures are not endorsed by NQF if risk-adjustment is determined to be appropriate and is found to be inadequate. CMS believes that additional risk-adjustment is not necessary because the NQF endorsed this measure. We invite public comment on our rationale for choosing a diabetes outcome measures.

C. Other Proposed Hospital Outpatient Measures

In addition to the 10 measures identified above, we are considering a number of other possible quality measures for use in assessing the care of services provided by hospital outpatient settings, for the determination of CY 2010 or subsequent calendar year payments. These measures are, for the most part, either currently in use or were developed for use in settings other than hospital outpatient. However, we believe that these measures are applicable to the hospital outpatient settings.

These measures have not received formal review by either the HQA or the NQF as measures of HOP performance. As noted in the chart, however, the inpatient or ambulatory versions of these measures have all been either recommended by an NQF-subgroup for endorsement, are pending endorsement by the NQF, or are currently endorsed by the NQF. The measures present the diversity of services and clinical topics provided to adult patients in hospital outpatient settings. The measures address some aspects of care provided to cancer patients, patients presenting with diabetes, pneumonia, chest pains, syncope, or depression, and patients receiving services related to bones, eyes, and problems associated with aging. While some of the measures relate to acute care provided in a hospital outpatient setting, others assess care that a hospital outpatient clinic might provide on an ongoing basis. We are interested in receiving comments from the public concerning all dimensions of these measures.

We expect that once the HOP QDRP is established, we will expand the set of measures on which hospital outpatient settings must report data. We are interested in receiving comments concerning the relative priority that should be assigned to each of the measures or topics identified in the list below, as well as any additional measures, measure sets, or topics that should be developed for future reporting.

We would like to note that, while we are committed to identifying measures that are relevant to care in hospital outpatient settings, it is also our intent to develop, where feasible, hospital outpatient measures that are ''harmonized'' with measures for assessing comparable inpatient and ambulatory care—that is, measures that are similar in both the care that is assessed and the manner in which data are collected, regardless of the setting. The goal of harmonization is to assure that comparable care in different care settings can be evaluated in similar ways, which further assures that quality measurement and improvement can focus more on the needs of a patient with a particular condition than on the specific program or policy attributes of the setting at which the care is provided.

Therefore, we are seeking public comment on the following 30 additional measures, which have been identified as hospital outpatient-appropriate measures and are under consideration for inclusion in the HOP QDRP measure set, for CY 2010 or subsequent calendar years:

Measure	NQF endorsed for inpatient or ambulatory setting	Description
1 PQRI #2 Low Density Lipoprotein Control in Type 1 or 2 Diabetes Mellitus.	Endorsed 2006	Percentage of patients aged 18–75 years with diabetes (type 1 or type 2) who had most recent LDL–C level in control (less than 100 mg/dl).
2 PQRI #3 High Blood Pressure Control in Type 1 or 2 Diabetes Mellitus.	Endorsed 2006	Percentage of patients aged 18–75 years with diabetes (type 1 or type 2) who had most recent blood pressure in control (less than 140/80 mm Hg).
3 PQRI #4 Screening for Fall Risk.	2 year Endorsement until May 8, 2009.	Percentage of patients aged 65 years and older who were screened for fall risk (2 or more falls in the past year or any fall with injury in the past year) at least once within 12 months.
4 PQRI #9 Antidepressant Medication During Acute Phase for Patient with New Episode of Major Depression.	Endorsed 2006	Percentage of patients aged 18 years and older diagnosed with new episode of major depressive disorder (MDD) and documented as treated with antidepressant medication during the entire 84-day (12 week) acute treatment phase.
5 PQRI #10 Stroke and Stroke Rehabilitation: Computed Tomography (CT) or Magnetic Resonance Imaging (MRI) Reports.	2 year Endorsement until May 8, 2009.	Percentage of patients aged 18 years and older with a diagnosis of ischemic stroke or transient ischemic attack (TIA) or intracranial hemorrhage undergoing CT or MRI of the brain within 24 hours of arrival to the hospital whose final report of the CT or MRI includes documentation of the presence or absence of each of the following: hemorrhage and mass lesion and acute infarction.
6 PQRI #11 Stroke and Stroke Rehabilitation: Carotid Imaging Reports.	2 year Endorsement until May 8, 2009.	Percentage of patients aged 18 years and older with a diagnosis of ischemic stroke or transient ischemic attack (TIA) whose final reports of the carotid imaging studies performed, with characterization of internal carotid stenosis in the 30–99% range, include reference to measurements of distal internal carotid diameter as the denominator for stenosis measurement.
7 PQRI #24 Osteoporosis: Communication with the Physician Managing Ongoing Care Post Fracture.	2 year Endorsement until May 8, 2009.	Percentage of patients aged 50 years and older treated for a hip, spine or distal radial fracture with documentation of communication with the physician managing the patient's ongoing care that a fracture occurred and that the patient was or should be tested or treated for osteoporosis.

Measure	NQF endorsed for inpatient or ambulatory setting	Description
8 PQRI #46 Medication Reconciliation.	2 year Endorsement until May 8, 2009.	Percentage of patients aged 65 years and older discharged from any inpatient facility (e.g., hospital skilled nursing facility, or rehabilitation facility) and seen within 60 days following discharge in the office by the physician providing on-going care who had a reconciliation of the discharge medications with the current medication list in the medical record documented.
9 PQRI #53 Asthma Pharmacological Therapy.	Endorsed 2006	Percentage of patients aged 5 to 40 with a diagnosis of mild, moderate, or severe persistent asthma who were prescribed either the preferred long-term control medication (inhaled corticosteroid) or an acceptable alternative treatment.
10 PQRI #58 Assessment of Mental Status for Community-acquired Pneumonia.	2 year Endorsement until May 8, 2009.	Percentage of patients aged 18 years and older with a diagnosis of community-acquired bacterial pneumonia with mental status assessed.
11 Radiation therapy is administered within 1 year of diagnosis for women under age 70 receiving breast conserving surgery for breast cancer.	Endorsed May 9, 2007	Radiation therapy to the breast initiated within 1 year of date of diagnosis.
12 Adjuvant chemotherapy is considered or administered within 4 months of surgery to patients under the age of 80 with AJCC III (lymph node positive) colon cancer.	Endorsed May 9, 2007	Consideration or administration of chemotherapy initiated within 4 months of date of diagnosis.
13 Adjuvant hormonal therapy	Endorsed May 9, 2007	Cancer—Breast—consideration or administration of accompanying hormonal therapy for treatment of breast cancer.
14 Needle biopsy to establish diagnosis of cancer precedes surgical excision/resection.	Endorsed May 9, 2007	Patient whose date of needle biopsy precedes the date of surgery.
15 Osteo–02: Screening or Therapy for Women Aged 65 years and Older.	2 year Endorsement until May 8, 2009.	Bone and joint conditions (osteoporosis)—Screening or therapy for women aged 65 years and older.
16 Osteo–03: Management following fracture.	2 year Endorsement until May 8, 2009.	Bone and joint conditions (osteoporosis)—Management following fracture.
17 Osteo–04: Pharmacologic Therapy.	2 year Endorsement until May 8, 2009.	Bone and joint conditions (osteoporosis)—Pharmacologic therapy.
18 EC–01: Electrocardiogram (ECG) for Patients with Non-Traumatic Chest Pain.	2 year Endorsement until May 8, 2009.	Percentage of patients aged 40 years and older with an emergency department discharge diagnosis of nontraumatic chest pain who had an electrocardiogram (ECG).
19 EC–03: ECG Performed for Patients with Syncope.	2 year Endorsement until May 8, 2009.	Percentage of patients aged 18 to 60 years with an emergency department discharge diagnosis of syncope who had an ECG performed.
20 EC–04: Vital Signs Recorded and Reviewed for Patients with Community-Acquired Bacterial Pneumonia.	2 year Endorsement until May 8, 2009.	Percentage of patients aged 18 years and older with a diagnosis of community-acquired bacterial pneumonia with vital signs recorded and reviewed.
21 Eye–01: Primary Open Angle Glaucoma—Optic Nerve Evaluation.	2 year Endorsement until May 8, 2009.	Primary open angle glaucoma—optic nerve evaluation.
22 Eye–02: Age-Related Macular Degeneration—Antioxidant Supplement Prescribed/Recommended.	Recommended for Endorsement	Age-related macular degeneration—antioxidant supplement prescribed/recommended.
23 Eye–03: Age-Related Macular Degeneration—Dilated Macular Examination.	2 year Endorsement until May 8, 2009.	Age-related macular degeneration—dilated macular examination.
24 Eye–07: Diabetic Retinopathy—Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy.	2 year Endorsement until May 8, 2009.	Documentation of presence or absence of macular edema and level of severity of retinopathy.
25 EYE–08: Diabetic Retinopathy—Communication with the Physician Managing Ongoing Diabetes Care.	2 year Endorsement until May 8, 2009.	Communication with the physician managing ongoing diabetes care.
26 GI–09: Colonoscopy for Polyp Surveillance—Description of Polyp Characteristics.	Recommended for Endorsement	Colonoscopy for polyp surveillance—description of polyp characteristics.
27 GER–02: Advance Care Plan	Recommended for Endorsement	Advance care plan.

Measure	NQF endorsed for inpatient or ambulatory setting	Description
28 GER–03: Urinary Incontinence—Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older.	2 year Endorsement until May 8, 2009.	Assessment of presence or absence of urinary incontinence in women aged 65 years and older.
29 GER–04: Urinary Incontinence—Characterization of Urinary Incontinence in Women Aged 65 Years and Older.	2 year Endorsement until May 8, 2009.	Characterization of urinary incontinence in women aged 65 years and older.
30 GER–05: Urinary Incontinence—Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older.	2 year Endorsement until May 8, 2009.	Plan of care for urinary incontinence in women aged 65 years and older.

While we are soliciting comments on these 30 additional measures for inclusion in the HOP QDRP for CY 2010 or subsequent calendar years, we also welcome comments on whether any of these additional measures should be included effective for services furnished on or after January 1, 2008 for the CY 2009 update.

D. Proposed Implementation of the HOP QDRP

For purposes of CY 2009 payments, we would require hospitals to begin to submit data on the 10 measures that we have identified under section XVII.B. of this proposed rule. While we would expect to focus on these 10 measures and will consider comments on them for the CY 2009 payment year, we will also consider the comments received from the public on the list of 30 additional measures cited above in developing the final lists of measures for future payment years.

As with the hemoglobin A1c diabetes intermediate outcome measure described in XVII.B of this preamble, we invite public comment on the two diabetes intermediate outcome measures proposed in this list of 30 additional measures—i.e., good control of blood pressure (less than 140/80 mm Hg) and LDL–C levels (less than 100 mg/dl). We invite comment on whether the use of these outcome measures will result in unintended consequences.

As described below, procedures for submission of hospital outpatient quality information will mirror as closely as possible all procedures for submission of inpatient quality information. The inpatient procedures are identified on the QualityNet Web site, at *http://www.qualitynet.org.* As required by new section 1833(t)(17)(E) of the Act, we will develop procedures to publicly report the measure results obtained under the HOP QDRP. Hospitals will have an opportunity to review the information that is to be made available to the public prior to its being made public.

We believe that assuring that Medicare beneficiaries receive the care they need and that such services are of appropriately high quality are the necessary initial steps to the incorporation of value-based purchasing into the OPPS. We seek to encourage care that is both efficient and of high quality in the hospital outpatient setting. We plan to work quickly and collaboratively with the hospital community to develop and implement quality measures for the OPPS that are fully and specifically reflective of the quality of hospital outpatient services.

We welcome the suggestion of other additional measures and topics relevant to the hospital outpatient setting for future development of the measure set, particularly measures from other settings (such as hospital inpatient, physician office, and emergency care settings) that would contribute to better coordination and harmonization of high quality patient care.

E. Proposed Requirements for HOP Quality Data Reporting for CY 2009 and Subsequent Calendar Years

To participate in the HOP QDRP for CY 2009 and subsequent calendar years, hospitals must meet administrative, data collection and submission, and data validation requirements. Hospitals not participating in the program or that withdraw from the program will not receive the full OPPS payment rate update. Instead, in accordance with the law, those hospitals would receive a reduction of 2.0 percentage points in their updates for the affected payment year.

Hospitals not meeting the requirements of the HOP QDRP also will not receive the full OPPS payment rate update. Instead, in accordance with the law, those hospitals also would receive a reduction of 2.0 percentage points in their payment update factor for the affected payment year.

Proposed requirements for participation in the HOP QDRP are:

1. Administrative Requirements

To participate in the HOP QDRP, the hospital must complete several administrative steps. These steps, as in the current IPPS RHQDAPU program, require the hospital to:

- Identify a QualityNet Exchange administrator who follows the registration process and submits the information through the CMS-designated contractor. The same person may be the QualityNet Exchange administrator for both the IPPS RHQDAPU program and the HOP QDRP. This designation must be kept current and must be done, regardless of whether the hospital submits data directly to the CMS designated contractor or uses a vendor for transmission of data.
- Register with the QualityNet Exchange, regardless of the method used for data submission.
- Complete the Notice of Participation form. All hospitals must send the form to a CMS-designated contractor no later than November 15, 2007 for the CY 2009 HOP QDRP. At this time, the participation form for the HOP QDRP is separate from the IPPS RHQDAPU program and completing a submission form for each program is required. Agreeing to participate includes acknowledging that the data submitted to the CMS designated contractor will be submitted to CMS and may be shared with a CMS contractor or contractors supporting the implementation of this program.

Hospitals not wishing to participate must submit a nonparticipation form. Hospitals that have completed a notice of participation form and subsequently wish to stop participating must submit a withdrawal form.

To reduce the burden on hospitals, once a hospital has indicated its intent to participate or not participate, we will consider the hospital to be in that status (either a participant or nonparticipant) until the hospital indicates a change in status by submitting a notice of participation or a withdrawal form.

2. Data Collection and Submission Requirements

We are proposing that, to be eligible for the full OPPS payment update in CY 2009 and subsequent years, hospitals must:

• Collect data required for the finalized set of measures, beginning with the specifications of the finalized set of measures that will be identified in the CY 2008 OPPS/ASC final rule (for payment updates for CY 2009 services) and that will be published and maintained in a specifications manual to be found on the Web site at: *http://www.qualitynet.org.*

• Submit the data according to a data submission schedule that will be available on the QualityNet Exchange Web site. We propose to have HOP data submitted through the QualityNet Exchange secure Web site (*https://www.qnetexchange.org*). This Web site meets or exceeds all current Health Insurance Portability and Accountability Act requirements. The submission deadline for January 2008 discharges will be May 31, 2008. Except for January 2008 discharges, submission deadlines will be 4 months after the last day of the calendar quarter. Data must be submitted to the CMS designated contractor using either the CMS Abstraction and Reporting Tool for Outpatient Department measures (CART–OPD) or another third-party vendor that has a tool which has met the measure specification requirements for data transmission to the QualityNet Exchange.

Hospitals must submit quality data through the CMS contractor's secure Web site. We will provide more detailed information about the Web site in the CY 2008 OPPS/ASC final rule, as we anticipate awarding the contract to design and manage the OPPS Clinical Warehouse before that final CY 2008 OPPS/ASC final rule is published. We expect the CMS contractor's Web site to meet or exceed all current Health Insurance Portability and Accountability Act requirements for security of personal health information.

The OPPS Clinical Warehouse will submit the data to CMS on behalf of the hospitals. While the CMS contract for managing the OPPS Clinical Warehouse was not awarded prior to publishing this proposed rule, it is possible that a QIO contractor (or subcontractor) would manage the OPPS Clinical Warehouse. Because the information in the OPPS Clinical Warehouse also may be considered QIO information, it may be subject to the stringent QIO confidentiality regulations in 42 CFR part 480.

For purposes of the CY 2009 annual payment update, we are proposing to require hospitals to submit data, for the finalized set of measures, beginning with services furnished on or after January 1, 2008. The deadline for submission of data for January 2008 discharges will be 4 months from the last day of the month, May 31, 2008. The deadline for submission for February–March 2008 discharges would be August 1, 2008. Thereafter, participating hospitals would be required to submit quarterly data on finalized measures 4 months from the last day of the calendar quarter for as long as the hospitals participated in the HOP QDRP. The deadline for April-June 2008 discharges, for example, would be November 1, 2009.

Hospitals will be expected to submit data under the HOP QDRP on 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 will be made to assure that data elements common to both inpatient and outpatient settings are defined consistently (such as ''time of arrival''). However, HOP QDRP quality data, not quality data required to be submitted for a patient treated under the IPPS RHQDAPU program, would be submitted under the HOP QDRP.

To be accepted by the CMS designated contractor, submissions would, at a minimum, need to be accurate, timely, and complete. Data are considered to have been ''accepted'' by the CMS designated contractor, for purposes of determining eligibility for the full payment rate update, only when data are submitted prior to the reporting deadline and after they have passed all CMS designated contractor edits.

• Submit complete and accurate data. A ''complete'' submission is determined based on sampling criteria that will be published and maintained in a specifications manual to be found on the Web site at *http://www.qualitynet.org,* and must correspond to both the aggregate number of cases submitted by a hospital and the number of Medicare claims it submits for payment. To be considered ''accurate'', submissions must pass validation.

• Submit the aggregate numbers of outpatient episodes of care which were eligible for submission under the HOP QRDP. These numbers would indicate the number of outpatient episodes of care in the universe to which sampling criteria are applied.

New hospitals are expected to begin reporting data as soon as possible, but no later than beginning with services provided the first day of the calendar quarter immediately following a hospital's receipt of its Medicare provider number and the hospital's timely completion of the administrative requirements for participating in the HOP QDRP.

3. HOP QDRP Validation Requirements

We would require that data submitted under this program meet validation requirements. The proposed validation requirements are similar to FY 2006 IPPS RHQDAPU program validation requirement (the initial year validation requirement was added to the IPPS RHQDAPU program) and include independent reabstraction of medical record data elements by a clinical data abstraction center (CDAC). The CMS contractor will randomly select 5 medical records from all January 2008 discharge cases successfully submitted to the OPPS Clinical Warehouse. The CDAC will mail requests to the hospitals to send the selected medical records to the CDAC within 30 calendar days. The CDAC will independently reabstract the medical record data elements. We will provide abstraction feedback to all hospitals on abstracted data elements.

We are proposing the following chart audit validation requirements for full CY 2009 payment updates:

• Apply to January 2008 discharges only.

• Require submission of 5 charts sampled from each hospital.

• Establish a passing threshold of 80 percent reliability reflecting the accuracy of submitted data elements used to calculate quality measures.

• Use an upper bound of 95 percent confidence interval to measure accuracy.

• Incorporate clustering of variability at the chart level into the confidence interval.

Validation is intended to provide some assurance of the accuracy of the hospital abstracted data. We have specifically chosen these validation requirements and thresholds to allow this assurance, provide sufficient time to fully process validation data, and minimize the burden on hospitals.

To receive the full OPPS payment rate update in CY 2009, the hospital must pass our validation requirement of a minimum of 80 percent reliability, based upon our chart-audit validation process, for the January 2008 discharges. The 80-percent reliability threshold is consistent with the inpatient RHQDAPU validation reliability threshold. Based on our previous RHQDAPU experience, we believe that this threshold is reasonable and attainable by the vast majority of hospitals. Several of the measures used in the OPPS HOP QDRP are similar in construction to inpatient measures used in the current RHQDAPU program. Based on the similar nature of the inpatient and outpatient measure sets, we believe that the 80-percent reliability threshold is applicable in the OPPS HOP QDRP.

These data are due to the CMS designated contractor by May 31, 2008. We will use confidence intervals, as discussed below, to determine if a hospital has achieved an 80-percent reliability. The use of confidence intervals would allow us to establish an appropriate range below the 80 percent reliability threshold that would demonstrate a sufficient level of reliability to allow the data to still be considered validated. We note that, for both timing and burden reasons, we are proposing to apply the validation requirements only to January 2008 discharges for purposes of determining eligibility for the full CY 2009 OPPS payment rate update. However, hospitals would still be required to submit data for subsequent time periods.

We will use January 2008 discharges to estimate the hospitals' validation score for the CY 2009 validation proposed requirement. The timeframe for data collection, abstraction, and validation tasks total about nine to ten months between patient discharges to completion of validation appeals. We believe that using later discharges for the CY 2009 annual payment update would adversely impact CMS' ability to complete these tasks and apply the results to the CY 2009 annual payment update.

Based on our proposed methodology, the confidence interval will be slightly wider than is currently utilized for the IPPS RHQDAPU program due to the smaller sample size. However, given this is the first year of the HOP QDRP, we believe this is appropriate. We would estimate the percent reliability based upon a review of five charts and then calculate the upper 95 percent confidence limit for that estimate. If this upper limit is above the required 80 percent reliability threshold, the hospital data would be considered validated. We are proposing to use the design-specific estimate of the variance for the confidence interval calculation, which, in this case, is a single stage cluster sample, with unequal cluster sizes. (For reference, see Cochran, William G. (1977) Sampling Techniques, John Wiley & Sons, New York, chapter 3, section 3.12.) Each sampled medical record is considered as a cluster for variance estimation purposes, as documentation and abstraction errors are believed to be clustered within specific medical records.

F. Publication of HOP QDRP Data Collected

New section 1833(t)(17)(E) of the Act requires that the Secretary establish procedures to make data collected under this program available to the public and to report the quality measures on the CMS Web site. Our intent is to make this information public in CY 2009 by posting it on the CMS Web site. Participating hospitals will be granted the opportunity to preview this information prior to its public posting as we have recorded it.

G. Proposed Attestation Requirement for Future Payment Years

CMS also solicits comments on whether to implement an HOP QDRP attestation requirement in CY 2010 and subsequent payment years similar to the proposed attestation requirement in the IPPS RHQDAPU program set out in the FY 2008 IPPS proposed rule (72 FR 24808). Hospitals would be required to submit a written form to a CMS contractor indicating that they formally attest to the accuracy and completeness of their data, including the volume of data submitted to the OPPS Data Warehouse. We anticipate that the attestation form submission deadlines would parallel the HOP QDRP periodic data submission deadlines.

H. HOP QDRP Reconsiderations

When the IPPS RHQDAPU program was initially implemented, it did not include a reconsideration submission process for hospitals. Subsequently, we received many requests for reconsideration of those payment decisions, and as a result, identified a process by which participating hospitals would submit requests for reconsideration. We anticipate similar concerns with the HOP QDRP and, therefore, we are proposing to establish a reconsideration process for the HOP QDRP for those hospitals that fail to meet the CY 2009 HOP QDRP requirements. The procedural details of that process will be posted to the QualityNet Exchange Web site, *http://www.qnetexchange.org.* In this proposed rule, we are seeking public comment specifically on the need for a structured reconsideration process for CY 2009 and subsequent calendar years. We also request comment on what such a process should entail. For example, such a process, if established, could include—

- A limited time, such as 30 days from the public release of the decision, for requesting a reconsideration;
- Specific individuals or functions in a hospital organization that can request such a reconsideration and that would be notified of its outcome;
- The specific factors that CMS will consider in such a reconsideration, such as an inability to submit data timely due to CMS systems failures;
- Specific requirements for submitting a reconsideration request, such as a written request for reconsideration specifically stating all reasons and factors why the hospital believes it did meet the HOP QDRP program requirements;
- Suggestions regarding the type of entity that should conduct the reconsideration process; and
- The timeframe, such as 60 days, for CMS to provide its reconsideration decision to the hospital.

We also are requesting comments on the reasons for not establishing such a reconsideration process. We plan to establish procedures that are as similar as possible to those used by the IPPS RHQDAPU program should we finalize our proposal to implement a reconsideration process for HOP QDRP.

I. Reporting of ASC Quality Data

As discussed above, section 109(b) of the MIEA–TRHCA (Pub. L. 109– 432) amended section 1833(i) of the Act by redesignating clause (iv) as clause (v), adding new section 1833(i)(2)(D)(iv), and adding new section 1833(i)(7) to the Act. These amendments authorize the Secretary to require ASCs to submit data on quality measures and to reduce the annual increase in a year by 2.0 percentage points for ASCs that fail to do so. These provisions permit, but do not require, the Secretary to require ASCs to submit such data and to reduce any annual increase for non-compliant ASCs.

We are not proposing to introduce quality measures for reporting in ASCs for CY 2008 as we are for the OPPS as described in sections XVII.B. through H. of this proposed rule. While we 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, we also believe that the transition to the revised payment system in CY 2008 poses such a significant challenge to ASCs that it would be most appropriate to allow some experience with the revised payment system before introducing other new requirements. Implementation of quality reporting at this time would require systems changes and other accommodations by ASCs, facilities which do not have prior experience with quality reporting as hospitals already have for inpatient quality measures, at a time when they are implementing a significantly revised payment system. We believe that our CY 2008 proposal to implement quality reporting for HOPs prior to establishing quality reporting for ASCs would allow time for ASCs to adjust to the changes in payment and case-mix that are anticipated under the revised payment system. We would also 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 in ASCs. We intend to implement the provisions of section 109(b) of the MIEA–TRHCA, Pub. L. 109–432, in a future rulemaking.

XVIII. Proposed Changes Affecting Critical Access Hospitals (CAHs) and Hospital Conditions of Participation (CoPs)

A. Proposed Changes Affecting CAHs

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

1. Background

CAHs are subject to different participation requirements than are hospitals. Among other requirements, a CAH must be located in a rural area (or an area treated as rural), and, under § 485.610(c), must meet an additional distance-related location requirement. Under this requirement, a CAH must be located at least 35-miles (or, in the case of mountainous terrain or in areas with only secondary roads, 15-miles) from the nearest hospital or other CAH. In addition, CAHs receive payment for services furnished to Medicare beneficiaries differently. CAHs receive cost-based payment for 101 percent of their reasonable costs.

Prior to January 1, 2006, States were permitted to waive the CAH minimum distance eligibility requirement by certifying that a CAH was a necessary provider. Approximately 850 current CAHs entered the program on the basis of a necessary provider designation. The criteria used to qualify a CAH as a necessary provider were established by each State in its Medicare Rural Hospital Flexibility Program (MRHFP). The State's MRHFP rural health care plan contains the necessary assurances that the plan was developed to further the goals of the statute and regulations to ensure access to essential health care services for rural residents. The statute and regulations give some discretion and flexibility within a Federal framework for a State to designate CAHs. States, in consultation with their hospital associations and Offices of Rural Health, have defined those CAHs that provide necessary services to a particular patient community in the event that the facility did not meet the required 35-mile (or, in the case of mountainous terrain or in areas with only secondary roads, 15-mile) distance requirement from the nearest hospital or CAH. Each State's criteria are different, but the criteria share certain similarities and all define a necessary provider related to the facility location.

However, section 405(h)(1) of Pub. L. 108–173 amended section 1820(c)(2)(B)(i)(II) of the Act by adding language that ended States' authority to waive the location requirement for a CAH by certifying the CAH as a necessary provider, effective January 1, 2006. In addition, section 405(h)(2) of Pub. L. 108–173 amended section 1820(h) of the Act to include a grandfathering provision for CAHs that were certified as necessary providers prior to January 1, 2006. We incorporated these amendments in § 485.610(c) of our regulations in the FY 2005 IPPS final rule (69 FR 49220). Because those regulations did not address the situation where the grandfathered CAH is no longer the same facility due to relocation, in the FY 2006 IPPS final rule (70 FR 47490), we amended § 485.610 of our regulations to add a new § 485.610(d) that addressed the relocation criteria a necessary provider CAH has to meet to retain its necessary provider designation.

Additional circumstances concerning CAHs with existing necessary provider designations have come to our attention that we believe also need to be addressed. Specifically, we have learned that some CAHs with grandfathered necessary provider designations are co-located with other hospitals, which typically are PPS-excluded inpatient psychiatric facilities or inpatient rehabilitation facilities. We are also aware that there is interest in the creation or acquisition by CAHs with necessary provider designation of off-campus facilities that they do not believe would be subject to CAH location requirements.

For the reasons noted below, we are taking a proactive approach by proposing a change in the regulation to be consistent with our belief that the intent of the CAH program is to maintain hospital-level services in rural communities while ensuring access to care. We believe that this proposed change to the regulations will help to maintain the integrity of the MRHFP within the statutory requirements.

2. Co-Location of Necessary Provider CAHs

Some necessary provider CAHs are co-located with other hospitals, particularly specialty psychiatric and or rehabilitation hospitals. Prior to the enactment of section 405(g) of Pub. L. 108–173, it is understandable that a State MRHFP might have allowed co-location of a CAH with a necessary provider designation with the specialized services of a psychiatric and/or an inpatient rehabilitation hospital. The State may have believed that beneficiary access to care would be enhanced through the provision of both CAH and these specialized services at the same location, and the CAH itself might have had difficulty in providing such services within its permitted bed limits. However, section 405 of Pub. L. 108 173 included several provisions that permit CAHs themselves to address such access to care issues.

Specifically, section 405(e) of Pub. L. 108–173 amended sections 1820(c)(2)(B)(iii) and 1820(f) of the Act to increase the permitted number of CAH inpatient beds from 15 to 25. In addition, section 405(g) of Pub. L. 108–173 added section 1820(c)(2)(E) to the Act, which permits a CAH to operate distinct part inpatient psychiatric and/or rehabilitation units, each subject to a 10-bed limit that is not included as part of the CAH's 25-bed limit. Therefore, a CAH can operate a 45-bed facility addressing a wide range of needs in the rural community it serves. We believe that CAHs seeking to provide access to specialized services should avail themselves of the statutory provisions governing distinct part units in CAHs rather than making arrangements with other hospital providers to share space at the CAH location.

In light of these changes to the statute, we are proposing to no longer allow a necessary provider CAH to enter into co-location arrangements between CAHs and hospitals unless such arrangements were in effect on or before January 1, 2008 and the type and scope of services offered by the facility co-located with

the necessary provider CAH do not change. We believe that this restriction will help to ensure that the current necessary services will remain in the community. Further, we are proposing to clarify that a change of ownership of the CAH, when the new owners assume the original provider agreement, does not constitute a new co-location arrangement and, thereby, under our proposal, a necessary provider CAH would be permitted to continue under an existing co-location arrangement.

We are concerned that, without this change, there may be situations where more necessary provider CAHs will co-locate with PPS hospitals. Currently, co-location arrangements seem to involve psychiatric or rehabilitation hospitals. We are concerned about co-location by a necessary provider CAHs with a short-term acute care hospital, including a physician-owned specialty hospital. We also cannot rule out a scenario where two necessary provider CAHs could co-locate after relocation. We believe the co-location of a necessary provider CAH with another hospital or necessary provider CAH is not consistent with the CAH statutory framework that establishes requirements for a CAH to be a certain minimum distance from other hospitals or CAHs. We believe that the elimination of States' authority to designate necessary provider CAHs and the ability for CAHs to operate psychiatric and rehabilitation units should provide sufficient flexibility for necessary provider CAHs to operate within the statutory framework without engaging in additional arrangements.

We also are clarifying in this proposed rule that under certain circumstances, a change of ownership of any of the facilities (either the CAH or the existing co-located facility) with a co-location arrangement that was in effect before January 1, 2008, will not be considered to be a new co-location arrangement. If a change of ownership should occur in a CAH with a grandfathered co-location arrangement on or after January 1, 2008, we note the provider agreement is generally automatically assigned to the new owner, unless the new owner rejects assignment of the provider agreement or assignment of the provider agreement is otherwise not made. If the new owner does not get assignment of the provider agreement, the new owner would have to go through the same enrollment process as any other new provider; that is, enrolling with the fiscal intermediary (or if applicable, the MAC), applying for participation, undergoing the Office of Civil Rights clearance and an initial certification survey that meets all the current Medicare conditions (see State Operations Manual 3210) to obtain CAH status. Thus, grandfathered necessary provider CAH status, including grandfathered co-location arrangements, would not transfer to a new CAH owner who does not assume the provider agreement from the previous owner. To obtain CAH designation, the new provider would have to comply with all the CAH designation requirements, including the location requirements relative to other providers, that is, more than a 35-mile drive (or 15 miles in areas of mountainous terrain or secondary roads).

3. Provider-Based Facilities of CAHs

We have consistently taken the position that the intent of the CAH program is to keep hospital-level services in rural communities, thereby ensuring access to care (FY 2006 IPPS final rule (70 FR 47469)). A CAH is permitted to create or acquire an off-campus location, including a distinct part unit that satisfies the location criteria for a CAH and operates under the CAH's provider agreement under the provider-based rules at 42 CFR 413.65. We note that, under section 1820(c)(2)(B)(i)(II) of the Act, a CAH does not have to meet the distance requirements relative to other hospitals or CAHs if it was certified prior to January 1, 2006, as a necessary provider by the State. We stated in the FY 2006 IPPS final rule (70 FR 47472), when addressing the relocation criteria for a necessary provider CAH, that the ''necessary provider'' designation is specific to the physical location(s) of the CAH in existence at the time of the designation. We believe the necessary provider CAH designation cannot be considered to extend to any new facilities not in existence when the CAH received its original necessary provider designation. Accordingly, we believe the creation of any new location that would cause any part of the CAH to be situated at a location not in compliance with the distance requirements at 42 CFR 485.610 would cause the entire CAH to violate the distance requirements.

Of the approximately 1,300 CAHs, 453 CAHs have health clinics, 81 have psychiatric units, and 20 have rehabilitation units. We do not know how many of the existing clinics and distinct part units are at off-site locations. However, we are concerned with CAHs creating or acquiring off-campus locations, including distinct part psychiatric and rehabilitation units, that do not comply with the CAH location requirement relative to other facilities. Therefore, when such off-campus facilities are created by a CAH with a necessary provider designation, there is no reason to assume that the distance exemption given to the CAH should be extended without qualification to any location for that CAH's off-campus facilities. Accordingly, any CAH off-campus locations must satisfy the current statutory CAH distance requirements, without exception and regardless of whether the main provider CAH is a necessary provider CAH.

Therefore, we are proposing to clarify that if a necessary provider CAH, or a CAH that does not have a necessary provider designation, operates a provider-based facility as defined in § 413.65(a)(2), or a psychiatric or rehabilitation distinct part unit as defined in § 485.647 that was created or acquired on or after January 1, 2008, it must comply with the distance requirement of a 35-mile drive to the nearest hospital or CAH (or 15 miles in the case of mountainous terrain or in areas with only secondary roads).

4. Termination of Provider Agreement

In the event that a CAH with a necessary provider designation enters into a co-location arrangement after January 1, 2008, or acquires or creates an off-campus facility after January 1, 2008, that does not satisfy the CAH distance requirements in § 485.610(c), we are proposing to terminate that CAH's provider agreement, in accordance with the provisions of § 489.53(a)(3). The necessary provider CAH could avoid termination by converting to a hospital that is paid under the IPPS, assuming that the facility satisfies all requirements for participation as a hospital in the Medicare program under the provisions in 42 CFR Part 482. We also note that if the necessary provider CAH corrects the situation that led to the noncompliance, a termination action will not be triggered. A CAH that is not a necessary provider CAH could not have a co-location situation due to the distance requirements it is required to meet at 485.610 (c).

5. Proposed Regulation Changes

We are proposing to amend § 485.610 by adding a new paragraph (e) to address situations under our proposal relating to off-campus and co-location requirements for CAHs with a necessary provider designation.

B. Proposed Revisions to Hospital CoPs

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

1. Background

On November 27, 2006, we published a final rule in the **Federal Register** entitled ''Medicare and Medicaid Programs; Hospital Conditions of Participation: Requirements for History and Physical Examinations; Authentication of Verbal Orders; Securing Medications; and Postanesthesia Evaluations'' (71 FR 68672). In that final rule (also frequently referred to as the ''Carve-out rule''), we finalized changes, which were based on timely public comments submitted on the proposed rule published in the March 25, 2005 **Federal Register** (70 FR 15266), to four of the current requirements (or conditions of participation (CoPs)) that hospitals must meet to participate in the Medicare and Medicaid programs. Specifically, that final rule revised and updated our CoP requirements for: completion of the history and physical examination in the Medical staff and the Medical record services CoPs; authentication of verbal orders in the Nursing services and the Medical record services CoPs; securing medications in the Pharmaceutical services CoP; and, completion of the postanesthesia evaluation in the Anesthesia services CoP. This action was initiated in response to broad criticism from the medical community that the then-current requirements governing these areas were burdensome and did not reflect current practice.

Since this final rule became effective on January 26, 2007, we have received a great number of comments and questions from providers about the timeframe requirements (for both the initial medical history and physical examination and its update) as well as about the postanesthesia evaluation requirements. In both areas, commenters have sought clarification on the application of these requirements for patients undergoing outpatient surgeries and procedures. While the new requirements contained in the Carve-out rule provide hospitals greater flexibility in ensuring the quality of inpatient care, the issues surrounding outpatient care in the hospital setting, particularly with regard to outpatient surgeries and procedures, are not clear. After conducting a thorough review of the hospital CoPs and the interpretive guidelines, we have isolated the relevant issues regarding outpatient care and are proposing revisions to the current regulations to address these concerns.

According to the most recent data, 30 million surgical procedures are performed each year in the United States with over 60 percent done as outpatient procedures and another 10 to 15 percent performed on a same-day admission basis. These figures combined translate to approximately 21 million surgical procedures performed each year in the U.S. on patients who are admitted to the hospital on the day of their procedure. A majority of these patients are also discharged from the hospital the same day that they are admitted. It is unclear whether these numbers also include other procedures, such as diagnostic ones, which also require anesthesia services, and which include all of the risks to patient safety inherent in such procedures. In either case, significant numbers of patients undergo surgeries and other procedures each year as either outpatients or same-day admission patients.

The current requirements for the completion of the medical history and physical examination are found in the regulations at § 482.22 (Medical staff CoP), § 482.24 (Medical record services CoP), and § 482.51 (Surgical services CoP). We believe that these requirements do not adequately address the patient who is admitted for outpatient or same-day surgery or a procedure requiring anesthesia services. The standards at § 482.22(c), Medical staff bylaws, and § 482.24(c), Content of record, both contain requirements for a medical history and physical examination, and an update of the medical history and physical examination documenting any changes in a patient's condition if the medical history and physical examination was completed within 30 days before admission, to be completed and documented within 24 hours after admission. Under the Surgical services CoP at § 482.51(b)(1), there is a provision that requires a complete history and physical workup to be in the chart of every patient prior to surgery. However, there is currently no requirement for an updated examination of the patient, including any changes to the patient's condition, to be completed and documented after admission or registration, and prior to any surgery or procedure being performed. For patients who are admitted as inpatients for surgery to be performed in the next day or so, this does not pose a problem. These inpatients will be followed while in the hospital with both daily progress and nursing notes made in their medical record. In addition, as required under the current regulations, these patients will also have an updated examination for any changes in their condition within 24 hours after their admission.

As evidenced by the numbers of outpatient and same day admission inpatient procedures discussed above, procedures that were once done only on an inpatient basis are now routinely performed in outpatient settings. Therefore, the patient is not admitted or registered as an outpatient until the day of the procedure. Often this admission or registration is just hours before the procedure is performed. In addition, there are many patients who are admitted as inpatients on the same day that they are scheduled for more complex procedures, which will then require postoperative hospital stays. However, for patients admitted or registered for outpatient procedures as well as for those patients admitted on the same day as their surgery, there is currently no mechanism to ensure that these patients are examined for any changes in their condition prior to undergoing a procedure. Paragraph (b)(1) of § 482.51 currently requires that every patient have a complete medical history and physical examination documented in the chart prior to surgery, except in emergencies. However, the timeframe requirements for this medical history and physical examination contained under both § 482.22(c)(5) and § 482.24(c) (2)(i)(A) allow for a medical history and physical examination that may be as much as 30 days old. Without a requirement that an updated examination be completed after admission and prior to surgery or other procedure, any changes in a patient's condition would most likely be missed by hospital staff. Failing to identify changes in a patient's condition prior to surgery may adversely impact not only the procedure but also consequently, and perhaps more significantly, the outcome of the procedure for the patient.

We are proposing revisions to §§ 482.22, 482.24, and 482.51 that would require an updated examination, including any changes in a patient's condition, to be completed and documented for each patient after admission or registration and prior to surgery or to a procedure requiring anesthesia services. These revisions would ensure that any changes in the patient's condition are discovered before a procedure is performed. With the most up-to-date information regarding a patient's condition readily available to hospital staff prior to a procedure, the risks to patient safety should be minimized and a poor outcome for the patient would be avoided. However, under these proposed requirements, it is not our intent to include those minor procedures that only require the administration of local anesthetics, as might be the case for procedures such as

biopsies of skin lesions or suturing of noncomplex lacerations.

Conversely, the current requirements at § 482.52, Anesthesia services, still distinguish between inpatients and outpatients with regard to postanesthesia evaluation, with the requirements for outpatient evaluation actually being less stringent than those for inpatients. When the current hospital regulations were originally written in 1986, these differences in regulatory oversight may have been entirely appropriate. At that time there were still very clear differences between inpatient and outpatient procedures, with inpatient procedures (and the anesthesia services required) considered much more serious and complex in nature. Since that time, there has been a gradual blurring of the distinctions between what were previously termed ''inpatient'' procedures and those that were classified as ''outpatient'' procedures. Procedures that were once done only on an inpatient basis are now routinely performed in outpatient settings. While advances in medical technology and surgical technique have allowed for this shift, the complexity and seriousness of these procedures still remain as do the risks to patient health and safety. Along with the increased complexity and types of outpatient procedures being performed today, come the higher levels of sedation and anesthesia required for these procedures. Thus, distinctions between inpatients and outpatients in the requirements for postanesthesia evaluations are less relevant than ever.

In addition, the current language regarding the completion and documentation of an evaluation ''within 48 hours after surgery'' assumes that all patients receiving anesthesia services have undergone surgery. It also assumes that they have not been discharged from the hospital prior to the end of this 48-hour timeframe and that they are still available for evaluation. Many patients who have received anesthesia services (either general anesthesia or monitored anesthesia care) have undergone diagnostic or therapeutic procedures as opposed to surgical ones and are discharged within hours after such procedures. Diagnostic and therapeutic procedures that require anesthesia services (either general anesthesia or monitored anesthesia care) include esophagogastroduodenoscopy (EGD), colonoscopy, endoscopic retrograde cholangiopancreatography (ERCP), and electroconvulsive therapy (ECT). Furthermore, and as noted above, even those patients who have undergone inpatient surgical procedures are often discharged well before 48 hours after surgery.

Therefore, we are proposing revisions to § 482.52(b) that would ensure that all patients who have received anesthesia services, regardless of inpatient or outpatient status, have a postanesthesia evaluation completed and documented by an individual qualified to administer anesthesia before they are discharged or transferred from the postanesthesia recovery area.

Finally, in our review of the CoPs, we discovered a cross-reference under § 482.23, Nursing services, that is no longer valid. We are taking the opportunity in this proposed rule to correct this error through a technical amendment.

2. Provisions of the Proposed Regulations

a. Proposed Timeframes for Completion of the Medical History and Physical Examination

The proposed revisions to § 482.22(c)(5) would retain the requirement that the medical staff bylaws include a requirement that a medical history and physical examination be completed no more than 30 days before or 24 hours after admission for each patient. We are proposing to revise this provision to include the requirement that the completion and documentation of the medical history and physical examination (and the updated examination) would also be required prior to surgery or a procedure requiring anesthesia services.

We also are proposing to retain the current provision that the medical staff bylaws contain a requirement for the completion and documentation of an updated examination within 24 hours after admission (when the medical history and physical examination has been completed within 30 days before admission). However, we are proposing to delete the language regarding the placement of the medical history and physical examination and the updated examination in the medical record within 24 hours after admission because we believe that the proposed language requiring not only the completion, but also the documentation, of both the medical history and physical examination and the updated examination, achieves this purpose. In addition, requirements for the physical placement of the medical history and physical examination and the updated examination in the patient's medical record are currently, and more appropriately, contained under the ''Medical record services'' CoP at § 482.24(c)(2), which we are proposing to retain under this rule.

Further, we are proposing to separate the requirements for the medical history and physical examination and for the updated examination under two provisions at § 482.22(c)(5)(i) and § 482.22(c)(5)(ii), respectively. At § 482.22(c)(5)(i), we are proposing to retain the current requirement that the medical history and physical examination be completed by a physician (as defined in section 1861(r) of the Act), an oromaxillofacial surgeon, or other qualified individual in accordance with State law and hospital policy. However, we are proposing to add the words ''and documented'' after ''be completed'' as well as ''licensed'' after ''qualified'' to further clarify this requirement. In addition, we are proposing to revise § 482.22(c)(5)(ii) to require that the updated examination of the patient must be completed and documented by the same individuals as proposed above. We also are proposing to add the words ''or registration'' to follow ''after admission'' to reflect differences in terminology that may exist with the admission of patients for outpatient procedures. We are proposing this revision here as well as in § 482.24 and § 482.51, where appropriate.

We are proposing to revise the words ''for any changes in the patient's condition'' to ''including any changes in the patient's condition'' at both § 482.22(c)(5) and § 482.24(c)(2)(i)(B).

Under § 482.24(c), Content of record, we are proposing to revise both § 482.24(c)(2)(i)(A) and § 482.24(c)(2)(i)(B) by adding the language ''but prior to surgery or a procedure requiring anesthesia services'' with regard to both the completion and the documentation of the medical history and physical examination and the updated examination.

We are proposing to revise the Surgical services CoP at § 482.51(b)(1) by deleting the language regarding medical histories and physical examinations that have been dictated but which are not yet recorded in the patient's chart. Our overall intent in this proposed rule is to require that the most current information regarding a patient's condition be available to the hospital staff prior to surgery or a procedure requiring anesthesia services so that risks to patient safety can be minimized and potential adverse outcomes can be avoided.

We are proposing to retain the language regarding the requirement for a medical history and physical examination prior to surgery, except in

the case of emergencies, and are proposing to extend this to a requirement for an updated examination. We are proposing to divide the requirements for the medical history physical examination and the updated examination under two separate provisions at § 482.51(b)(1)(i) and § 482.51(b)(1)(ii) in the Surgical services CoP.

b. Proposed Requirements for Preanesthesia and Postanesthesia Evaluations

At § 482.52(b)(1), under the ''Delivery of services'' standard of the ''Anesthesia services'' CoP, we are proposing to revise the requirement for a preanesthesia evaluation to include the language ''or a procedure requiring anesthesia services'' to include the range of procedures that require anesthesia services, but that are not necessarily surgical in nature. We also are proposing to add this language under § 482.52(b)(3) for the postanesthesia evaluation requirement.

Further, we are proposing to revise this standard by deleting both the words ''with respect to inpatients'' at § 482.52(b)(3) and the entire provision at § 482.52(b)(4), which are the current requirements for postanesthesia evaluations for patients. We are proposing to revise § 482.52(b)(3) by requiring that the postanesthesia evaluation be completed and documented before discharge or transfer from the postanesthesia recovery area. As discussed above, the intent of this section of the proposed rule is to eliminate the distinctions currently found in the regulations between inpatients and outpatients with regard to anesthesia services.

c. Proposed Technical Amendment to Nursing Services CoP

We are proposing to revise the cross-reference to § 405.1910(c) currently found under the nursing services CoP at § 482.23(b)(1) as this citation has been changed and is no longer valid. We are proposing a technical amendment to this provision to correct the cross-reference to § 488.54(c).

XIX. Files Available to the Public Via the Internet

A. Information in Addenda Related to the Revised CY 2008 Hospital OPPS

Addenda A and B to this proposed rule provide various data pertaining to the CY 2008 payment for items and services under the OPPS. Addendum A, a complete list of all APCs payable under the OPPS, and Addendum B, a complete list of all active HCPCS codes regardless of their assigned payment status or comment indicators under the OPPS, will be available to the public by clicking ''Addendum A and Addendum B Updates'' on the CMS Web site at: *http://www.cms.hhs.gov/HospitalOutpatientPPS/.*

For the convenience of the public, we are also including on the CMS Web site a table that displays the HCPCS data in Addendum B sorted by APC assignment, identified as Addendum C.

Addendum D1 defines payment status indicators that are used in Addenda A and B. Addendum D2 defines comment indicators that are used in Addendum B. Addendum E lists HCPCS codes that are only payable as inpatient procedures and are not payable under the OPPS. Addendum L contains the out-migration wage adjustment for CY 2008. Addendum M lists the HCPCS codes that are members of a composite APC and identifies the composite APC to which they are assigned. This addendum also identifies the status indicator for the code and a change indicator if there has been 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 OCE logic that applies to the APC. We refer readers to the discussion of composite APCs in section II.A.4.d. of this proposed rule for a complete description of the proposed composite APCs.

Those addenda and other supporting OPPS data files are available on the CMS Web site at: *http://www.cms.hhs.gov/HospitalOutpatientPPS.*

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

Addenda AA, BB, DD1, and DD2 to this proposed rule provide various data pertaining to the ASC covered surgical procedures and the covered ancillary services for which ASCs may receive separate payment beginning in CY 2008 when the ancillary service provided in the ASC is integral to a covered surgical procedure and provided immediately before, during, or immediately following the covered surgical procedure. All relative payment weights and payment rates are proposed and exemplify the results of applying the revised ASC payment system methodology established in the final rule for the revised ASC payment system published elsewhere in this issue of the **Federal Register**, to the proposed CY 2008 OPPS and MPFS ratesetting information.

Addendum DD1 defines the payment indicators that are used in Addenda AA and BB to this proposed rule. Addenda AA and BB provide payment information regarding covered surgical procedures and covered ancillary services under the revised ASC payment system. Addendum DD2 defines the comment indicators that we are proposing to use to provide additional information about the status of ASC covered surgical procedures and covered ancillary services. Those addenda and other supporting ASC data files are included on the CMS Web site at: *http://www.cms.hhs.gov/ASCPayment/* in a format that can be easily downloaded and manipulated. The final ASC relative weights and payment rates for CY 2008 will be published in the CY 2008 OPPS/ASC final rule with comment period, and related data files will be included on the CMS Web site as noted above. MPSF data files are located at *http://www.cms.hhs.gov/PhysicianFeeSched/.*

The links to all of the FY 2008 IPPS wage index related tables (that would be used for the CY 2008 OPPS) from the FY 2008 IPPS proposed rule (72 FR 24851 through 24960) and to the correction notice for the FY 2008 IPPS proposed rule that was published in the **Federal Register** on June 7, 2007 (72 FR 31507) are accessible on the CMS Web site at: *http://www.cms.hhs.gov/AcuteInpatientPPS/WIFN/list.asp#TopOfPage*

For additional assistance, contact Chuck Braver, (410) 786–6719.

XX. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995, we are required to provide 60-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. In order to fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 (PRA) 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.

We are soliciting public comment on each of these issues for the following sections included in this proposed rule that contain information collection requirements.

Section 419.43(h) Adjustment to national program payment and beneficiary co-payment amounts: Applicable adjustments to conversion factor for CY 2009 and for subsequent calendar years

Section 419.43(h) requires hospitals, in order to qualify for the full annual update, to submit quality data to CMS, as specified by CMS. In this proposed rule, we are proposing the specific requirements related to the data that must be submitted for the update for CY 2009. The burden associated with this section is the time and effort associated with collecting and submitting the data, completing participating forms and submitting charts for chart audit validation. We estimate that there will be approximately 3,500 respondents per year.

For hospitals to collect and submit the information on the required measures, we estimate it will take 30 minutes per sampled case. Further, based on an estimated ten percent sample size and estimated populations of 2.5–5 million outpatient visits per measure, we estimate a total of 1,800,000 cases per year. In addition, we estimate that completing participation forms with require approximately 4 hours per hospital per year. We expect the burden for all of these hospitals to total 914,000 hours per year.

For CY 2009. our validation process requires participating hospitals to submit 5 charts. The burden associated with this requirement is the time and effort associated with collecting, copying, and submitting these charts. It will take approximately 2 hours per hospital to submit the 5 charts. There will be a total of approximately 17,500 charts (3,500 hospitals x 5 charts per hospital) submitted by the hospitals to CMS for a total burden of 7,000 hours. Therefore, the total burden for all hospitals would be 921,000 hours per year.

Section 482.22 Condition of participation: Medical staff

Proposed § 482.22(c)(5)(i) would require that a medical history and physical examination be completed and documented no more than 30 days before or 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services, for each patient by a physician (as defined in section 1861(r) of the Act), an oromaxillofacial surgeon, or other qualified licensed individual in accordance with State law and hospital policy.

The burden associated with this proposed requirement is the time and effort it would take for medical staff to document the patient's medical history and the results of a physical examination. While the burden associated with this proposed requirement is subject to the PRA, we believe the burden is exempt as defined in 5 CFR 1320.3(b) (2) because the time, effort, and financial resources necessary to comply with the requirement would be incurred by persons in the normal course of their activities.

Proposed § 482.22(c)(5)(ii) would require that an updated examination of the patient, including any changes in the patient's condition, be completed and documented within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services, when the medical history and physical examination are completed within 30 days before admission or registration. The updated examination must also be completed and documented by the same individuals as required under proposed § 482.22(c)(5)(i).

The burden associated with this proposed requirement is the time and effort it would take for medical staff to document any changes in the patient's condition. While the burden associated with this proposed requirement is subject to the PRA, we believe the burden is exempt as defined in 5 CFR 1320.3(b)(2) because the time, effort, and financial resources necessary to comply with the requirement would be incurred by persons in the normal course of their activities.

Section 482.24 Condition of participation: Medical record services

Proposed § 482.24(c)(2)(i) would require evidence of:

(1) A medical history and physical examination completed and documented no more than 30 days before or 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The medical history and physical examination must be placed in the patient's medical record within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia.

(2) An updated examination of the patient, including any changes in the patient's condition, when the medical history and physical examination are completed within 30 days before admission or registration. Documentation of the updated examination must be placed in the patient's medical record within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services.

While the burden associated with these two proposed requirements is subject to the PRA, we believe the burden is exempt as defined in 5 CFR 1320.3(b)(2) because the time, effort, and financial resources necessary to comply with the requirement would be incurred by persons in the normal course of their activities.

Section 482.51 Condition of participation: Surgical services

Proposed § 482.51(b)(1) would require medical staff, prior to surgery or a procedure requiring anesthesia services, and except in the case of emergencies, to document no more than 30 days before or 24 hours after admission or registration a patient's medical history, the results of the patient's physical examination, and any changes in the patient's condition.

While the burden associated with these proposed requirements is subject to the PRA, we believe the burden is exempt as defined in 5 CFR 1320.3(b)(2) because the time, effort, and financial resources necessary to comply with the requirement would be incurred by persons in the normal course of their activities.

Section 482.52 Condition of participation: Anesthesia services

Proposed § 482.52(b)(1) would require a preanesthesia evaluation to be completed and documented by an individual qualified to administer anesthesia, performed within 48 hours prior to surgery or a procedure requiring anesthesia services. Proposed § 482.52(b)(3) would require a postanesthesia evaluation to be completed and documented by an individual qualified to administer anesthesia, after surgery or a procedure requiring anesthesia services, but before discharge or transfer from the postanesthesia recovery area.

While the burden associated with these requirements is subject to the PRA, we believe the burden is exempt as defined in 5 CFR 1320.3(b)(2) because the time, effort, and financial resources necessary to comply with the requirement would be incurred by

persons in the normal course of their activities.

We have submitted a copy of this proposed rule to OMB for its review of the information collection requirements described above. These requirements are not effective until they have been approved by OMB.

If you comment on these information collection and recordkeeping requirements, please mail copies directly to the following:

Centers for Medicare & Medicaid Services, Office of Strategic Operations and Regulatory Affairs, Division of Regulations Development, Attn: Melissa Musotto, (CMS–1392–P), Room C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850; and

Office of Information and Regulatory Affairs, Office of Management and Budget, Room 10235, New Executive Office Building, Washington, DC 20503, Attn: Carolyn Lovett, CMS Desk Officer, CMS–1392–P, *carolyn_lovett@omb.eop.gov.* Fax (202) 395–6974.

XXI. 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 proposed rule, and, when we proceed with a subsequent document(s), we will respond to those comments in the preamble to that document(s).

XXII. Regulatory Impact Analysis

A. Overall Impact

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

We have examined the impacts of this proposed rule as required by Executive Order 12866 (September 1993, Regulatory Planning and Review), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96–354), section 1102(b) of the Social Security Act, the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4), and Executive Order 13132.

1. Executive Order 12866

Executive Order 12866 (as amended by Executive Order 13258, which merely reassigns responsibility of duties) directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in any 1 year).

We estimate that the effects of the OPPS provisions that would be implemented by this proposed rule would result in expenditures exceeding $100 million in any 1 year. We estimate the total increase (from changes in this proposed rule as well as enrollment, utilization, and case-mix changes) in expenditures under the OPPS for CY 2008 compared to CY 2007 to be approximately $3.3 billion.

We estimate that implementing the revised ASC payment system in CY 2008 based on the July 2007 final rule for the revised ASC payment system and the proposals in this CY 2008 OPPS/ASC proposed rule (such as adding 4 procedures to the ASC list of covered surgical procedures and designating 19 additional procedures as office-based) will have no net effect on Medicare expenditures in CY 2008 compared to the level of expenditures that would have occurred in CY 2008 in the absence of the revised payment system. A more detailed discussion of the effects of the changes to the ASC list of covered surgical procedures and the effects of the revisions to the ASC payment system in CY 2008 is provided in section XXII.C. of this proposed rule.

While we estimate that there will be no net change in Medicare expenditures in CY 2008 as a result of implementing the revised ASC payment system and the proposed ASC provisions of this proposed rule, we estimate that the revised system will result in savings of $200 million over 5 years due to migration of new ASC covered surgical procedures from HOPDs and physicians' offices to ASCs over time. In addition, we note that there will be a total increase in Medicare payments to ASCs of approximately $240 million for CY 2008 compared to Medicare expenditures that would have occurred in the absence of the revised payment system. These additional payments to ASCs of approximately $240 million in CY 2008 will be fully offset by savings from reduced Medicare spending in HOPDs and physicians' offices on services that migrate from these settings to ASCs, as described in detail in section XVI.L. of this proposed rule.

Our estimate in this proposed rule of 5-year savings as a result of the revised ASC payment system and our estimate of additional payments to ASCs in CY 2008 differ slightly from the estimates presented in the July 2007 final rule for the revised ASC payment system. The ASC budget neutrality adjustment and the resulting savings estimates in the July 2007 final rule are calculated using CY 2005 utilization data, the current CY 2007 OPPS relative weights with an estimated update factor for CY 2008, and the CY 2007 MPFS PE RVUs trended forwarded to CY 2008. The ASC budget neutrality adjustment and the resulting savings estimates in this proposed rule are calculated using the newly available CY 2006 utilization data, the CY 2008 OPPS relative payment weights proposed in this proposed rule, and and the CY 2008 MPFS PE RVUs proposed in the CY 2008 MPFS proposed rule (72 FR 38234 through 38361). As we indicated in the July 2007 final rule, the estimates in that rule are meant to be illustrative of the final policies only, in large part because they use the existing CY 2007 OPPS relative payment weights and the existing CY 2007 MPFS PE RVUs to estimate the CY 2008 values. Since the savings estimates in this proposed rule are based on the actual proposed CY 2008 OPPS relative payment weights that have just become available in this proposed rule and the actual proposed CY 2008 MPFS PE RVUs that recently became available in the CY 2008 MPFS proposed rule, the estimates in this proposed rule based on that newly available information represent our best estimates at this time. Our final budget neutrality adjustment and savings estimates will be provided in the CY 2008 OPPS/ASC final rule.

This proposed rule is an economically significant rule under Executive Order 12866, and a major rule under 5 U.S.C. 804(2).

2. Regulatory Flexibility Act (RFA)

The RFA requires agencies to determine whether a rule would have a significant economic impact on a substantial number of small entities. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small governmental jurisdictions. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having average annual revenues of $31 million or less.

For purposes of the RFA, we have determined that approximately 37 percent of hospitals and 73 percent of ASCs would be considered small entities according to the Small Business Administration (SBA) size standards. We do not have data available to calculate the percentages of entities in the pharmaceutical preparation, manufacturing, biological products, or medical instrument industries that

would be considered to be small entities according to the SBA size standards. For the pharmaceutical preparation manufacturing industry (NAICS 325412), the size standard is 750 or fewer employees. For biological products (except diagnostic) (NAICS 325414), the standard size is 500 or fewer employees, and for surgical and medical instrument manufacturing (NAICS 339112), the standard is 500 or fewer employees (see the standards Web site at: *http//www.sba.gov/idc/groups/public/documents/serv_sstd_tablepdf.pdf*). Individuals and States are not included in the definition of a small entity.

Not-for-profit organizations are also considered to be small entities under the RFA. There are 2,146 voluntary hospitals that we consider to be not for-profit organizations to which this proposed rule applies.

3. Small Rural Hospitals

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 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 previously defined a small rural hospital as a hospital with fewer than 100 beds that is located outside of a Metropolitan Statistical Area (MSA) (or New England County Metropolitan Area (NECMA)). However, under the new labor market definitions that we adopted in the CY 2005 final rule with comment period (consistent with the FY 2005 IPPS final rule), we no longer employ NECMAs to define urban areas in New England. Therefore, we now define a small rural hospital as a hospital with fewer than 100 beds that is located outside of an MSA. Section 601(g) of the Social Security Amendments of 1983 (Pub. L. 98–21) designated hospitals in certain New England counties as belonging to the adjacent NECMA. Thus, for purposes of the OPPS, we classify these hospitals as urban hospitals. We believe that the changes to the OPPS in this proposed rule would affect both a substantial number of rural hospitals as well as other classes of hospitals and that the effects on some may be significant. The changes to the ASC payment system for CY 2008 will have no effect on small rural hospitals. Therefore, we conclude that this proposed rule would have a significant impact on a substantial number of small rural hospitals.

4. Unfunded Mandates

Section 202 of the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4) also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. That threshold level is currently approximately $120 million. This proposed rule would not mandate any requirements for State, local, or tribal government, nor would it affect private sector costs.

5. Federalism

Executive Order 13132 establishes certain requirements that an agency must meet when it publishes any rule (proposed or final) that imposes substantial direct costs on State and local governments, preempts State law, or otherwise has Federalism implications.

We have examined this proposed rule in accordance with Executive Order 13132, Federalism, and have determined that it would not have an impact on the rights, roles, and responsibilities of State, local or tribal governments. As reflected in Table 67, we estimate that OPPS payments to governmental hospitals (including State and local governmental hospitals) would increase by 3.6 percent under this proposed rule. The provisions related to payments to ASCs in CY 2008 would not affect payments to government hospitals.

B. Effects of OPPS Changes in This Proposed Rule

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

We are proposing to make several changes to the OPPS that are required by the statute. We are required under section 1833(t)(3)(C)(ii) of the Act to update annually the conversion factor used to determine the APC payment rates. We are also required under section 1833(t)(9)(A) of the Act to revise, not less often than annually, the wage index and other adjustments. In addition, we must review the clinical integrity of payment groups and weights at least annually. Accordingly, in this proposed rule, we are proposing to update the conversion factor and the wage index adjustment for hospital outpatient services furnished beginning January 1, 2008, as we discuss in sections II.C. and II.D., respectively, of this proposed rule. We also are proposing to revise the relative APC payment weights using claims data from January 1, 2006, through December 31, 2006, and updated cost report information. In response to a provision in Pub. L. 108–173 that we analyze the cost of outpatient services in rural hospitals relative to urban hospitals, we are proposing to continue increased payments to rural SCHs, including EACHs. Section II.F. of this proposed rule provides greater detail on this rural adjustment. Finally, we are proposing to remove one device category, HCPCS code C1820 (Generator, neurostimulator, (implantable), with rechargeable battery and charging system), from pass-through payment status in CY 2008.

Under this proposed rule, the update change to the conversion factor as provided by statute would increase total OPPS payments by 3.3 percent in CY 2008. The one-time wage reclassification under section 508 expires September 30, 2007, and therefore is not contemplated in this proposed rule. The proposed changes to the APC weights including the changes that would result from the proposal to expand packaging, changes to the wage indices, the continuation of a payment adjustment for rural SCHs and EACHs would not increase OPPS payments because these changes to the OPPS are budget neutral. However, these proposed updates do change the distribution of payments within the budget neutral system as shown in Table 67 and described in more detail in this section.

1. Alternatives Considered

Alternatives to the changes we are proposing to make and the reasons that we have chosen the options are discussed throughout this proposed rule. Some of the major issues discussed in this proposed rule and the options considered are discussed below.

a. Alternatives Considered for the Packaging Proposals for CY 2008 OPPS

In section II.A.4.c. of this proposed rule, we are proposing to package payment for the following seven categories of ancillary supportive services into payment for the independent service with which they are billed. We are also proposing to pay for low dose rate prostate brachytherapy and cardiac electrophysiology evaluation and ablation services under composite APCs in which a single payment is made for multiple major services that are commonly performed on the same date. We discuss each category of services that we propose to package and each set of services for which we propose a composite APC below:

(1) Guidance Services

We are proposing to package payment for supportive guidance services into the payment for the independent procedure to which the guidance service is ancillary and supportive. In the case of one particular guidance procedure, which would usually be provided in conjunction with another independent procedure but may occasionally be provided without another independent service on the same date of service, we propose to permit separate payment if the service is billed without an independent procedure on the same date of service. We refer readers to section II.A.4.c.(1) of this proposed rule for the complete discussion of this proposal. We considered several policy options for the payment of guidance services in CY 2008.

The first alternative we considered was to propose no changes to packaging for the CY 2008 OPPS. Under this alternative, codes that were packaged for CY 2007 would remain packaged for CY 2008 and codes that were separately paid for CY 2007 would remain separately paid for CY 2008. There are a number of CPT codes that describe independent surgical procedures for which the code descriptors indicate that guidance is included in the code reported for the surgical procedure if it is used and, therefore, for which the OPPS already makes packaged payment for the associated guidance service. With a number of guidance services already packaged, we did not select this option in part because we did not want to create financial incentives for hospitals to use one form of guidance instead of another or to use guidance all the time, even if a procedure could be safely provided without guidance. Furthermore, we believe this alternative would not provide additional incentives for hospitals to utilize the most cost-effective and clinically advantageous method of guidance that is appropriate in each situation.

The second alternative we considered was to package the costs of guidance services in all cases, without regard to the possibility of the service being furnished without an independent service on the same date of service. We did not select this alternative because we believe that in the case of one particular guidance procedure, the procedure may sometimes be appropriately furnished without other independent services on the same date and in these cases, we believe that there should be separate payment for the guidance service.

The third alternative we considered, and the alternative we selected, was to always package payment for most supportive guidance services, while allowing separate payment for one particular guidance service when that guidance service is furnished without an independent service. When guidance services are furnished as an ancillary and supportive adjunct to an independent procedure, we are proposing to package payment for all guidance procedures. When one specific guidance service (which is occasionally not provided in conjunction with an independent procedure on the same date of service) is not provided on the same date as an independent procedure, we would pay separately for that service. We believe that this alternative would provide the most appropriate incentives to control volume and spending for these services, without discouraging the performance of the service in those infrequent cases when one particular guidance service is provided without an independent procedure.

(2) Image Processing

We are proposing to package payment for image processing services into the payment for the major independent service to which the image processing service is ancillary and supportive. We refer readers to section II.A.4.(c)(2) of this proposed rule for the complete discussion of this proposal. We considered several policy options for the payment of image processing services in CY 2008.

The first alternative we considered was to propose no changes to packaging for CY 2008 OPPS. Under this alternative, codes that were packaged for CY 2007 would remain packaged for CY 2008 and codes that were separately paid for CY 2007 would remain separately paid for CY 2008. We did not select this alternative because we believe it would not provide additional incentives for hospitals to utilize the most cost-effective and clinically advantageous image processing services that are appropriate in each situation.

The second alternative we considered was to package the costs of image processing services in cases in which the image processing service is furnished on the same date as an independent service to which the image processing service is ancillary and supportive but to pay separately for the image processing service when it is furnished without an independent service on the same date of service. We did not select this alternative because it would not have provided substantial additional incentives for hospitals to utilize image processing in the most cost-effective and clinically advantageous manner.

The third alternative we considered, and ultimately selected, was to package payment for the costs of image processing services in all cases, without regard to the possibility of the service being furnished without an independent service on the same date of service. While an image processing service is not necessarily provided on the same date of service as the independent procedure to which it is ancillary and supportive, providing separate payment for each imaging processing service whenever it is performed is not consistent with encouraging value-based purchasing under the OPPS. We believe it is important to package payment for supportive dependent services that accompany independent procedures but that may not need to be provided face-to-face with the patient in the same encounter as the independent service. Packaging encourages hospitals to establish protocols that ensure that services are furnished only when they are medically necessary and to carefully scrutinize the services ordered by practitioners to minimize unnecessary use of hospital resources. We also note that our standard methodology to calculate median costs packages the costs of dependent services with the costs of independent services on ''natural'' single claims across different dates of service, so we are confident that we would capture the costs of the supportive image processing services for ratesetting, even if they were provided on a different date than the independent procedure. Therefore, we believe that this alternative would provide additional appropriate incentives to control volume and spending for these services, without discouraging the use of the service in those infrequent cases when it is provided with an independent procedure but on a different date of service.

(3) Intraoperative Services

We are proposing to package payment for intraoperative services into the payment for the independent procedure to which the intraoperative service is ancillary and supportive. In the case of one intraoperative service, which would usually be provided in conjunction with another independent procedure but may occasionally be provided without another independent service on the same date of service, we propose to permit separate payment if the service is billed without an independent procedure on the same date of service. We refer readers to section II.A.4.c.(3) of this proposed rule for the complete discussion of this proposal. We

considered several policy options for the payment of intraoperative services in CY 2008.

The first alternative we considered was to propose no changes to packaging for CY 2008 OPPS. Under this alternative, codes that were packaged for CY 2007 would remain packaged for CY 2008 and codes that were separately paid for CY 2007 would remain separately paid for CY 2008. We did not select this alternative because we believe it would not provide additional incentives for hospitals to utilize the most cost-effective and clinically advantageous intraoperative services that are appropriate in each situation.

The second alternative we considered was to package payment for the costs of intraoperative services in all cases, without regard to the possibility of the service being furnished without an independent service on the same date of service. We did not select this alternative because we believe that in the case of one particular intraoperative procedure, the procedure may sometimes be appropriately furnished without other independent services on the same date and in these cases, we believe that there should be separate payment for the intraoperative service.

The third alternative we considered, and ultimately selected, was to unconditionally package the costs of intraoperative services in all cases except one, to allow for the possibility of this one commonly intraoperative service being furnished without an independent service on the same date of service. We believe that there is some possibility that this procedure could be appropriately performed without another independent procedure on the same date of service. We do not believe this to be true of the other intraoperative services that we propose to unconditionally package. We selected this alternative because we thought it unlikely that intraoperative services other than the one particular service would ever be provided without an independent service. Packaging encourages hospitals to establish protocols that ensure that services are furnished only when they are medically necessary and to carefully scrutinize the services ordered by practitioners to minimize unnecessary use of hospital resources. We believe that this is the most appropriate alternative because, in general, it creates additional incentives for hospitals to provide intraoperative services only when both medically necessary and cost efficient for the individual patient. Therefore, we believe that this alternative would provide the most appropriate incentives to control volume and spending for these services.

(4) Imaging Supervision and Interpretation Services

We are proposing to package payment for imaging supervision and interpretation services into the payment for the independent service to which the imaging supervision and interpretation service is ancillary and supportive. For some imaging supervision and interpretation services, we are proposing to permit separate payment if the service is the only separately paid service billed for the date of service. We refer readers to section II.A.4.c.(4) of this proposed rule for the complete discussion of this proposal. We considered several policy options for the payment of imaging supervision and interpretation services in CY 2008.

The first alternative we considered was to propose no changes to packaging for CY 2008 OPPS. Under this alternative, codes that were packaged for CY 2007 would remain packaged and codes that were separately paid for CY 2007 would remain separately paid for CY 2008. We did not select this alternative because we believe it would not provide additional incentives for hospitals to utilize the most cost-effective and clinically advantageous radiological supervision and interpretation services that are appropriate in each situation.

The second alternative we considered was to package the costs of imaging supervision and interpretation services in all cases, without regard to the possibility of the service being furnished without an independent separately payable service on the same date of service. This alternative might substantially reduce the financial incentive to furnish the service because separate payment would never be made in any case for the service, even when it was furnished without a separately payable service on the same date of service. We did not select this alternative because we believe that some of the imaging supervision and interpretation services may occasionally be furnished in conjunction with other services that are currently packaged under the OPPS. In these circumstances, if we were to unconditionally package payment for these imaging supervision and interpretation services, hospitals would receive no payment at all for providing the imaging supervision and interpretation service and the other minor procedure(s).

The third alternative we considered, and the alternative we selected, was to unconditionally package imaging supervision and interpretation procedures that we believe are always integral to and dependent upon an independent separately payable procedure, but to conditionally package payment for those imaging supervision and interpretation services that we believe are sometimes furnished without another separately payable service on the same date. We believe that this alternative is the most appropriate choice because it creates additional incentives for hospitals to provide services only when medically necessary to the individual patient when the supervision and interpretation services is furnished as an ancillary and supportive adjunct to the independent procedure. We would pay separately for some imaging supervision and interpretation services in those cases, which our data show are limited, where they are not furnished on the same date as another separately paid procedure. Therefore, we believe that this alternative would provide the most appropriate incentives to control volume and spending for these services, without discouraging the performance of the services in those relatively infrequent cases when they are the only services furnished.

(5) Diagnostic Radiopharmaceuticals

We are proposing to package payment for diagnostic radiopharmaceuticals into the payment for their associated nuclear medicine procedures. We refer readers to section II.A.4.c.(5) of this proposed rule for the complete discussion of this proposal. We considered several policy options for the payment of diagnostic radiopharmaceuticals in CY 2008.

The first alternative we considered was to propose no changes to our packaging methodology for diagnostic radiopharmaceuticals in the CY 2008 OPPS. Under this alternative, diagnostic radiopharmaceuticals with a mean per-day cost of $60 or under would be packaged into the payment for associated procedures present on the claim. Diagnostic radiopharmaceuticals with a per-day cost over $60 would receive separate payment. We did not select this alternative because we believe it would not provide additional incentives for hospitals to utilize the most cost-effective and clinically advantageous diagnostic radiopharmaceuticals that are appropriate in each situation.

The second alternative we considered was to package the costs of diagnostic radiopharmaceuticals in cases in which the diagnostic radiopharmaceutical is furnished on the same date as an independent service to which the diagnostic radiopharmaceutical is ancillary and supportive but to pay

separately for the diagnostic radiopharmaceutical when it is furnished without an independent service on the same date of service. We did not select this alternative because diagnostic radiopharmaceuticals are always intended to be used with a diagnostic nuclear medicine procedure. Our claims data indicate that diagnostic radiopharmaceuticals are infrequently provided on a different date of service from a nuclear medicine procedure. Since our standard OPPS ratesetting methodology packages costs across dates of service on ''natural'' single claims, we believe that our standard methodology adequately captures the costs of diagnostic radiopharmaceuticals associated with diagnostic nuclear medicine procedures that are not provided on the same date of service.

The third alternative we considered, and the alternative we selected, was to package the costs of diagnostic radiopharmaceuticals with their associated nuclear medicine procedures. Packaging the costs of supportive items and services into the payment for the independent procedure or service with which they are associated encourages additional hospital efficiencies and enables hospitals to better manage their resources with maximum flexibility. Diagnostic radiopharmaceuticals are always intended to be used with a diagnostic nuclear medicine procedure, and are, therefore, particularly well suited for packaging under the OPPS for the reasons identified in section II.A.4.c.(5) of this proposed rule.

(6) Contrast Media

We are proposing to package payment for contrast media into their associated independent diagnostic and therapeutic procedures. We refer readers to section II.A.4.c.(6) of this proposed rule for the complete discussion of this proposal. We considered several policy options for the payment of contrast media in CY 2008.

The first alternative we considered was to propose no changes to our packaging methodology for contrast media in the CY 2008 OPPS. Under this alternative, contrast media with a mean per-day cost of $60 or under would be packaged into the payment for associated procedures present on the claim. Contrast media with a per-day cost over $60 would receive separate payment. We did not select this alternative because we believe it would not provide additional incentives for hospitals to utilize contrast media in the most cost-effective and clinically advantageous manner. With most contrast media already packaged based on our proposed $60 packaging threshold, this alternative would potentially maintain inconsistent payment incentives across similar products.

The second alternative we considered was to package the costs of contrast media in cases in which the contrast medium is furnished on the same date as an independent service but to pay separately for the contrast medium when it is furnished without an independent service on the same date of service. We did not select this alternative because we thought it unlikely that contrast media would ever be provided without an independent service on the same date of service.

The third alternative we considered, and the alternative we selected, was to unconditionally package the costs of contrast media with their associated independent diagnostic and therapeutic procedures. The vast majority of contrast media would currently be packaged under the proposed $60 packaging threshold. Given that most contrast agents would already be packaged under the OPPS in CY 2008, we believe it would be desirable to package payment for the remaining contrast agents as this approach promotes additional efficiency and results in a more consistent payment policy across products that may be used in many of the same independent procedures.

(7) Observation Services

We are proposing to package payment for all observation care, reported under HCPCS code G0378 (Hospital observation services, per hour) for CY 2008. Payment for observation would be packaged as part of the payment for the separately payable services with which it is billed. We refer readers to section II.A.4.c.(7) of this proposed rule for the complete discussion of this proposal. We considered several policy options for the payment of observation services in CY 2008.

The first alternative we considered was to propose no changes to payment of observation services for the CY 2008 OPPS. Since January 1, 2006, hospitals have reported observation services based on an hourly unit of care using HCPCS code G0378. This code has a status indicator of ''Q'' under the CY 2007 OPPS, meaning that the OPPS claims processing logic determines whether the observation is packaged or separately payable. The OCE's current logic determines whether observation care billed under G0378 is separately payable through APC 0339 (Observation), or whether payment for observation services would be packaged into the payment for other separately payable services provided by the hospital in the same encounter based on criteria discussed in more detail in section II.A.4.c.(7) of this proposed rule. For CY 2007, we continued to apply the criteria for separate payment for observation care and the coding and payment methodology for observation care that were implemented in CY 2006. We did not select this alternative because the current criteria for separate payment for observation services treat payment for observation care for various clinical conditions differently and may provide disincentives for efficiency. In addition, there has been substantial growth in program expenditures for hospital outpatient services under the OPPS in recent years, a trend that is reflected in the rapidly increasing volume of claims for separately payable observation services. This alternative would not provide additional incentives for hospitals to utilize observation services in the most cost-effective and clinically advantageous manner.

The second alternative we considered was to accept the APC Panel's recommendations to add syncope and dehydration to the list of diagnoses eligible for separate payment or to consider other clinical conditions for separate payment for observation care. We believe that in certain circumstances observation could be appropriate for patients with a range of diagnoses. Both the APC Panel and numerous commenters to prior OPPS proposed rules have confirmed their agreement with this perspective. However, as packaging payment provides additional desirable incentives for more efficient delivery of health care and provides hospitals with significant flexibility to manage their resources, we believe it is most appropriate to treat observation care for all diagnoses similarly by packaging its costs into payment for the separately payable procedures with which the observation is associated. Consequently, we did not select this alternative to expand separate observation payment to additional diagnoses.

The third alternative we considered, and the alternative we selected, was to package payment for all observation services reported with CPT code G0378 under the CY 2008 OPPS. We believe this is the most appropriate alternative within the context of our proposed packaging approach because observation is always provided as a supportive service in conjunction with other independent separately payable hospital outpatient services such as an emergency department visit, surgical procedure, or another separately payable service, and thus its costs can

be packaged into the OPPS payment for such services. We believe that packaging payment into larger payment bundles creates incentives for providers to furnish services in the most efficient way that meets the needs of the patient, encouraging long-term cost containment. With approximately 70 percent of the occurrences of observation care billed under the OPPS currently packaged, this alternative would extend the incentives for efficiency already present for the vast majority of observation care that is already packaged under the OPPS to the remaining 30 percent of observation care for which we currently make separate payment. (8) Composite APCs

We are proposing to establish two composite APCs for CY 2008 OPPS. A composite APC is an APC that provides a single payment for several independent services when they are furnished on the same date of service. Composite APCs are intended to establish APC payment rates for combinations of services that are frequently furnished together so that the multiple procedure claims on which they are submitted may be used to set the payment rates for them and so that the payment for the services provides greater incentives for efficient use of hospital resources. Specifically, we are proposing to establish composite APCs for low dose rate prostate brachytherapy (which would be paid when CPT codes 55875 (Transperineal placement of needles or catheters into prostate for interstitial radioelement application, with or without cystoscopy) and 77778 (Interstitial radiation source application; complex) are billed with the same date of service) and for cardiac electrophysiology evaluation and ablation services (which would be paid when at least one designated electrophysiology evaluation service is billed on the same date as at least one designated cardiac ablation service). We refer readers to sections II.A.4.d.(2) and II.A.4.d.(3) of this proposed rule for a detailed discussion of the proposals for these APCs. We note that we will continue to pay individual services under their single procedure APCs as we have in the past, in recognition that there are clinical circumstances in which the combinations of services proposed for payment through the composite APCs are not furnished on the same date. We considered two alternatives with regard to the proposal to create composite APCs.

The first alternative we considered was to make no change to how we pay for these services. If we were to make no change, we could continue to pay separately for each service. The payment rates would continue to be based on single procedure claims, which we have been told by stakeholders do not represent the typical treatment scenario. Interested parties have repeatedly told us, and our examination of claims data supports, that these services are typically furnished in combination with one another and, therefore, this may suggest that the use of single procedure claims to establish the median costs that form the basis for payment for these services may result in our using clinically unusual or incorrectly coded claims as the basis for payment.

The second alternative we considered, and the alternative we selected, is to propose to create composite APCs for these services which are commonly furnished in combination with one another and to make a single payment for the multiple services specified in the composite APC at a prospectively established rate based on the total cost of the combination of services furnished. This alternative responds to public comments that multiple procedure claims for these services that we have heretofore been unable to use for ratesetting reflect the most common treatment scenarios. It also provides additional incentives for efficient provision of services by bundling payment for multiple services into a single payment. Composite APCs enable us to use more of our claims data and to use single procedure claims only to set payment rates for the uncommon circumstances in which a particular service is not furnished in combination with other related independent services. Therefore, we are proposing to establish two composite APCs for the CY 2008 OPPS.

b. Partial Device Credits

We are proposing to reduce payment by 50 percent of the device offset amount for specified APCs when hospitals report that they have received a credit for a replacement device of greater than or equal to 20 percent of the cost of the new replacement device being implanted, if the device is on a list of specified devices. We refer readers to section IV.A.3. of this proposed rule for a complete discussion of this proposal. This is an extension of the current policy that reduces the APC payment by the full device offset amount when the hospital receives a replacement device without cost or receives a credit for the full cost of the device being replaced. We considered several alternatives in developing this partial device credit proposal for CY 2008.

The first alternative we considered was to make no change to the current policy. Under this alternative, Medicare and the beneficiary would continue to pay the full APC rate, which is calculated using only claims for which the full cost of a device is billed by the hospital, even if the hospital received a substantial credit towards the cost of the replacement device. We did not select this alternative because we believe that, as long as the APC payment amount is initially established to reflect the full cost of the device when there is no credit, there should be a reduction in the Medicare payment amount when the hospital receives a substantial credit toward cost of the replacement device. Similarly, we believe that the beneficiary cost sharing should be based on an amount that also reflects the credit.

The second alternative we considered was to extend the current policy to cases of partial credit without change. This would reduce the payment in all cases in which the hospital received a credit by the full offset amount for the APC, that is, by 100 percent of the estimated device cost contained in the APC. We considered this alternative because, in our discussions with hospitals about partial credits for devices, they advised us that hospitals generally charge the same amount for a device regardless of whether they receive a significant amount in credit towards the cost of that device. Hence, in such a case the costs that are packaged into the APC payment for the applicable procedure contain the same amount of device cost as if the hospital incurred the full cost of the device. We did not select this alternative because we did not believe it was appropriate to reduce the payment to the hospital by the full cost of a device if the hospital only received a partial credit, and not a full credit, towards the cost of the device.

The third alternative, which we are proposing, is to reduce the APC payment by 50 percent of the offset amount (that would be applied if the hospital received full credit) in cases in which the hospital receives a partial credit of 20 percent or more of the cost of the new replacement device being implanted. Moreover, we are proposing to require hospitals to report a new modifier when the hospital receives a partial credit that is 20 percent or more of the cost of the device being replaced. We are proposing this alternative because we believe that this approach provides an appropriate and equitable payment to the hospital from Medicare and, depending on the service, may reduce the beneficiary's cost sharing for the service.

c. Brachytherapy Sources

Pursuant to sections 1833(t)(2)(H) and 1833(t)(16)(C) of the Act, we paid for brachytherapy sources furnished from January 1, 2004 through December 31, 2006 on a per source basis at an amount equal to the hospital's charge adjusted to cost by application of the hospital-specific overall CCR. Moreover, pursuant to section 107(a) of the MIEA–TRHCA, which 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, we are paying for brachytherapy sources using the charges adjusted to cost methodology through December 31, 2007. Section 107(b)(1) of the MIEA–TRHCA 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 devices beginning July 1, 2007. In section VII. B. of this proposed rule, we are proposing prospective payment for all brachytherapy sources, including separate payment for stranded and non-stranded versions of sources currently known to us, that is, iodine–125, palladium–103 and cesium–131. For each of the sources for which we have information that only non-stranded source versions are marketed, we are proposing to pay based on the median cost per source based on our CY 2006 claims data. For sources for which we have information that both stranded and non-stranded versions are marketed and for which our CY 2006 billing codes do not differentiate stranded and non-stranded sources, we are proposing to base payment for stranded and non-stranded brachytherapy sources on the 60th percentile and 40th percentile of our claims data, respectively, for CY 2008. We discuss each option we considered below.

The first alternative we considered was to pay for each source of brachytherapy based on our CY 2006 median costs, with the exception of the 3 sources for which we do not have separately reported cost data for their stranded and non-stranded versions, i.e., iodine–125, palladium–103, and cesium–131. Under this option, for these six stranded and non-stranded sources, we considered payment based on hospital charges reduced to cost for CY 2008. This approach would be a step toward prospective payment for brachytherapy sources, as the sources that only have non-stranded versions would receive prospective payment consistent with the overall OPPS methodology. However, payment for stranded and non-stranded iodine–125, palladium–103 and cesium–131 would deviate from the overall OPPS framework for prospective payment and from the proposed prospective payment of the non-stranded only sources specifically. This approach would subject similar items that are essential to brachytherapy treatments to different payment methodologies and could potentially create financial incentives for the use of some products over others.

The second alternative we considered was to continue making payments for all sources based on hospital charges reduced to cost. Although hospitals are familiar with this payment methodology and this methodology would be consistent with the requirement that brachytherapy sources be paid separately, we believe that to continue to pay on this basis would be inconsistent with the general methodology of a prospective payment system and would provide no incentive for hospitals to provide brachytherapy treatments in the most cost-effective and clinically advantageous manner.

The third alternative we considered, and the alternative we selected, is to propose prospective payment for each brachytherapy source based on its median costs. For the sources which only have non-stranded versions, we are proposing to use our standard median cost methodology. For the three sources which have stranded and non-stranded versions and for which we do not yet have separately reported stranded and non-stranded claims data, we are proposing to calculate the median costs based on the assumption that the reportedly lower cost non-stranded sources would be unlikely to be in the top 20 percent of the cost distribution of our aggregate CY 2006 claims data for each respective source, and on the assumption that the reportedly higher cost stranded sources would be unlikely to be in the bottom 20 percent of the CY 2006 cost distribution for each source. This approach to calculating median costs for stranded and non-stranded iodine–125, palladium–103, and cesium–131 sources results in proposed Medicare payment rates based on the 60th percentile of our aggregate data for stranded sources and the 40th percentile of our aggregate data for non-stranded sources. This methodology provides for separate payment of all sources, including stranded and non-stranded sources, recognizes a cost differential between stranded and non-stranded sources, is consistent with our prospective payment methodology for setting payment rates for other services, and is consistent with the expiration of the requirement of the MIEA–TRHCA that payment for brachytherapy sources be made at charges reduced to cost through December 31, 2007.

2. Limitations of Our Analysis

The distributional impacts presented here are the projected effects of the policy changes on various hospital groups. We estimate the effects of individual policy changes by estimating payments per service, while holding all other payment policies constant. We use the best data available but do not attempt to predict behavioral responses to our policy changes. In addition, we do not make adjustments for future changes in variables such as service volume, service-mix, or number of encounters. As we have done in previous rules, we are soliciting comments and information about the anticipated effect of the proposed changes on hospitals and our methodology for estimating them. We discuss below several specific limitations of our analysis.

One limitation of our analysis is our inability to estimate behavioral responses to our proposal to increase packaging and our proposal to pay for multiple procedures based on one composite payment rate. Specifically, it is possible that there could be a behavioral response to our proposals to package guidance services, image processing services, intraoperative services, imaging supervision and interpretation services, diagnostic radiopharmaceuticals, contrast agents, and observation services, and to pay some services using composite APCs when the services are furnished in specified combinations. However, we are unable to estimate what the effect of the behavioral response may be on payment to hospitals. We refer readers to section II.A.4. of this proposed rule for further discussion of the proposed packaging approach. The purpose of packaging these services and creating composite APCs is to remove financial incentives to furnish additional services and, instead, to provide greater incentives for hospitals to assess the most cost-effective and appropriate means to furnish necessary services. In addition, we expect that hospitals will negotiate for lower prices from suppliers to maximize the margin between their cost of providing services and the Medicare payment for the services. We recognize that it is also possible that hospitals could change behavior in a manner that seeks to overcome any reductions in total payments by ceasing to provide certain packaged services on the same date of service and instead requiring patients to receive those services on different dates of service or at different locations, so as to either

receive separate additional payment for services that would otherwise be packaged or to not incur the additional costs of those services. We believe that this will be uncommon for several reasons. We anticipate that hospitals would continue to provide care that is aligned with the best interests of the patient. In the vast majority of cases for the services that are newly proposed for unconditional packaging in CY 2008, the services would need to be provided in the same facility and during the same encounter as the independent procedure they support. Furthermore, in the case of conditionally packaged services, we note that the supportive services that we have included in our packaging proposals are typically services that are provided during or shortly preceding the independent procedure to which they are ancillary and supportive, and thus it is unlikely that the supportive service that is packaged and the independent procedure would be performed in different locations. However, we are unable to quantify the extent to which such behavioral change may impact Medicare payments to hospitals.

Secondly, we are not able to estimate the impact on hospitals of our proposal to reduce payment when a hospital receives a partial credit for a medical device that fails while under warranty or otherwise. We do not currently require hospitals to notify us when they received a partial credit for a device for which they are billing. In addition, hospitals have informed us that hospitals generally do not currently reduce the charge for a device when they receive a partial credit toward the device for which they are billing Medicare. Therefore, we have no means of knowing the frequency with which this happens or the extent to which hospitals' costs for the devices being replaced are reduced as a result of the partial credits and cannot estimate the impact of the proposed policy on hospital payments under OPPS in CY 2008.

Third, we are unable to estimate the extent to which hospitals will incur no cost for devices or will receive full credits for devices being replaced as a result of the failure of the device. In CY 2006, hospitals reported the ''FB'' modifier on codes for devices that they received without cost or for which they received a full credit. However, we are unable to forecast the extent to which the frequency or the type of device for which this occurred in CY 2006 will recur for CY 2008. We believe that most of these occurrences were the result of specific activity that we have no reason to believe will occur in CY 2008 at the same frequency at which it occurred in CY 2006, and hence we have made no estimates of how such activity may impact payments to hospitals.

Fourth, for purposes of this impact analysis, for those brachytherapy sources with proposed new codes to distinguish between stranded and non-stranded version, we assumed that half of the brachytherapy sources that hospitals will use in CY 2008 will be stranded sources and that half of them will be non-stranded sources. The statute requires us to pay for stranded and non stranded sources through different APC groups, but given the lack of separately reported claims data for stranded and non-stranded sources, for the purposes of this impact analysis, we made this assumption. We welcome data that would provide the expected CY 2008 ratio of stranded sources to non-stranded sources for purposes of the CY 2008 final rule impact analysis.

The final limitation of our analysis is that we cannot predict the utilization of new CY 2007 CPT codes that replace existing CY 2006 CPT codes for which we have cost data on which we base the proposed CY 2008 OPPS payment rates. In years past, we have estimated the impact of these code changes as if the deleted codes would continue to exist for the applicable year for which we were estimating impacts. For this proposed rule, we applied the AMA's estimates of new code utilization which are used for the MPFS proposed rule. However, we do not know whether these estimates of physician utilization are equally applicable to outpatient hospital services. We request comments regarding whether it is appropriate for us to use the AMA estimates of utilization for new codes in the estimation of the impact of proposed CY 2008 payments on hospitals.

3. Estimated Impacts of This Proposed Rule on Hospitals and CMHCs

Table 67 below shows the estimated impacts of this proposed rule 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. This year, for the first time, we are also including CMHCs in the first line that includes all providers because we included CMHCs in our weight scaler estimate. We are not showing the estimated impact of the proposed changes on CMHCs alone because CMHCs bill only one service under the OPPS, partial hospitalization, and each CMHC can, therefore easily estimate the impact of the proposed changes by referencing payment for APC 0033 in Addendum A to this proposed rule.

The estimated increase in the total payments made under the OPPS is limited by the increase to the conversion factor set under the methodology in the statute. The distributional impacts presented do not include assumptions about changes in volume and service-mix. The enactment of Pub. L. 108–173 on December 8, 2003, provided for the additional payment outside of the budget neutrality requirement for wage indices for specific hospitals reclassified under section 508. The amounts attributable to this reclassification are incorporated into the CY 2007 estimates but because section 508 expires for CY 2008 rates, no additional payments under section 508 are considered for CY 2008 in this impact analysis.

Table 67 shows the estimated redistribution of hospital and CMHC payments among providers as a result of APC reconfiguration and recalibration without the proposal to expand packaging; APC reconfiguration and recalibration including the proposal to expand packaging; wage indices and continuation of the adjustment for rural SCHs and EACHs with extension to brachytherapy sources in CY 2008; the estimated distribution of increased payments in CY 2008 resulting from the combined impact of the APC recalibration with the proposal to expand packaging, wage effects, the rural SCH and EACH adjustment, and the market basket update to the conversion factor; and, finally, estimated payments considering all payments for CY 2008 relative to all payments for CY 2007, including the impact of expiring wage provisions of section 508, changes in the outlier threshold, and changes to the pass-through estimate. Because updates to the conversion factor, including the update of the market basket and the addition of money not dedicated to pass-through payments, are applied uniformly, observed redistributions of payments in the impact table 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 would change), the impact of the wage index changes on the hospital, and the impact of the payment adjustment for rural SCHs, including EACHs. However, total payments made under this system and the extent to which this proposed rule would redistribute money during implementation also would depend on changes in volume, practice patterns, and the mix of services billed between

CY 2007 and CY 2008, which CMS cannot forecast.

Overall, the proposed OPPS rates for CY 2008 would have a positive effect for providers paid under the OPPS, resulting in a 3.3 percent increase in Medicare payments. Removing cancer and children's hospitals because their payments are held harmless to the pre–BBA ratio between payment and cost, and CMHCs, suggests that changes would result in a 3.5 percent increase in Medicare payments to all other hospitals, exclusive of transitional pass-through payments.

To illustrate the impact of the proposed CY 2008 changes, our analysis begins with a baseline simulation model that uses the final CY 2007 weights, the FY 2007 final post-reclassification IPPS wage indices, and the final CY 2007 conversion factor. Column 2A in Table 67 shows the independent effect of changes resulting from the proposed reclassification of services among APC groups and the proposed recalibration of APC weights without the proposed changes to packaging, based on 12 months of CY 2006 hospital OPPS claims data and more recent cost report data. We modeled the independent effect of APC recalibration by varying only the weights, the final CY 2007 weights versus the estimated CY 2008 weights without expanded packaging in our baseline model, and calculating the percent difference in payments. Column 2B in Table 67 shows the independent effect of changes resulting from the proposed packaging approach, including the proposed creation of composite APCs 8000 and 8001, based on 12 months of CY 2006 hospital OPPS claims data and more recent cost report data. We modeled the independent effect of APC recalibration by varying only the weights in the baseline model, the proposed CY 2008 weights without packaging and CY 2008 weights with expanded packaging, and calculating the percent difference in payments relative to the CY 2007 base used in Column 2A in order to show the packaging proposal's additive effect. Column 2B also reflects the independent effect of changes resulting from APC reclassification and recalibration changes and changes in multiple procedure discount patterns that occur as a result of the proposed changes to packaging. When services were packaged as proposed, the resulting median costs at the HCPCS code level often changed, requiring migration of HCPCS codes to different APCs to address violations of the two times rule (that is, to ensure that the HCPCS codes within the APC remained homogeneous with regard to clinical and resource characteristics). The placement of the HCPCS code in a new APC as a result of the effect of the proposed packaging approach often changed the APC median cost. Furthermore, changing the cost of a service subject to the multiple procedure discount policy, as well as packaging some services previously subject to the multiple procedure discount policy, changed the relative weight ranking of services on a claim subject to the multiple procedure discount policy, significantly changing discounting patterns in some cases.

Column 2 reflects the combined effects of APC reclassification and recalibration changes attributable to changes resulting from the proposed reclassification of services codes among APC groups and the proposed recalibration of APC weights without the proposed packaging approach in addition to all APC reclassification and recalibration changes attributable to the proposed packaging approach. We modeled the independent effect of all APC recalibration by varying only the weights in the baseline model, the final CY 2007 weights versus the proposed CY 2008 weights, and calculating the percent difference in payments.

Column 3 reflects the independent effects of updated wage indices, including the new occupational mix data described in the FY 2008 IPPS final rule, and the proposed 7.1 percent rural adjustment for SCHs and EACHs with extension to brachytherapy sources. The OPPS wage index for CY 2008 includes the budget neutrality adjustment for the rural floor, as discussed in section II.D. of this proposed rule. We modeled the independent effect of updating the wage index and the rural adjustment by varying only the wage index, using the proposed CY 2008 scaled weights, and a CY 2007 conversion factor that included a budget neutrality adjustment for changes in wage effects and the rural adjustment between CY 2007 and CY 2008.

Column 4 demonstrates the combined ''budget neutral'' impact of proposed APC recalibration with the packaging proposal (that is, Column 2), the wage index update and the proposed adjustment for rural SCHs and EACHs on various classes of hospitals (that is, Column 3), as well as the impact of updating the conversion factor with the market basket update. We modeled the independent effect of the proposed budget neutrality adjustments and the proposed market basket update by using the weights and wage indices for each year, and using a CY 2007 conversion factor that included the proposed market basket update and budget neutrality adjustments for differences in wages and the adjustment for rural SCHs and EACHs.

Finally, Column 5 depicts the full impact of the proposed CY 2008 policy on each hospital group by including the effect of all the proposed changes for CY 2008 (including the APC reconfiguration and recalibration with the packaging changes shown in Column 2) and comparing them to all estimated payments in CY 2007, including changes to the wage index under section 508 of Pub. L. 108–173 and expiring in September 2007. Column 5 shows the combined budget neutral effects of Columns 2 through 4, plus the impact of the proposed change to the fixed outlier threshold from $1,825 to $2,000, expiring section 508 reclassification wage index increases, and the impact of changing the percentage of total payments dedicated to transitional pass through payments. We estimate that these cumulative changes increase payments by 3.3 percent.

We modeled the independent effect of all changes in Column 5 using the final weights for CY 2007 and the proposed weights for CY 2008. We used the final conversion factor for CY 2007 of $61.468 and the proposed CY 2008 conversion factor of $63.693. Column 5 also contains simulated outlier payments for each year. We used the charge inflation factor used in the FY 2008 IPPS proposed rule of 7.26 percent (1.0726) to increase individual costs on the CY 2006 claims to reflect CY 2007 dollars, and we used the most recent overall CCR in the April Outpatient Provider-Specific File. Using the CY 2006 claims and a 7.26 percent charge inflation factor, we currently estimate that actual outlier payments for CY 2007, using a multiple threshold of 1.75 and a fixed-dollar threshold of $1,825 would be approximately 1.0 (0.96) percent of total payments. Outlier payments of 0.96 percent appear in the CY 2007 comparison in Column 5. We used the same set of claims and a charge inflation factor of 15.04 percent (1.1504) and the CCRs on the April Outpatient Provider-Specific File with an adjustment of 0.9912 to reflect relative changes in cost and charge inflation between CY 2007 and CY 2008 to model the CY 2008 outliers at 1.0 percent of total payments using a multiple threshold of 1.75 and a fixed dollar threshold of $2,000.

Column 1: Total Number of Hospitals

The first line in Column 1 in Table 67 shows the total number of providers (4,171), including cancer and children's hospitals and CMHCs for which we were able to use CY 2006 hospital

outpatient claims to model CY 2007 and CY 2008 payments by classes of hospitals. We excluded all hospitals for which we could not accurately estimate CY 2007 or CY 2008 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 proposed rule. At this time, we are unable to calculate a disproportionate share (DSH) variable for hospitals not participating in the IPPS. Hospitals for which we do not have a DSH variable are grouped separately and generally include psychiatric hospitals, rehabilitation hospitals, and LTCHs. We show the total number (3,911) 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 a proportion of their pre-BBA payment relative to their pre-BBA costs and, therefore, we removed them from our impact analyses. We excluded CMHCs, because they only bill one service under the OPPS, and thus they can easily determine the impact of the proposed changes.

Column 2A: APC Recalibration Prior to the Packaging Proposal

This column estimates what the effects of APC reconfiguration and recalibration would be if we were not to finalize the proposed packaging changes. The effects described in this column reflect updated cost report and claims data, as well as policy changes not related to proposed additional packaging, including APC Panel recommendations and proposed payment for brachytherapy sources. We assumed that radiopharmaceuticals would be paid prospectively based on their mean unit cost. In general, the combined effects of the APC reclassification and recalibration without the packaging proposal for hospitals in Column 2A are similar to the effects of APC recalibration in recent years. The 0.3 percent increase for all hospitals reflects the redistribution of lost partial hospitalization per diem payment from CMHCs to other hospitals. For example, overall, these changes would increase payments to urban hospitals by 0.3 percent. We estimate that large urban hospitals would see a 0.2 percent increase, while ''other'' urban hospitals experience an increase of 0.5 percent.

Overall, rural hospitals would show a modest 0.2 percent increase as a result of proposed changes to the APC structure that would occur without the proposed changes in packaging. In general, rural hospitals with 101 or more beds would experience increases greater than rural hospitals with 100 beds or fewer. Similarly, rural hospitals that bill greater than 10,999 lines (that is, total payable claim lines in CY 2006) would experience increases greater than rural hospitals that bill 10,999 lines and fewer. Urban and rural hospitals that bill Medicare fewer than 5,000 lines would see reductions of 10.7 percent and 8.1 percent respectively, due to the proposed reduction in payment for partial hospitalization (APC 0033) for CY 2008 and due to the limitation on the aggregate total OPPS payment per day for mental health services to the per diem payment for partial hospitalization (APC 0034).

Among teaching hospitals, the largest observed impacts resulting from proposed APC recalibration include an increase of 0.5 percent for minor teaching hospitals and an increase of 0.1 percent for major teaching hospitals.

Classifying hospitals by type of ownership suggests that proprietary hospitals would not experience any change in payment, governmental hospitals would experience an increase of 0.2 percent, and voluntary hospitals would experience an increase of 0.4 percent.

Column 2B: APC Recalibration and Addition of the Packaging Proposal

This column estimates what the additional, independent effects of APC reconfiguration and recalibration, and resulting changes in discounting patterns, would be with the expanded packaging and all other changes that we propose for CY 2008. Significant changes not related to packaging were addressed in column 2A. In general, the packaging proposal redistributes payments from larger and urban hospitals to smaller and rural hospitals that provide fewer packaged services and fewer of the independent services into which the supportive services were packaged. Overall, these additional changes would decrease payments to urban hospitals by 0.1 percent. We estimate that urban hospitals that bill less than 11,000 lines would see an increase of slightly over 1 percent, while urban hospitals that bill at least 11,000 lines or more would experience less of an increase or a small decrease.

Overall, rural hospitals would show a modest 0.4 percent increase as a result of proposed changes to packaging. Rural hospitals with 150 or more beds would experience decreases while smaller rural hospitals would experience increases in payment.

Among teaching hospitals, the largest observed impacts resulting from the proposed packaging include a decrease of 0.4 percent for minor teaching hospitals and an increase of 0.3 percent for major teaching hospitals.

Classifying hospitals by type of ownership suggests that proprietary hospitals would decrease 0.2 percent, and governmental and voluntary hospitals would experience no change.

Column 2: Combination of Columns 2A and 2B

This column shows the combined effects of proposed policies other than the proposed changes to packaging (for example, changes to payment for brachytherapy sources and therapeutic radiopharmaceuticals), which are reflected in part in column 2A with the additional changes to reconfiguration and recalibration that would be made if we were to finalize the packaging proposal (Column 2B). In many cases, the redistribution created by the reduction in the partial hospitalization payment offsets other recalibration losses. Overall, these changes would increase payments to urban hospitals by 0.2 percent. We estimate that both large urban hospitals and other urban hospitals would see a 0.2 percent increase in payments attributable to all recalibration.

Overall, rural hospitals would show a modest 0.6 percent increase as a result of proposed changes to the APC structure and the packaging proposal. Rural hospitals with 200 or more beds would experience decreases while smaller rural hospitals would experience increases in payment.

Among teaching hospitals, the largest observed impacts resulting from proposed APC recalibration and the packaging proposal include an increase of 0.5 percent for major teaching hospitals and an increase of 0.1 percent for minor teaching hospitals.

Classifying hospitals by type of ownership suggests that proprietary hospitals would decrease 0.2 percent, governmental hospitals would increase by 0.2 percent, and voluntary hospitals would increase by 0.4 percent.

Column 3: New Wage Indices and the Effect of the Rural Adjustment

This column estimates impact of applying the proposed IPPS FY 2008 wage indices for CY 2008, continuing the rural adjustment for CY 2008, and extending the rural adjustment to

include brachytherapy sources. Overall, these changes would not change the payments to urban hospitals. Overall, rural hospitals would show no change as a result of proposed changes to the wage indices and the continuation of the rural adjustment.

Among teaching hospitals, the largest observed impacts resulting from proposed changes to the wage indices and the continuation of the rural adjustment include a decrease of 0.2 percent for major teaching hospitals and no change for minor teaching hospitals.

Classifying hospitals by type of ownership suggests that proprietary hospitals would gain 0.2 percent, government hospitals would experience an increase of 0.1 percent, and voluntary hospitals would experience no change.

Column 4: All Budget Neutrality Changes and Market Basket Update

The addition of the proposed market update alleviates any negative impacts on payments for CY 2008 created by the proposed budget neutrality adjustments made in Columns 2 and 3, with the exception of urban and rural hospitals with the lowest volume of services and hospitals not paid under the IPPS, including psychiatric hospitals, rehabilitation hospitals, and LTCHs (DSH not available). In many instances, the redistribution of payments created by APC recalibration offsets those introduced by updating the wage indices.

Overall, these changes would increase payments to urban hospitals by 3.5 percent. We estimate that both large urban hospitals and other urban hospitals would see a 3.5 percent increase. In contrast, small urban hospitals that bill fewer than 5000 lines per year would experience a decrease in payment of 6 percent, largely as a result of the proposed decreases in payment for partial hospitalization and mental health services appearing in Column 2A.

Overall, rural hospitals would show a 3.9 percent increase as a result of proposed market basket update. Rural hospitals that bill less than 5,000 lines would see a 4.2 percent decrease, also as a result of proposed decreases in payment for partial hospitalization appearing in Column 2A. Rural hospitals that bill more than 5,000 lines would experience increases.

Among teaching hospitals, the largest observed impacts resulting from the proposed market basket update include an increase of 3.6 percent for major teaching hospitals and an increase of 3.4 percent for minor teaching hospitals.

Classifying hospitals by type of ownership suggests that proprietary hospitals would gain 3.3 percent, government hospitals would experience an increase of 3.6 percent, and voluntary hospitals would experience an increase of 3.6 percent.

Column 5: All Proposed Changes for CY 2008

Column 5 compares all proposed changes for CY 2008 to final payment for CY 2007 and includes the expiring section 508 reclassification wage indices, the proposed change in the outlier threshold, and the difference in pass through estimates which are not included in the combined percentages shown in Column 4. Overall, we estimate that providers would gain 3.3 percent under this proposed rule in CY 2008 relative to total spending in CY 2007. The 3.3 percent for all providers in Column 5 is rounded from 3.26 percent, which reflects the 3.3 percent market basket increase, plus 0.06 percent for the change in the pass-through estimate between CY 2007 and CY 2008, plus 0.04 percent for the difference in estimated outlier payments between CY 2007 and CY 2008, less 0.14 percent for expiring 508 wage payments. When we exclude cancer and children's hospitals (which are held harmless to their pre-OPPS costs), and CMHCs, the gain becomes 3.5 percent.

The combined effect of all proposed changes for CY 2008 would increase payments to urban hospitals by 3.5 percent. We estimate that large urban hospitals would see a 3.5 percent increase, while ''other'' urban hospitals experience an increase of 3.4 percent. Urban hospitals that bill less than 5,000 lines experience a decrease of 5.4 percent, up from 6.0 percent in column 4 due to increases in outlier payments for partial hospitalization.

Overall, rural hospitals would show a 3.8 percent increase as a result of the combined effects of all proposed changes for CY 2008. Rural hospitals that bill less than 5,000 lines experience a decrease of 3.0 percent, which is less than the 4.2 percent in column 4 due to an increase in outlier payments for partial hospitalization. All rural hospitals that bill greater than 5,000 lines experience increases ranging from 3.3 percent to 4.9 percent.

Among teaching hospitals, the largest observed impacts resulting from the combined effects of all proposed changes include an increase of 3.5 percent for major teaching hospitals and an increase of 3.3 percent for minor teaching hospitals.

Classifying hospitals by type of ownership suggests that proprietary hospitals would gain 3.4 percent, government hospitals would experience an increase of 3.6 percent, and voluntary hospitals would experience an increase of 3.5 percent.

TABLE 67.—PROPOSED IMPACT OF CHANGES FOR CY 2008 HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM

	Number of hospitals	APC changes			New wage index and rural adjustment	Comb (cols 2,3) with update	All changes
		Prior to packaging proposal	Packaging proposal	Comb (cols 2A,2B)			
	(1)	(2A)	(2B)	(2)	(3)	(4)	(5)
Proposed Impact of CY 2008 Hospital Outpatient Prospective Payment System Changes							
ALL PROVIDERS*	4171	0.0	0.0	0.0	0.0	3.3	3.3
ALL HOSPITALS (excludes hospitals held harmless and CMHCs)	3911	0.3	0.0	0.3	0.0	3.6	3.5
URBAN HOSPITALS	2916	0.3	−0.1	0.2	0.0	3.5	3.5
LARGE URBAN (GT 1 MILL.)	1591	0.2	0.1	0.2	0.0	3.5	3.5
OTHER URBAN (LE 1 MILL.)	1325	0.5	−0.3	0.2	0.0	3.5	3.4
RURAL HOSPITALS	995	0.2	0.4	0.6	0.0	3.9	3.8
SOLE COMMUNITY	410	0.3	0.4	0.7	0.2	4.2	3.9

TABLE 67.—PROPOSED IMPACT OF CHANGES FOR CY 2008 HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM—Continued

	Number of hospitals	APC changes			New wage index and rural adjustment	Comb (cols 2,3) with update	All changes
		Prior to packaging proposal	Packaging proposal	Comb (cols 2A,2B)			
	(1)	(2A)	(2B)	(2)	(3)	(4)	(5)
OTHER RURAL	585	0.2	0.4	0.5	−0.2	3.7	3.8
BEDS (URBAN):							
0–99 BEDS	947	−0.2	0.5	0.3	0.1	3.7	3.7
100–199 BEDS	917	0.1	0.1	0.2	0.0	3.5	3.4
200–299 BEDS	469	0.5	−0.2	0.3	−0.1	3.6	3.5
300–499 BEDS	409	0.4	−0.2	0.2	0.1	3.6	3.6
500 + BEDS	174	0.4	−0.3	0.1	0.0	3.4	3.3
BEDS (RURAL):							
0–49 BEDS***	345	0.1	1.2	1.4	−0.1	4.6	4.5
50–100 BEDS***	383	0.1	0.9	1.0	0.2	4.5	4.5
101–149 BEDS	159	0.3	0.4	0.7	0.0	4.0	4.0
150–199 BEDS	64	0.4	−0.3	0.1	−0.6	2.7	2.7
200 + BEDS	44	0.3	−0.7	−0.5	0.1	2.9	2.6
VOLUME (URBAN):							
LT 5,000 Lines	591	−10.7	1.4	−9.3	0.0	−6.0	−5.4
5,000–10,999 Lines	165	−1.6	1.2	−0.3	0.1	3.1	3.0
11,000–20,999 Lines	269	−0.5	0.6	0.1	0.1	3.6	3.7
21,000–42,999 Lines	545	0.3	0.3	0.6	0.2	4.0	4.0
GT 42,999 Lines	1346	0.4	−0.2	0.2	0.0	3.5	3.5
VOLUME (RURAL):							
LT 5,000 Lines	82	−8.1	1.3	−6.8	−0.6	−4.2	−3.0
5,000–10,999 Lines	104	0.0	1.2	1.2	0.3	4.9	4.8
11,000–20,999 Lines	208	0.3	1.3	1.6	0.1	5.0	4.8
21,000–42,999 Lines	310	0.3	1.1	1.4	0.2	4.9	4.9
GT 42,999 Lines	291	0.2	0.0	0.2	−0.1	3.4	3.3
REGION (URBAN):							
NEW ENGLAND	157	0.0	0.8	0.8	−0.1	4.0	3.8
MIDDLE ATLANTIC	378	0.4	0.6	1.0	−0.4	3.9	3.5
SOUTH ATLANTIC	454	0.4	−0.4	0.0	0.1	3.5	3.5
EAST NORTH CENT	461	0.5	−0.2	0.3	−0.2	3.4	3.2
EAST SOUTH CENT	195	0.7	−0.6	0.1	0.1	3.4	3.5
WEST NORTH CENT	187	0.4	−0.2	0.2	0.3	3.8	3.8
WEST SOUTH CENT	464	0.5	−0.8	−0.3	−0.2	2.8	2.9
MOUNTAIN	181	0.6	−0.1	0.5	0.0	3.8	3.9
PACIFIC	388	−0.4	0.2	−0.3	0.6	3.6	3.7
PUERTO RICO	51	1.0	0.3	1.2	−0.2	4.4	4.4
REGION (RURAL):							
NEW ENGLAND	21	0.0	0.9	0.8	−0.5	3.6	3.7
MIDDLE ATLANTIC	70	0.1	0.8	0.8	0.0	4.2	4.2
SOUTH ATLANTIC	171	0.2	0.4	0.6	−0.2	3.7	3.8
EAST NORTH CENT	126	0.2	0.3	0.5	0.0	3.8	3.4
EAST SOUTH CENT	177	0.2	−0.1	0.1	−0.1	3.3	3.4
WEST NORTH CENT	116	0.3	0.2	0.5	0.1	3.9	3.6
WEST SOUTH CENT	198	0.2	0.1	0.4	−0.6	3.0	3.2
MOUNTAIN	78	0.4	1.3	1.7	0.7	5.7	5.5
PACIFIC	38	0.4	0.9	1.3	1.8	6.4	6.0
TEACHING STATUS:							
NON-TEACHING	2889	0.3	0.0	0.3	0.1	3.7	3.7
MINOR	739	0.5	−0.4	0.1	0.0	3.4	3.3
MAJOR	283	0.1	0.3	0.5	−0.2	3.6	3.5
DSH PATIENT PERCENT:							
.0	10	2.8	2.2	5.0	0.0	8.4	8.3
GT 0–0.10	394	0.6	0.1	0.6	−0.1	3.8	3.8
0.10–0.16	467	0.5	−0.1	0.4	−0.1	3.6	3.4
0.16–0.23	764	0.4	−0.1	0.3	0.1	3.7	3.6
0.23–0.35	955	0.4	−0.1	0.3	0.0	3.6	3.6
GE 0.35	757	0.0	0.1	0.1	0.1	3.5	3.6
DSH NOT AVAILABLE**	564	−10.7	0.8	−9.9	0.2	−6.4	−6.0
URBAN TEACHING/DSH:							
TEACHING & DSH	916	0.4	−0.1	0.3	−0.1	3.5	3.4
NO TEACHING/DSH	1455	0.4	−0.1	0.3	0.1	3.7	3.7
NO TEACHING/NO DSH	9	2.8	2.2	5.0	0.0	8.4	8.3
DSH NOT AVAILABLE[2]	536	−10.7	0.8	−9.9	0.3	−6.4	−5.9
TYPE OF OWNERSHIP:							
VOLUNTARY	2146	0.4	0.0	0.4	0.0	3.6	3.5

TABLE 67.—PROPOSED IMPACT OF CHANGES FOR CY 2008 HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM—Continued

	Number of hospitals	APC changes			New wage index and rural adjustment	Comb (cols 2,3) with update	All changes
		Prior to packaging proposal	Packaging proposal	Comb (cols 2A,2B)			
	(1)	(2A)	(2B)	(2)	(3)	(4)	(5)
PROPRIETARY	1179	0.0	−0.2	−0.2	0.2	3.3	3.4
GOVERNMENT	586	0.2	0.0	0.2	0.1	3.6	3.6

Column (1) shows total providers.

Column (2A) shows the impact of changes resulting from the reclassification of HCPCS codes among APC groups resulting from updated 2006 claims data and implementation of policies not related to packaging, such as proposed payment for brachytherapy sources.

Column (2B) shows the impact of changes resulting from the packaging proposal and any resulting changes to APC recalibration and discounting patterns.

Column (2) shows the combined impact of all APC reconfiguration and recalibration changes in columns 2A and 2B.

Column (3) shows the budget neutral impact of updating the wage index and rural adjustment by applying the FY 2008 hospital inpatient wage index and extending the rural adjustment to brachytherapy sources.

Column (4) shows the impact of all budget neutrality adjustments and the addition of the market basket update.

Column (5) shows the additional adjustments to the conversion factor resulting from the change in the pass-through estimate and outlier payments. This column also shows the impact of the expiring 508 wage reclassification, which ends in September 2007

* These 4,171 providers include children and cancer hospitals, which are held harmless to pre-BBA payment to cost ratios, and Community Mental Health Centers.

** Complete DSH numbers are not available for providers that are not paid under IPPS, including rehabilitation, psychiatric, and long-term care hospitals.

*** Section 1833(t)(7)(D) of the Act specifies that rural hospitals with 100 or fewer beds (that are not also sole community hospitals) receive additional payment for covered hospital outpatient services furnished during CY 2008 for which the prospective payment system amount is less than the pre-BBA amount. The amount of payment is increased by 85 percent of that difference for CY 2008.

4. Estimated Effect of This Proposed Rule on Beneficiaries

For services for which the beneficiary pays a copayment of 20 percent of the payment rate, the beneficiary share of payment would increase for services for which the OPPS payments would rise and would decrease for services for which the OPPS payments would fall. For example, for an electrocardiogram (APC 0099), the minimum unadjusted copayment in CY 2007 was $4.66. In this proposed rule, the minimum unadjusted copayment for APC 0099 is $4.98 because the OPPS payment for the service would increase under this proposed rule. In another example, for a Level IV Needle Biopsy (APC 0037), in the CY 2007 OPPS, the national unadjusted copayment was $228.76, and the minimum unadjusted copayment was $126.20. In this proposed rule, the national unadjusted copayment for APC 0037 is $228.70. The minimum unadjusted copayment for APC 0037 is $177.83, or 20 percent of the payment for APC 0037. The minimum unadjusted copayment would rise because the payment rate for APC 0037 would rise. In all cases, the statute limits beneficiary liability for copayment for a service to the inpatient hospital deductible for the applicable year. For CY 2007, the inpatient deductible is $992.

In order to better understand the impact of changes in copayment on beneficiaries, we modeled the percent change in total copayment liability using CY 2006 claims. We estimate, using the claims of the 4,171 hospitals and CMHCs on which our modeling is based, that total beneficiary liability for copayments would decline as an overall percentage of total payments from 26.6 percent in CY 2007 to 25.6 percent in CY 2008. This estimated decline in beneficiary liability is a consequence of the APC recalibration and reconfiguration we are proposing to make for CY 2008.

With respect to partial hospitalization, the copayment in CY 2007 of $46.95 would decline to $35.98 under this proposed rule as a result of the proposed decline in the per diem payment for partial hospitalization from $234.73 in CY 2007 to $179.88 for CY 2008.

5. Conclusion

The changes in this proposed rule would affect all classes of hospitals. Some classes of hospitals experience significant gains and others less significant gains, but almost all classes of hospitals would experience positive updates in OPPS payments in CY 2008. Table 67 demonstrates the estimated distributional impact of the OPPS budget neutrality requirements and an additional 3.3 percent increase in payments for CY 2008, after considering all proposed changes to APC reconfiguration and recalibration, including those resulting from the proposal to expand packaging and the proposal to pay for brachytherapy sources on a prospective payment basis, as well as the proposed market basket increase, and the estimated cost of outliers and proposed changes to the pass through estimate. The accompanying discussion, in combination with the rest of this proposed rule constitutes a regulatory impact analysis.

6. Accounting Statement

As required by OMB Circular A–4 (available at *http://www.whitehouse.gov/omb/circulars/a004/a-4.pdf*), in Table 68, we have prepared an accounting statement showing the CY 2008 estimated hospital OPPS incurred benefit impact associated with the estimated CY 2008 outpatient hospital market basket update shown in this proposed rule, based on the 2007 Trustees' Report baseline. This estimate only reflects the effect of the statutorily required market basket update and does not take into account potential enrollment, utilization, or case-mix changes. All estimated impacts are classified as transfers.

TABLE 68.—ACCOUNTING STATEMENT: CY 2008 ESTIMATED HOSPITAL OPPS INCURRED BENEFIT IMPACT ASSOCIATED WITH THE ESTIMATED CY 2008 OUTPATIENT HOSPITAL MARKET BASKET UPDATE

[in billions]

Category	Transfers
Annualized Monetized Transfers	$0.8
From Whom To Whom?	Federal Government to outpatient hospitals and other providers who receive payment under the hospital OPPS.

C. Effects of ASC Payment System Changes in This Proposed Rule

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

We are publishing elsewhere in this issue of the **Federal Register** the final rule for the revised ASC payment system, effective January 1, 2008. In the July 2007 final rule for the revised ASC payment system, we adopted the method we will use to set payment rates for ASC services furnished in association with covered surgical procedures and covered ancillary procedures beginning January 1, 2008. In that final rule, we established that the OPPS relative payment weights and payment rates will be used as the basis for the payment of most covered surgical procedures and covered ancillary services under the revised ASC payment system.

In the July 2007 final rule for the revised ASC payment system, we also established that we would update the ASC payment system annually as part of the OPPS rulemaking cycle. As part of the annual OPPS rulemaking cycle, we indicated we would update the ASC covered surgical procedures and covered ancillary services, as well as their payment rates. Such an update is very important because the OPPS relative payment weights and rates will be used as the basis for the payment of most covered surgical procedures and covered ancillary services under the revised ASC payment system. This joint update process will ensure that the ASC updates occur in a regular, predictable, and timely manner, and that the ASC payment rates immediately reflect the updated OPPS relative payment weights.

In this CY 2008 OPPS/ASC proposed rule, we are proposing to update the revised ASC payment system for CY 2008 to reflect the proposed CY 2008 OPPS relative payment weights and rates, as well as update the list of covered surgical and covered ancillary services. We are also proposing to revise the regulations to make practice expense payment to physicians who perform noncovered ASC procedures in ASCs based on the MPFS facility PE RVUs and to exclude covered ancillary radiology services and covered ancillary drugs and biologicals from the categories of DHS that are subject to the physician self-referral prohibition.

The revised Medicare ASC payment system that we are implementing beginning January 1, 2008 could have a far-reaching effect on the provision of outpatient surgical services for a number of years to come for several reasons. First, the list of procedures that will be eligible for payment under the revised ASC payment system is greatly expanded from the list of surgical procedures eligible for payment under the ASC payment system in CY 2007 and earlier years. In addition, we are moving from a limited fee schedule based on nine disparate payment groups to a payment system incorporating relative payment weights for groups of procedures with similar clinical and resource characteristics, that is, the APC groups that are the unit of payment in the OPPS.

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

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

In the July 2007 final rule for the revised ASC payment system, we estimated the CY 2008 ASC payment rates, budget neutrality factor, and impacts using the CY 2007 OPPS relative payment weights with an estimated update factor for CY 2008, the CY 2007 MPFS PE RVUs trended forward to CY 2008, and CY 2005 utilization data projected forward to CY 2008. In that final rule, we indicated that these estimates were illustrative and that the CY 2008 ASC payment rates and budget neutrality factor would be proposed in the CY 2008 OPPS/ASC proposed rule based on the methodology for calculating budget neutrality established in the July 2007 final rule and incorporating the proposed CY 2008 OPPS relative payment weights, the proposed CY 2008 MPFS PE RVUs, and CY 2006 utilization information projected forward to CY 2008. The final CY 2008 ASC payment rates and budget neutrality factor will be established in the CY 2008 OPPS/ASC final rule with comment period, in accord with the methodology for calculating budget neutrality established in the July 2007 final rule and based on the final CY 2008 OPPS payment weights, the final CY 2008 MPFS RVUs, and updated CY 2006 utilization data projected forward to CY 2008.

Our final methodology for calculating the budget neutrality adjustment factor established in the July 2007 final rule considered not only the effects of the new payment rates to be implemented under the revised payment system, but also the estimated net effect of migration of new ASC procedures across ambulatory care settings. Both the estimated budget neutrality adjustment factor presented in the July 2007 final rule and the budget neutrality adjustment factor proposed in this rule are based on that methodology, which takes into account projected migration. In the final model, we assume that over the first 2 years of the revised payment system, approximately 25 percent of the HOPD volume of new ASC procedures would migrate from the HOPD service setting to ASCs, and that over the 4-year transition period, approximately 15 percent of the physicians' office volume

of new ASC procedures would migrate to ASCs.

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

1. Alternatives Considered

Alternatives to the changes we are making and the reasons that we have chosen the options are discussed throughout this proposed rule. Some of the major issues discussed in this proposed rule and the options considered are discussed below.

a. 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 code and/or, if appropriate, the clinical characteristics, utilization, and volume of related codes. We establish payment for procedures designated as office-based at the lesser of the MPFS nonfacility PE RVU amount or the ASC rate developed according to the standard methodology of the revised ASC payment system. In the July 2007 final rule for the revised ASC payment system, we designated a number of procedures as office-based, based on our evaluation of the most recent available CY 2005 volume and utilization data for each individual procedure code and/or related codes. In developing this proposed rule, we reviewed the newly available CY 2006 utilization data for all those surgical procedures newly added for ASC payment in CY 2008 that were assigned payment indicator ''G2'' as non-office-based additions in the July 2007 final rule for the revised ASC payment system. Based on this analysis, we are proposing to designate 19 additional procedures as office-based for CY 2008. We considered two alternatives in developing this proposal.

The first alternative we considered was to make no change to the current policy for these 19 procedures. This would mean that we would continue to pay these procedures at the standard ASC payment rate developed according to the standard methodology of the revised ASC payment system. We did not select this alternative because our analysis of the most recently available utilization data for these services and related procedures indicates that these 19 procedures could be considered to be predominantly performed in physicians' offices. We were concerned that if these services were not designated as office-based, it could create financial incentives for these procedures to shift from physicians' offices to ASCs for reasons unrelated to the most appropriate setting for surgical care.

The second alternative we considered, and the alternative we selected, is to propose to designate 19 additional procedures as office-based for CY 2008. We selected this alternative because our claims data 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 ASC payment rate for these procedures being capped at the physician office rate (that is, the MPFS nonfacility practice PE RVU 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.

b. Partial Device Credits

We are proposing to reduce the ASC payment by one half of the device offset amount for certain surgical procedures into which the device cost is packaged, when an ASC receives a partial credit toward replacement of specific implantable devices. This partial payment reduction would apply when the amount of the device credit is greater than or equal to 20 percent of the cost of the new replacement device being implanted. Under this proposed policy, both the Medicare payment to the ASC and the beneficiary coinsurance liability would be reduced when an ASC receives a partial device credit. This proposal is an extension of the policy established in the final rule for the revised ASC payment system, which reduces the ASC payment by the full device offset amount for certain devices when the ASC receives a replacement device without cost or receives a credit for the full cost of the device being replaced. This partial device credit proposal for ASCs mirrors the partial device credit proposal for the OPPS in this proposed rule. We considered several alternatives in developing this partial device credit proposal for CY 2008.

The first alternative we considered was to make no change to the current policy. Under this alternative, Medicare and the beneficiary would continue to pay the ASC the full payment rate for the device implantation procedure even if the ASC received a substantial credit towards the cost of the replacement device. The ASC payment for the device implantation procedure is based on the OPPS relative weight for the procedure, which is calculated using only OPPS claims for which the full cost of a device is billed. We did not select this alternative because we believe that, as long as the ASC payment amount is established based on an OPPS relative weight that is calculated using only claims that reflect the full cost of the device when there is no credit, there should be a reduction in the Medicare payment amount when the ASC receives a substantial credit toward cost of the replacement device. Similarly, we

believe that the beneficiary cost sharing should be based on an amount that also reflects the credit.

The second alternative we considered was to extend the current no cost/full credit reduction policy to cases of partial credit without change. This would reduce the payment in all cases in which the ASC received a credit by the full offset amount for the device implantation procedure, that is, by 100 percent of the estimated device cost included in the procedure payment rate. We did not select this alternative because we did not believe it was appropriate to reduce the payment to the ASC by the full cost of a device if the ASC only received a partial credit, and not a full credit, towards the cost of the device.

The third alternative, which we are proposing, is to reduce the ASC procedure payment by 50 percent of the offset amount (that would be applied if the ASC received full credit) in cases in which the ASC receives a partial credit greater than or equal to 20 percent of the cost of the new replacement device being implanted. Moreover, we are proposing to require the ASC to report a new modifier when the ASC receives a partial credit that is equal to or greater than 20 percent of the cost of the device being replaced. We are proposing this alternative because we believe that this approach provides an appropriate and equitable payment to the ASC from Medicare and will reduce the beneficiary's cost sharing for the service.

c. Payment to Physicians for Services Not on the ASC List of Covered Surgical Procedures

Under current policy, when physicians perform surgical procedures in ASCs that are included on the ASC list of covered surgical procedures, they are paid under the MPFS for the PE component using the facility PE RVUs. When physicians perform surgical procedures in ASCs that are not included on the ASC list of covered surgical procedures and for which Medicare does not allow facility payments to ASCs, physicians currently are paid for the PE component at the higher nonfacility rate (unless a nonfacility rate does not exist in which case Medicare pays the facility rate). In this proposed rule, we are proposing that regardless of whether a procedure is on the ASC list of covered surgical procedures, a physician performing that procedure in an ASC would receive payment based on the facility PE RVUs and excluding the technical component (TC) payment, if applicable. We considered two alternatives in developing this proposal.

The first alternative we considered was to make no change to the current policy concerning physician payment for services performed in ASCs that are not on the ASC list of covered surgical procedures. Under current policy, the physician is paid the higher nonfacility PE amount when the physician performs a service in an ASC that is not on the ASC list of covered surgical procedures (unless a nonfacility rate does not exist in which case Medicare pays the facility rate). In the final rule for the revised ASC payment system, we adopted a final policy that identifies and excludes from ASC payment only those procedures that could pose a significant risk to beneficiary safety or would be expected to require an overnight stay. Because these excluded procedures have been specifically identified by CMS as procedures that could pose a significant risk to beneficiary safety or would be expected to require an overnight stay, we do not believe it would be appropriate to provide payment based on the higher nonfacility PE RVUs to physicians who furnish them as we do not believe these procedures are safe for performance in an ASC. Consequently, we did not select this alternative.

The second alternative that we considered, and that we selected, was to propose that a physician performing a procedure in an ASC would receive payment based on the facility PE RVUs and excluding the TC payment, if applicable, regardless of whether a procedure is on the ASC list of covered surgical procedures. We selected this alternative for several reasons. We believe ASCs are facilities that are similar, insofar as the delivery of surgical and related nonsurgical services, to HOPDs. Specifically, when services are provided in ASCs, the ASC, not the physician, bears responsibility for the facility costs associated with the service. This situation parallels the hospital facility resource responsibility for hospital outpatient services. Therefore, we believe it would be more appropriate for physicians to be paid for all services furnished in ASCs just as they would be paid for all services furnished in the hospital outpatient setting. In addition, because we have adopted a final policy for the revised ASC payment system that identifies and excludes from ASC payment only those procedures that could pose a significant risk to beneficiary safety or would be expected to require an overnight stay, we believe that it would be incongruous with the revised ASC payment system methodology to continue to pay the higher nonfacility rate to physicians who furnish excluded ASC procedures.

2. Limitations of Our Analysis

Presented here are the projected effects of the policy and statutory changes that will be effective for CY 2008 on aggregate ASC utilization and Medicare payments. One limitation of this analysis is that we could only infer the effects of the revised payment system on different types of ASCs, for example, single or multispecialty, high or low volume, and urban or nonurban ASCs, based on an overall comparison of procedure volumes and facility payments between the current and the revised payment system. At this time, we do not have a provider-level dataset of CY 2006 ASC utilization that accurately identifies unique ASCs and their geographic information that would allow us to compare estimated payments and geographic adjustment among classes of ASCs based on a provider-level analysis.

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

A third limitation of our analysis is our inability to predict changes in service mix between CY 2006 and CY 2008 with precision. The aggregated impact tables below are based upon a methodology that assumes no changes in service mix with respect to the CY 2006 ASC data used for this proposed rule. We believe that the net effect on Medicare expenditures of changes in service mix for current ASC covered surgical procedures will be negligible in the aggregate. Such changes may have differential effects across surgical specialties as ASCs adjust to proposed payment rates. However, we are unable to accurately project such changes at a disaggregated level. Clearly, individual ASCs will experience changes in payment that differ from the aggregated estimated changes presented below.

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

3. Estimated Effects of This Proposed Rule on ASCs

a. Payment 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 procedures, gastrointestinal procedures, or orthopedic surgery. The combined effect on an individual ASC of the CY 2008 revised payment system and the expanded ASC list of covered surgical procedures will depend on a number of factors, including, but not limited to, the mix of services the ASC provides, the volume of specific services provided by the ASC, the percentage of its patients who are Medicare beneficiaries, and the extent to which an ASC will choose to provide different services. The following discussion presents two tables that provide estimates of the impact of the revised ASC payment system on Medicare payments to ASC for current ASC services, assuming the same mix of services as offered by ASCs in our CY 2006 claims data. The first table depicts aggregate percent change in payment by surgical specialty group and the other compares payment for procedures estimated to receive the most payment in CY 2008 under the current payment system. A third table highlights changes in payment rates between this CY 2008 proposed rule and those in the July 2007 final rule for the revised ASC payment system for procedures estimated to receive the most payment in CY 2008 under the existing payment system.

In section XVI.C. of this proposed rule, we reiterate the transition of 4 years, where payments will generally be made using a blend of the rates based on the CY 2007 ASC payment rate and the revised ASC payment rate. In CY 2008, we will pay ASCs using a 75/25 blend, in which payment will be calculated by adding 75 percent of the CY 2007 ASC rate for a surgical procedure on the CY 2007 ASC list of covered surgical procedures and 25 percent of the revised CY 2008 ASC rate for the same procedure. For CYs 2009 and 2010, we will transition the blend first to 50/50 and then to a 25/75 blend of the CY 2007 ASC rate and the revised ASC payment rate. Beginning in CY 2011, we will pay ASCs for covered surgical procedures on the CY 2007 ASC list at the fully implemented revised ASC payment rates. We will not transition payment for procedures that were not included on the ASC list of covered surgical procedures in CY 2007; we will pay these procedures as at the fully implemented ASC rate, beginning in CY 2008.

Table 69 shows the impact of the revised payment system by surgical specialty group. We have aggregated the surgical HCPCS codes by specialty group and estimated the effect on aggregated payment for surgical specialty groups, considering separately the proposed CY 2008 transitional rate and the proposed fully implemented revised payment rate discussed above. The groups are sorted for display in descending order by estimated Medicare program payment to ASCs for CY 2008 in the absence of the revised ASC payment system. The following is an explanation of the information presented in Table 69.

- Column 1—*Surgical Specialty Group* indicates the surgical specialties into which ASC procedures are grouped. 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 proposed Medicare program payments are attributed.
- Column 2—*Estimated CY 2008 ASC Payments* in the absence of the revised ASC payment system were calculated by multiplying the CY 2007 ASC payment rate by CY 2008 ASC utilization (which is based on CY 2006 ASC utilization multiplied by a factor of 1.176 to take into account expected volume growth with volume adjustment, as appropriate, for the multiple procedure discount). The resulting amount was then multiplied by 0.8 to estimate the Medicare program's share of the total payments to the ASC. The estimated CY 2008 payment amounts are expressed in millions of dollars.
- Column 3—*Estimated CY 2008 Percent Change with Transition (75/25 Blend)* is the aggregate percentage increase or decrease in Medicare program payment to ASCs for each surgical specialty group that is attributable to proposed changes in the ASC payment rates for CY 2008 under the 75/25 blend of the CY 2007 ASC payment rate and the CY 2008 revised ASC payment rate.
- Column 4—*Estimated CY 2008 Percent Change without Transition (Fully Implemented)* is the aggregate percentage increase or decrease in Medicare program payment to ASCs for each surgical specialty group that is attributable to proposed changes in the ASC payment rates for CY 2008 if there were no transition period to the revised payment rates. The percentages appearing in column 4 are presented as a comparison for the transition policy in column 3 and do not depict the impact of the fully implemented proposal in 2011.

Table 69 depicts estimated proposed changes to ASCs' payments at the surgical specialty group level. For all but gastrointestinal procedures, if an ASC offers the same mix of services in CY 2008 that is reflected in our national CY 2006 claims data, proposed Medicare payments to the ASC for services in that surgical specialty group are expected to increase under the revised payment system. If the revised payment system was fully implemented in CY 2008, we would expect all but gastrointestinal procedures and nervous system procedures to receive greater Medicare payment. In addition to the impacts on Medicare payments for current ASC procedures shown in Table 69, it is important to note that estimated CY 2008 payments to ASCs are estimated to increase by more than $240 million in CY 2008 due to projected migration of new ASC services from HOPDs and physician offices to ASC. This increased spending in ASCs is projected to be fully offset by savings from reduced spending in HOPDs and physicians' offices due to service migration.

TABLE 69.—ESTIMATED CY 2008 IMPACT OF THE REVISED ASC PAYMENT SYSTEM ON ESTIMATED AGGREGATE PROPOSED CY 2008 MEDICARE PROGRAM PAYMENTS UNDER THE 75/25 TRANSITION BLEND AND WITHOUT A TRANSITION, BY SURGICAL SPECIALTY GROUP

Surgical specialty group (1)	Estimated CY 2008 ASC payments (in millions) (2)	Estimated CY 2008 percent change with transition (75/25 blend) (3)	Estimated CY 2008 percent change without transition (fully implemented) (4)
Eye and ocular adnexa	$1,205	1	5
Digestive system	661	−4	−14
Nervous system	251	3	−2
Musculoskeletal system	148	25	100
Integumentary system	81	8	34
Genitourinary system	68	12	46
Respiratory system	19	18	72
Cardiovascular system	7	25	98
Auditory system	4	24	83
Hemic and lymphatic systems	2	32	129
Other systems	0.1	29	116

Table 70 below shows the estimated impact of the revised payment system on proposed aggregate ASC payments for selected procedures during the first year of implementation (CY 2008) with and without the transitional blended rate. The table displays 30 of the procedures receiving the highest estimated CY 2008 ASC payments under the existing Medicare payment system. The HCPCS codes are sorted in descending order by estimated program payment.

- Column 1—*HCPCS code*
- Column 2—*Short Descriptor* of the HCPCS code
- Column 3—*Estimated CY 2008 ASC Payments* in the absence of the revised payment system were calculated by multiplying the CY 2007 ASC payment rate by CY 2008 ASC utilization (which is based on CY 2006 ASC utilization multiplied by a factor of 1.176 to take into account expected volume growth with volume adjustment, as appropriate, for the multiple procedure discount). The resulting amount was then multiplied by 0.8 to estimate the Medicare program's share of the total payments to the ASC. The estimated CY 2008 payment amounts are expressed in millions of dollars.
- Column 4—*CY 2008 Proposed Percent Change with Transition (75/25 Blend)* reflects the percent differences between the estimated ASC payment rates for CY 2008 under the current system and the proposed payment rates for CY 2008 under the revised system, incorporating a 75/25 blend of the estimated ASC payment using the CY 2007 ASC payment rate and the CY 2008 revised ASC payment rate.
- Column 5—*CY 2008 Proposed Percent Change without Transition (Fully Implemented)* reflects the percent differences between the estimated ASC payment rates for CY 2008 under the current system and the proposed estimated payment rates for CY 2008 under the revised payment system if there were no transition period to the revised payment rates. The percentages appearing in column 5 are presented as a comparison for the transition policy in column 4 and do not depict the impact of the fully implemented proposal in 2011.

TABLE 70.—ESTIMATED CY 2008 IMPACT OF PROPOSED REVISED ASC PAYMENT SYSTEM ON AGGREGATE PAYMENTS FOR PROCEDURES WITH THE HIGHEST ESTIMATED CY 2008 PAYMENTS UNDER THE CURRENT SYSTEM

HCPCS code (1)	Short Descriptor (2)	Estimated CY 2008 ASC payments (in millions) (3)	Estimated CY 2008 percent change (75/25 blend) (4)	Estimated CY 2008 percent changes without transition (fully implemented) (5)
66984	Cataract surg w/iol, 1 stage	$981	1	3
43239	Upper GI endoscopy, biopsy	143	−5	−19
45378	Diagnostic colonoscopy	133	−4	−16
45380	Colonoscopy and biopsy	110	−4	−16
66821	After cataract laser surgery	87	−8	−31
45385	Lesion removal colonoscopy	87	−4	−16
62311	Inject spine l/s (cd)	70	−3	−11
64483	Inj foramen epidural l/s	42	−3	−11
66982	Cataract surgery, complex	37	1	3
45384	Lesion remove colonoscopy	36	−4	−16
15823	Revision of upper eyelid	35	5	21
G0121	Colon ca scrn not hi rsk ind	34	−6	−26
G0105	Colorectal scrn; hi risk ind	27	−6	−26
64476	Inj paravertebral l/s ADD-on	24	−12	−48
64475	Inj paravertebral l/s	24	−3	−11

TABLE 70.—ESTIMATED CY 2008 IMPACT OF PROPOSED REVISED ASC PAYMENT SYSTEM ON AGGREGATE PAYMENTS FOR PROCEDURES WITH THE HIGHEST ESTIMATED CY 2008 PAYMENTS UNDER THE CURRENT SYSTEM—Continued

HCPCS code	Short Descriptor	Estimated CY 2008 ASC payments (in millions)	Estimated CY 2008 percent change (75/25 blend)	Estimated CY 2008 percent changes without transition (fully implemented)
(1)	(2)	(3)	(4)	(5)
43235	Uppr gi endoscopy, diagnosis	23	2	8
52000	Cystoscopy	21	−6	−24
67904	Repair eyelid defect	16	7	26
64721	Carpal tunnel surgery	15	18	72
29881	Knee arthroscopy/surgery	15	23	94
43248	Uppr gi endoscopy/guide wire	14	−5	−19
62310	Inject spine c/t	12	−3	−11
64484	Inj foramen epidural ADD-on	11	−3	−11
29880	Knee arthroscopy/surgery	11	23	94
G0260	Inj for sacroiliac jt anesth	9	−3	−11
28285	Repair of hammertoe	9	18	72
67038	Strip retinal membrane	9	30	120
29848	Wrist endoscopy/surgery	9	−2	−9
64623	Destr paravertebral n ADD-on	9	−3	−11
45383	Lesion removal colonoscopy	8	−4	−16

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

Table 70 identifies a number of ASC procedures receiving the highest estimated CY 2008 payment under the current system and shows that most of them will experience payment decreases in CY 2008 under the revised ASC payment system. This contrasts with the estimated aggregate payment increases at the surgical specialty group level displayed in Table 69. In fact, Table 69 shows only one surgical specialty group of procedures for which the proposed payments are expected to decrease in the first year under the revised ASC payment system, and only two groups for which a decrease would be expected if there were no transition period to the revised CY 2008 payment rates. The estimated increased payments at the full group level are due to the moderating effect of the proposed payment increases for the less frequently performed procedures within the surgical specialty group. The exception to this is the surgical specialty group of eye and ocular adnexa where the projected aggregate increase in CY 2008 under the revised system is driven by a small proposed increase, 1 percent, in payment for the highest volume procedure (CPT code 66984, Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedures), manual or mechanical technique (e.g., irrigation and aspiration or phacoemulsification)).

As a result of the redistribution of payments across the expanded breadth of surgical procedures for which Medicare will provide an ASC payment, we believe that ASCs may change the mix of services they provide over the next several years. The revised ASC payment system should encourage ASCs to expand their service mix beyond the handful of the highest paying procedures which comprise the majority of ASC utilization under the existing ASC payment system. For example, although the proposed payment rate for cystoscopy (CPT code 52000), the highest volume ASC genitourinary procedure, is 6 percent less for CY 2008 than under the existing payment system, overall proposed payment to ASCs for the group of genitourinary procedures currently performed in ASCs is expected to increase by 12 percent. Although a urology specialty ASC may currently perform more cystoscopy procedures than any other genitourinary procedure, we believe that under the revised ASC payment system, each ASC has the opportunity to adapt to the payment decrease for its most frequently performed procedures by offering an increased breadth of procedures, still within the clinical specialty area, and receive payments that are adequate to support continued operations. Similarly, proposed payment for all of the highest volume pain management injection procedures are expected to decrease in CY 2008, although payment for nervous system procedures overall are expected to increase. However, without a transition for CY 2008, we estimate that payments also would decrease slightly for the nervous system surgical specialty group.

For those procedures that will be paid a significantly lower amount under the revised payment system than they are currently paid, we believe that their current payment rates, which are closer to the OPPS payment rates than other ASC procedures, are likely to be generous relative to ASC costs, so ASCs would, in all likelihood, continue performing those procedures under the revised payment system. We also note that the majority of the most frequently performed ASC procedures specifically studied by the GAO, as described in the July 2007 final rule for the revised ASC payment system, appear in Table 70 with proposed payment decreases under

the revised ASC payment system. The GAO concluded that for these procedures the OPPS APC groups accurately reflect the relative costs of procedures performed at ASCs and that ASCs have substantially lower costs.

For some procedures the proposed payment amounts in CY 2008 are much higher than the CY 2007 rates currently paid to ASCs. For example, payment for CPT code 67038 (Vitrectomy, mechanical, pars plana approach; with epiretinal membrane stripping) increases by 30 percent compared to estimated CY 2008 payments under the current system. Similarly, the proposed CY 2008 ASC payment for CPT code 29880 (Arthroscopy, knee, surgical; with meniscetomy (medial AND lateral, including any meniscal shaving)) increases by 23 percent. For these two procedures and the other procedures with estimated payment increases greater than 10 percent, the increases are due to the comparatively higher OPPS rates which, when adjusted by the ASC budget neutrality factor and blended with the CY 2007 ASC payment amounts, generate CY 2008 ASC payment rates that are substantially above the current CY 2007 ASC payment amounts.

As proposed in this rule, payments for most of the highest volume colonoscopy and upper gastrointestinal endoscopy procedures will decrease under the revised payment system. Table 69 estimates that payment decreases also are expected for the gastrointestinal surgical specialty group overall. We believe that decreased payments for so many of the gastrointestinal procedures are because current ASC payment rates are close to the OPPS rates. Procedures with current payment rates that are nearly as high as their OPPS rates are negatively affected under the revised payment system while procedures for which ASC rates have historically been much lower than the comparable OPPS rates are positively affected. The payment decreases expected in the first year under the revised ASC payment system for some of the high volume gastrointestinal procedures are not large (all less than 7 percent). We believe that ASCs can generally continue to cover their costs for these procedures, and that ASCs specializing in providing those services will be able to adapt their business practices and case mix to manage declines for individual procedures.

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

Table 71 displays a comparison of the Medicare payment rates for ASC procedures receiving the highest estimated CY 2008 payment under the current ASC payment system, based on the estimates provided in the July 2007 ASC final rule for illustrative purposes, and the proposed payment rates presented in this CY 2008 OPPS/ASC proposed rule.

- Column 1—*HCPCS code.*
- Column 2—*Short Descriptor* of the HCPCS code.
- Column 3—*Estimated CY 2008 ASC Payments* in the absence of the revised payment system were calculated by multiplying the CY 2007 ASC payment rate by CY 2008 ASC utilization (which is based on CY 2006 ASC utilization multiplied by a factor of 1.176 to take into account expected volume growth with volume adjustment, as appropriate, for the multiple procedure discount). The resulting amount was then multiplied by 0.8 to estimate the Medicare program's share of the total payments to the ASC. The estimated CY 2008 payment amounts are expressed in millions of dollars.
- Column 4—*Final Rule Estimated CY 2008 Payment Rate with Transition* (75/25 Blend) presents the estimated CY 2008 payment rate from the July 2007 final rule for the revised ASC payment system.
- Column 5—*Proposed Rule Estimated CY 2008 Payment Rate* presents the proposed CY 2008 payment rate in this proposed rule.
- Column 6—*Estimated Percent Change from Final Rule to Proposed Rule* presents the percent change in the payment rate from the final rule to this proposed rule.

Table 71 shows that although the estimated ASC budget neutrality percentage has changed from the July 2007 final rule for the revised ASC payment system (67 percent) to this CY 2008 OPPS/ASC proposed rule (65 percent), payment rates for individual procedures generally change very little from the final rule to this proposed rule. Due to the proposed OPPS APC recalibration for CY 2008, including the OPPS packaging proposal, the CY 2008 OPPS payment rates are typically increasing slightly for many surgical procedures compared to the CY 2007 OPPS payment rates. Because the proposed CY 2008 ASC payment rates in this proposed rule are a product of typically higher OPPS payment rates and a slightly lower budget neutrality factor (as compared to the final rule on the revised ASC payment system), these two forces in many cases balance each other, and the resulting ASC payment rates estimated in this proposed rule for many procedures change little compared with the final rule for the revised ASC payment system. Because we have not revised our budget neutrality methodology nor other ASC ratesetting policies from the July 2007 final rule, to the extent that there are significant observed changes for particular surgical procedures in estimated payment rates between the final rule and this proposed rule, these reflect more specific changes in the OPPS payment rates stemming from the proposed APC recalibration, including the effects of the OPPS packaging proposal, under the proposed CY 2008 OPPS.

TABLE 71.—COMPARISON OF ESTIMATED CY 2008 MEDICARE PAYMENT RATES IN THE JULY 2007 FINAL RULE FOR THE REVISED ASC PAYMENT SYSTEM AND CY 2008 OPPS/ASC PROPOSED RULE FOR PROCEDURES WITH THE HIGHEST ESTIMATED CY 2008 PAYMENTS UNDER THE CURRENT SYSTEM

HCPCS code	Short Descriptor	Estimated CY 2008 ASC payments (in millions)	July 2007 ASC final rule estimated CY 2008 payment rate (75/25 blend)	Proposed rule estimated CY 2008 payment rate (75/25 blend)	Estimated percent change from July 2007 ASC final rule to proposed rule
66984	Cataract surg w/iol, 1 stage	$981	$981.09	$980.43	0
43239	Upper GI endoscopy, biopsy	143	422.96	424.27	0
45378	Diagnostic colonoscopy	133	427.76	428.0	2
45380	Colonoscopy and biopsy	110	427.76	428.02	0
66821	After cataract laser surgery	87	288.45	288.60	0
45385	Lesion removal colonoscopy	87	427.76	428.02	0
62311	Inject spine l/s (cd)	70	317.40	323.62	2
64483	Inj foramen epidural l/s	42	317.40	323.62	2
66982	Cataract surgery, complex	37	981.09	980.43	0
45384	Lesion remove colonoscopy	36	427.76	428.02	0
15823	Revision of upper eyelid	35	687.02	754.42	10
G0121	Colon ca scrn not hi rsk ind	34	417.98	417.44	0
G0105	Colorectal scrn; hi risk ind	27	417.98	417.44	0
64476	Inj paravertebral l/s ADD-on	24	310.64	292.80	−6
64475	Inj paravertebral l/s	24	317.40	323.62	2
43235	Uppr gi endoscopy, diagnosis	23	338.21	339.52	0
52000	Cystoscopy	21	318.83	312.97	−2
67904	Repair eyelid defect	16	654.63	671.51	3
64721	Carpal tunnel surgery	15	524.35	526.05	0
29881	Knee arthroscopy/surgery	15	776.94	777.27	0
43248	Uppr gi endoscopy/guide wire	14	422.96	424.27	0
62310	Inject spine c/t	12	317.40	323.62	2
64484	Inj foramen epidural ADD-on	11	317.40	323.62	2
29880	Knee arthroscopy/surgery	11	776.94	777.27	0
G0260	Inj for sacroiliac jt anesth	9	310.64	323.62	4
28285	Repair of hammertoe	9	599.75	601.67	0
67038	Strip retinal membrane	9	935.83	932.21	0
29848	Wrist endoscopy/surgery	9	1,308.69	1,309.02	0
64623	Destr paravertebral n ADD-on	9	317.40	323.62	2
45383	Lesion removal colonoscopy	8	427.76	428.02	0

b. Payment to Physicians for Performing Excluded ASC Procedures in an ASC

As discussed in section XVI.G. of this proposed rule, we are proposing to pay physicians at the facility rate for furnishing procedures in ASCs that are excluded from the ASC list of covered procedures. This policy reduces site of service (facility versus nonfacility) differentials that currently exist and aligns physician payment policies for services furnished in ASCs and hospital outpatient departments.

We believe that the effect of the proposed change will be small. Currently, physicians are paid for procedures performed in ASCs that are not on the list of ASC covered surgical procedures based on the nonfacility PE RVUs, unless a nonfacility rate does not exist in which case they are paid based on the facility rate. For CY 2008, we excluded procedures from the ASC list of covered surgical procedures because they could pose a significant risk to beneficiary safety or would be expected to require an overnight stay and, as such, these procedures are generally more complex than procedures furnished in physicians' offices. Consequently, most surgical procedures that will be excluded from the list of ASC covered surgical procedures in CY 2008 do not have nonfacility PE RVUs. Specifically, only 25 of approximately 280 excluded ASC procedures for CY 2008 have nonfacility PE RVUs. As a result, even under our current policy, physicians performing an excluded ASC procedure in an ASC would be paid for most excluded procedures based on the facility PE RVUs. Thus, our proposed policy to pay physicians for excluded ASC procedures performed in ASCs based on the facility PE RVUs would only impact Medicare payment rates for the small proportion of excluded procedures that have nonfacility PE RVUs.

4. Estimated Effects of This Proposed Rule on Beneficiaries

a. Payment to ASCs

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

ASC payment system on beneficiary coinsurance, taking into account the migration of services from HOPDs and physicians' offices, is estimated to be $20 million in beneficiary savings in CY 2008.

In addition to the lower out-of-pocket expenses, we believe that beneficiaries also will have access to more services in ASCs as a result of the addition of approximately 790 surgical procedures to the ASC list of covered surgical services eligible for Medicare payment. We expect that ASCs will provide a broader range of surgical services under the revised payment system and that beneficiaries will benefit from having access to a greater variety of surgical procedures in ASCs.

b. Payment to ASCs for Excluded Procedures Performed in an ASC

In addition, the proposed revision to § 414.22(b)(5)(i) (A) and (B) would impose beneficiary liability for facility costs associated with surgical procedures that are not Medicare covered surgical procedures in ASCs. In the July 2007 final rule for the revised ASC payment system, CMS determined that the only surgical procedures that will be excluded from ASC payment in CY 2008 are those that could pose a significant safety risk to beneficiaries when furnished in an ASC or are expected to require an overnight stay when furnished in ASCs and, therefore, Medicare provides no payment to ASCs for these procedures. The proposed revision to § 414.22(b)(5)(i)(A) and (B) would also provide for no payment to physicians for the facility resources required to furnish these services, leaving the beneficiary liable for the facility payment if a surgical procedure excluded by Medicare from ASC payment is, in fact, performed in the ASC setting. In reality, however, we do not expect that the proposed change would result in a meaningful increase in beneficiary liability because we do not expect that these excluded services, which we have determined could pose a significant risk to beneficiary safety or would be expected to require an overnight stay, will be furnished to Medicare beneficiaries in ASCs. We expect further that physicians and ASCs would advise beneficiaries of all of the possible consequences (including denial of Medicare payment with concomitant beneficiary liability and significant surgical risk) if surgical procedures excluded from ASC payment were provided in ASCs.

5. Conclusion

The changes to the ASC payment system for CY 2008 will affect each of the approximately 4,600 ASCs currently approved for participation in the Medicare program. The effect on an individual ASC will depend on the ASC's mix of patients, the proportion of the ASC's patients that are Medicare beneficiaries, the degree to which the payments for the procedures offered by the ASC are changed under the revised payment system, and the degree to which the ASC chooses to provide a different set of procedures.

The revised ASC payment system is designed to result in the same aggregate amount of Medicare expenditures in CY 2008 that would be made in the absence of the revised ASC payment system. As mentioned previously, we estimate that the revised ASC payment system and the expanded ASC list of covered surgical procedures that we are implementing in CY 2008 will have no net effect on Medicare expenditures compared to the level of Medicare expenditures that would have occurred in CY 2008 in the absence of the revised payment system. However, there will be a total increase in Medicare payments to ASCs for CY 2008 of approximately $240 million as a result of the revised ASC payment system, which will be fully offset by savings from reduced Medicare spending in HOPDs and physicians' offices on services that migrate from these settings to ASCs (as discussed in detail in section XVI.L. of this proposed rule). Furthermore, we estimate that the revised ASC payment system will result in Medicare savings of $200 million over 5 years due to migration of new ASC services from HOPDs and physicians' offices to ASCs over time. We anticipate that this proposed rule will have a significant economic impact on a substantial number of small entities.

6. Accounting Statement

As required by OMB Circular A–4 (available at *http://www.whitehousegov/omb/circulars/a004/a-4.pdf)*, in Table 72 below, we have prepared an accounting statement showing the classification of the expenditures associated with the implementation of the CY 2008 revised ASC payment system, based on the provisions of this final rule. As explained above, we estimate that Medicare payments to ASCs for CY 2008 will be about $240 million higher than they otherwise would be in the absence of the revised ASC payment system. This $240 million in additional payments to ASCs will be fully offset by savings from reduced Medicare spending in HOPDs and physicians' offices on services that migrate from these settings to ASCs. This table provides our best estimate of Medicare payments to providers and suppliers as a result of the CY 2008 revised ASC payment system, as presented in this proposed rule. All expenditures are classified as transfers.

TABLE 72.—ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED EXPENDITURES FROM CY 2007 TO CY 2008 AS A RESULT OF THE CY 2008 REVISED ASC PAYMENT SYSTEM

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

D. Effects of the Proposed Requirements for Reporting of Quality Data for Hospital Outpatient Settings

In section XVII. of this proposed rule, we discuss our proposed measures and requirements for reporting of quality data to CMS for services furnished in hospital outpatient settings under the HOP QDRP. We also note that, for the CY 2009 payment update, hospitals must pass our validation requirement of a minimum of 80 percent reliability, based upon our chart-audit validation process, for January 2008. These data are due to the OPPS Clinical Warehouse by May 31, 2008. CMS and its contractors will provide assistance to all hospitals that wish to submit data. As noted in section XVIII of this proposed rule, we are also providing additional validation criteria to ensure that the quality data being sent to CMS are accurate. The requirement of 5 charts

per hospital will result in the submission of approximately 21,500 charts for services furnished in January 2008 to the agency. We reimburse hospitals for the cost of sending charts to the Clinical Data Abstraction Center (CDAC) at the rate of 12 cents per page for copying and approximately $4.00 per chart for postage. Our experience shows that the average inpatient chart received at the CDAC is approximately 150 pages, and we estimate outpatient charts will contain a similar number of pages. Thus, the agency estimates that it will have expenditures of approximately $473,200 to collect the January 2008 charts. Given that we reimburse for the copying and mailing related to this data collection effort, we believe that a requirement for five charts per hospital for services furnished in January 2008 represents a minimal burden to the participating hospital.

E. Effects of the Proposed Policy on CAH Off-Campus and Co-Location Requirements

In section XVIII.A. of this proposed rule, we discuss our proposed changes regarding a CAH's ability to co-locate with another acute care hospital or establish an off-campus location that does not comply with the location requirements (more than a 35-mile drive, or in the case of mountainous terrain or in areas with only secondary roads available, a 15-mile drive) for CAHs. We are proposing to clarify in this proposed rule that if a CAH with a necessary provider designation has a co-location arrangement with another hospital or CAH that was in effect before January 1, 2008, and the type and scope of services offered by the facilities co-located with the necessary provider CAH do not change, the CAH can continue those arrangements. In addition, if a CAH (including one with a necessary provider designation) operates a provider-based location or an off-campus distinct part psychiatric or rehabilitation unit after January 1, 2008, the CAH must comply with the location requirements. We have proposed that CAHs can continue current co-location and off-campus arrangements that are in place as of January 1, 2008. We believe there is no burden associated with this proposed clarifying regulation.

F. Effects of Proposed Policy Revisions to the Hospital CoPs

In section XVIII.B. of this proposed rule, we discuss proposed changes to the hospital CoPs relating to timeframes for completion of medical history and physical examination and proposed requirements for preanesthesia and postanesthesia evaluations of Medicare beneficiaries. We believe that these proposed revisions would impose minimal additional costs on hospitals. In fact, hospitals may realize some minimal cost savings. The cost of implementing these proposed changes would largely be limited to the one-time cost related to the revision of a hospital's medical staff bylaws and its policies and procedures as they relate to the proposed requirements for medical history and physical examinations and for preanesthesia and postanesthesia evaluations. There also may be some minimal cost associated with communicating these changes to affected hospital staff. However, we believe that these costs would be offset by the benefits derived from the overall intent of these proposed revisions to require that the most current information regarding a patient's condition be available to hospital staff so that risks to patient safety can be minimized and potential adverse outcomes can be avoided. Furthermore, the proposed changes would clarify existing hospital CoPs to make them more consistent with current practice, while still retaining the flexibility and reduction in burden that hospitals are currently provided in meeting those CoPs. Therefore, no burden is being assessed on the revision of medical staff bylaws and hospital policies and procedures or on the communication of these revisions to staff that would be required by these proposed revisions as these practices are usual and customary business practices.

G. Executive Order 12866

In accordance with the provisions of Executive Order 12866, this proposed rule was reviewed by the OMB.

List of Subjects

42 CFR Part 410

Health facilities, Health professions, Laboratories, Medicare, Rural areas, X rays.

42 CFR Part 411

Kidney diseases, Medicare, Physician referral, Reporting and recordkeeping requirements.

42 CFR Part 414

Administrative practice and procedure, Health facilities, Health professions, Kidney diseases, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 416

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

42 CFR Part 419

Hospitals, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 482

Grant program-health, Hospitals, Medicaid, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 485

Grant program-health, Health facilities, Medicaid, Medicare, Reporting and recordkeeping requirements.

For reasons stated in the preamble of this proposed rule, the Centers for Medicare & Medicaid Services is proposing to amend 42 CFR Chapter IV as set forth below:

PART 410—SUPPLEMENTARY MEDICAL INSURANCE (SMI) BENEFITS

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

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

2. Section 410.27 is amended by—
a. Revising paragraph (a)(1)(iii).
b. Revising paragraph (f).
The revisions read as follows:

§ 410.27 Outpatient hospital services and supplies incident to a physician service: Conditions.

(a) * * *
(1) * * *
(iii) In the hospital or at a department of a provider, as defined in § 413.65(a)(2) of this subchapter, that has provider-based status in relation to a hospital under § 413.65 of this subchapter; and
* * * * *
(f) Services furnished at a department of a provider, as defined in § 413.65(a)(2) of this subchapter, that has provider-based status in relation to a hospital under § 413.65 of this subchapter, must be under the direct supervision of a physician. ''Direct supervision'' means 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.

PART 411—EXCLUSIONS FROM MEDICARE AND LIMITATIONS ON MEDICARE PAYMENT

3. 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, and 1395nn.

4. Section 411.351 is amended by revising the definitions of ''outpatient prescription drugs'' and ''radiology and certain other imaging services'' to read as follows:

§ 411.351 Definitions.

* * * * *

Outpatient prescription drugs means all drugs covered by Medicare Part B or D, except for those drugs that are ''covered ancillary services,'' as defined at § 416.164(b) of this chapter, for which separate payment is made to an ambulatory surgical center.

* * * * *

Radiology and certain other imaging services means those particular services so identified on the List of CPT/HCPCS Codes. All services identified on the List of CPT/HCPCS Codes are radiology and certain other imaging services for purposes of this subpart. Any service not specifically identified as radiology and certain other imaging services on the List of CPT/HCPCS Codes is not a radiology or certain other imaging service for purposes of this subpart. The list of codes identifying radiology and certain other imaging services includes the professional and technical components of any diagnostic test or procedure using x-rays, ultrasound, computerized axial tomography, magnetic resonance imaging, nuclear medicine (effective January 1, 2007), or other imaging services. All codes identified as radiology and certain other imaging services are covered under section 1861(s)(3) of the Act and § 410.32 and § 410.34 of this chapter, but do not include—

(1) X ray, fluoroscopy, or ultrasound procedures that require the insertion of a needle, catheter, tube, or probe through the skin or into a body orifice;

(2) Radiology or certain other imaging services that are integral to the performance of a medical procedure that is not identified on the list of CPT/HCPCS codes as a radiology or certain other imaging service and is performed—

(i) Immediately prior to or during the medical procedure; or

(ii) Immediately following the medical procedure when necessary to confirm placement of an item placed during the medical procedure.

(3) Radiology and certain other imaging services that are ''covered ancillary services,'' as defined at § 416.164(b), for which separate payment is made to an ASC.

* * * * *

PART 414—PAYMENT FOR PART B MEDICAL AND OTHER HEALTH SERVICES

5. The authority citation for Part 414 continues to read as follows:

Authority: Secs. 1102, 1871, and 1881(b)(1) of the Social Security Act (42 U.S.C. 1302, 1395hh, and 1395rr(b)(1)).

6. Section 414.22 is amended by revising paragraphs (b)(5)(i)(A) and (B) to read as follows:

§ 414.22 Relative value units (RVUs).

* * * * *

(b) * * *

(5) * * *

(i) * * *

(A) *Facility practice expense RVUs.* The lower facility practice expense RVUs apply to services furnished to patients in the hospital, skilled nursing facility, community mental health center, or in an ambulatory surgical center. (The facility practice expense RVUs for a particular code may not be greater than the nonfacility RVUs for the code.)

(B) *Nonfacility practice expense RVUs.* The higher nonfacility practice expense RVUs apply to services performed in a physician's office, a patient's home, a nursing facility, or a facility or institution other than a hospital or skilled nursing facility, community mental health center, or ASC.

* * * * *

PART 416—AMBULATORY SURGICAL SERVICES

7. 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).

8. Added in a separate final rule published elsewhere in this issue of the **Federal Register**, § 416.179 is amended by—

a. Revising the section heading.

b. Revising paragraphs (a)(1) and (a)(2)

c. Adding new paragraph (a)(3).

d. Redesignating the text of paragraph (b) as paragraph (b)(1).

e. Revising newly redesignated paragraph (b)(1).

f. Adding new paragraph (b)(2).

The revisions and additions read as follows:

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

(a) * * *

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

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

(3) The ASC receives partial credit for the cost of a replaced device but only where the amount of the device credit is greater than or equal to 20 percent of the cost of the new replacement device being implanted.

(b) *Amount of reduction to the ASC payment for the covered surgical procedure.* (1) The amount of the reduction to the ASC payment made under paragraphs (a)(1) and (a)(2) of this section is calculated in the same manner as the device payment reduction that would be applied to the ASC payment for the covered surgical procedure in order to remove predecessor device costs so that the ASC payment amount for a device with pass-through status under § 419.66 of this subchapter represents the full cost of the device, and no packaged device payment is provided through the ASC payment for the covered surgical procedure.

(2) The amount of the reduction to the ASC payment made under paragraph (a)(3) of this section is 50 percent of the payment reduction that would be calculated under paragraph (b)(1) of this section.

* * * * *

PART 419—PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES

9. The authority citation for Part 419 continues to read as follows:

Authority: Secs. 1102, 1833(t), and 1871 of the Social Security Act (42 U.S.C. 1302, 1395l(t), and 1395hh).

10. Section 419.43 is amended by revising paragraph (g)(4) to read as follows:

§ 419.43 Adjustments to national program payment and beneficiary copayment amounts.

* * * * *

(g) * * *

(4) *Excluded services and groups.* Drugs and biologicals that are paid under a separate APC and devices paid under § 419.66 are excluded from qualification for the payment adjustment in paragraph (g)(2) of this section.

* * * * *

11. Section 419.44 is amended by—

a. Revising the section heading.

b. Revising paragraph (b).

The revisions and addition read as follows:

§ 419.44 Payment reductions for procedures.

* * * * *

(b) *Interrupted procedures.* When a procedure is terminated prior to

completion due to extenuating circumstances or circumstances that threaten the well-being of the patient, the Medicare program payment amount and the beneficiary copayment amount are based on—

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

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

(3) One-half of the full program and beneficiary copayment amounts if a procedure for which anesthesia is not planned is discontinued after the patient is prepared and taken to the room where the procedure is to be performed.

12. Section 419.45 is amended by—

a. Revising the section heading.

b. Revising paragraph (a)(1).

c. Revising paragraph (a)(2).

d. Adding new paragraph (a)(3).

e. Revising paragraph (b).

The revisions and additions read as follows:

§ 419.45 Payment and copayment reduction for devices replaced without cost or when full or partial credit is received.

(a) * * *

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

(2) The provider receives full credit for the cost of a replaced device; or

(3) The provider receives partial credit for the cost of a replaced device but only where the amount of the device credit is greater than or equal to 20 percent of the cost of the new replacement device being implanted.

(b) *Amount of reduction to the APC payment.*

(1) The amount of the reduction to the APC payment made under paragraphs (a)(1) and (a)(2) of this section is calculated in the same manner as the offset amount that would be applied if the device implanted during a procedure assigned to the APC had transitional pass-through status under § 419.66.

(2) The amount of the reduction to the APC payment made under paragraph (a)(3) of this section is 50 percent of the offset amount that would be applied if the device implanted during a procedure assigned to the APC had transitional pass-through status under § 419.66.

* * * * *

§ 419.70 [Amended]

13. Section 419.70 is amended by—

a. In paragraph (d)(1)(i), removing the cross-reference ''§ 412.63(b)'' and adding the cross-reference ''§ 412.64(b)'' in its place.

b. In paragraph (d)(2)(i), removing the cross-reference ''§ 412.63(b)'' and adding the cross-reference ''§ 412.64(b)'' in its place.

c. In paragraph (d)(4)(ii), removing the cross-reference ''§ 412.63(b)'' and adding the phrase ''§ 412.63(b) or § 412.64(b), as applicable,'' in its place.

PART 482—CONDITIONS OF PARTICIPATION FOR HOSPITALS

14. The authority citation for Part 482 continues to read as follows:

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

15. Section 482.22 is amended by revising paragraph (c)(5) to read as follows:

§ 482.22 Condition of participation: Medical staff.

* * * * *

(c) * * *

(5) Include a requirement that—

(i) A medical history and physical examination be completed and documented for each patient no more than 30 days before or 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The medical history and physical examination must be completed and documented by a physician (as defined in section 1861(r) of the Act), an oromaxillofacial surgeon, or other qualified licensed individual in accordance with State law and hospital policy.

(ii) An updated examination of the patient, including any changes in the patient's condition, be completed and documented within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services, when the medical history and physical examination are completed within 30 days before admission or registration. The updated examination of the patient, including any changes in the patient's condition, must be completed and documented by a physician (as defined in section 1861(r) of the Act), an oromaxillofacial surgeon, or other qualified licensed individual in accordance with State law and hospital policy.

* * * * *

§ 482.23 [Amended]

16. In § 482.23(b)(1), the cross-reference ''§ 405.1910(c)'' is removed and the cross-reference ''§ 488.54(c)'' is added in its place.

17. Section 482.24 is amended by revising paragraph (c)(2)(i) to read as follows:

§ 482.24 Condition of participation: Medical record services.

* * * * *

(c) * * *

(2) * * *

(i) Evidence of—

(A) A medical history and physical examination completed and documented no more than 30 days before or 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The medical history and physical examination must be placed in the patient's medical record within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services.

(B) An updated examination of the patient, including any changes in the patient's condition, when the medical history and physical examination are completed within 30 days before admission or registration. Documentation of the updated examination must be placed in the patient's medical record within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services.

* * * * *

18. Section 482.51 is amended by revising paragraph (b)(1) to read as follows:

§ 482.51 Condition of participation: Surgical services.

* * * * *

(b) * * *

(1) Prior to surgery or a procedure requiring anesthesia services and except in the case of emergencies:

(i) A medical history and physical examination must be completed and documented no more than 30 days before or 24 hours after admission or registration.

(ii) An updated examination of the patient, including any changes in the patient's condition, must be completed and documented within 24 hours after admission or registration when the medical history and physical examination are completed within 30 days before admission or registration.

* * * * *

19. Section 482.52 is amended by—

a. Revising paragraph (b)(1).

b. Revising paragraph (b)(3).

c. Removing paragraph (b)(4).

The revisions read as follows:

§ 482.52 Condition of participation: Anesthesia services.

* * * * *

(b) * * *

(1) A preanesthesia evaluation completed and documented by an individual qualified to administer anesthesia, as specified in paragraph (a) of this section, performed within 48 hours prior to surgery or a procedure requiring anesthesia services.

* * * * *

(3) A postanesthesia evaluation completed and documented by an individual qualified to administer anesthesia, as specified in paragraph (a) of this section, after surgery or a procedure requiring anesthesia services, but before discharge or transfer from the postanesthesia recovery area.

* * * * *

PART 485—CONDITIONS OF PARTICIPATION: SPECIALIZED PROVIDERS

20, The authority citation for Part 485 continues to read as follows:

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

21. Section 485.610 is amended by adding new paragraph (e) to read as follows:

§ 485.610 Condition of participation: Status and location.

* * * * *

(e) *Standard: Off-campus and co-location requirements for CAHs.* A CAH may continue to meet the location requirement of paragraph (c) of this section based only if the CAH meets the following:

(1) If a CAH with a necessary provider designation is co-located (that is, it shares a campus, as defined in § 413.65(a)(2) of this chapter, with another hospital or CAH), the necessary provider CAH can continue to meet the location requirement of paragraph (c) of this section only if the co-location arrangement was in effect before January 1, 2008, and the type and scope of services offered by the facility co-located with the necessary provider CAH do not change. A change of ownership of any of the facilities with a co-location arrangement that was in effect before January 1, 2008 will not be considered to be a new co-location arrangement.

(2) If a CAH or a necessary provider CAH operates a provider-based location, including a department or remote location, as defined in § 413.65(a)(2) of this chapter, or an off-campus distinct part psychiatric or rehabilitation unit, as defined in § 485.647, that was created or acquired by the CAH after January 1, 2008, the CAH can continue to meet the location requirement of paragraph (c) of this section only if the provider-based location or off-campus distinct part unit is located more than a 35-mile drive (or, in the case of mountainous terrain or in areas with only secondary roads available, a 15-mile drive) from a hospital or another CAH.

(3) If either a CAH or a CAH that has been designated as a necessary provider by the State does not meet the requirements in paragraph (e)(1) of this section, by co locating with another hospital or CAH after January 1, 2008, or creates or acquires a provider-based location or off-campus distinct part unit after January 1, 2008, that does not meet the requirements in paragraph (e)(2) of this section, the CAH's provider agreement will be subject to termination in accordance with the provisions of § 489.53(a)(3), unless the CAH terminates the off-campus arrangement or the co-location arrangement, or both.

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

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

Dated: July 5, 2007.

Leslie V. Norwalk,

Acting Administrator, Centers for Medicare & Medicaid Services.

Approved: July 10, 2007.

Michael O. Leavitt,

Secretary.

ADDENDUM A.—PROPOSED OPPS APCS FOR CY 2008

APC	Group Title	SI	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
0001	Level I Photochemotherapy	S	0.5204	$33.15	$7.00	$6.63
0002	Level I Fine Needle Biopsy/Aspiration	T	1.1915	$75.89		$15.18
0003	Bone Marrow Biopsy/Aspiration	T	3.2390	$206.30		$41.26
0004	Level I Needle Biopsy/Aspiration Except Bone Marrow	T	4.5062	$287.01		$57.40
0005	Level II Needle Biopsy/Aspiration Except Bone Marrow	T	7.3012	$465.04		$93.01
0006	Level I Incision & Drainage	T	1.4630	$93.18		$18.64
0007	Level II Incision & Drainage	T	12.5792	$801.21		$160.24
0008	Level III Incision and Drainage	T	19.0457	$1,213.08		$242.62
0012	Level I Debridement & Destruction	T	0.2682	$17.08		$3.42
0013	Level II Debridement & Destruction	T	0.8046	$51.25		$10.25
0015	Level III Debridement & Destruction	T	1.5119	$96.30		$19.26
0016	Level IV Debridement & Destruction	T	2.7493	$175.11		$35.02
0017	Level VI Debridement & Destruction	T	20.0977	$1,280.08		$256.02
0019	Level I Excision/Biopsy	T	4.4463	$283.20	$71.80	$56.64
0020	Level II Excision/Biopsy	T	8.7155	$555.12		$111.02
0021	Level III Excision/Biopsy	T	16.5832	$1,056.23	$219.40	$211.25
0022	Level IV Excision/Biopsy	T	21.4534	$1,366.43	$354.40	$273.29
0023	Exploration Penetrating Wound	T	9.5721	$609.68		$121.94
0028	Level I Breast Surgery	T	20.9980	$1,337.43	$303.70	$267.49
0029	Level II Breast Surgery	T	32.4940	$2,069.64	$581.50	$413.93
0030	Level III Breast Surgery	T	40.4634	$2,577.24	$747.00	$515.45
0031	Smoking Cessation Services	X	0.1660	$10.57		$2.11
0033	Partial Hospitalization	P	2.8241	$179.88		$35.98
0034	Mental Health Services Composite	P	2.8241	$179.88		$35.98
0035	Arterial/Venous Puncture	T	0.2091	$13.32		$2.66
0037	Level IV Needle Biopsy/Aspiration Except Bone Marrow	T	13.9599	$889.15	$228.70	$177.83
0039	Level I Implantation of Neurostimulator	S	197.4688	$12,577.38		$2,515.48
0040	Percutaneous Implantation of Neurostimulator Electrodes, Excluding Cranial Nerve.	S	63.7536	$4,060.66		$812.13
0041	Level I Arthroscopy	T	29.4467	$1,875.55		$375.11
0042	Level II Arthroscopy	T	47.7765	$3,043.03	$804.70	$608.61
0043	Closed Treatment Fracture Finger/Toe/Trunk	T	1.8742	$119.37		$23.87
0045	Bone/Joint Manipulation Under Anesthesia	T	15.0176	$956.52	$268.40	$191.30

ADDENDUM A.—PROPOSED OPPS APCS FOR CY 2008—Continued

APC	Group Title	SI	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
0047	Arthroplasty without Prosthesis	T	35.9249	$2,288.16	$537.00	$457.63
0048	Level I Arthroplasty with Prosthesis	T	51.0431	$3,251.09		$650.22
0049	Level I Musculoskeletal Procedures Except Hand and Foot	T	21.5761	$1,374.25		$274.85
0050	Level II Musculoskeletal Procedures Except Hand and Foot	T	29.3263	$1,867.88		$373.58
0051	Level III Musculoskeletal Procedures Except Hand and Foot	T	43.5953	$2,776.72		$555.34
0052	Level IV Musculoskeletal Procedures Except Hand and Foot	T	78.6518	$5,009.57		$1,001.91
0053	Level I Hand Musculoskeletal Procedures	T	16.8220	$1,071.44	$253.40	$214.29
0054	Level II Hand Musculoskeletal Procedures	T	26.7322	$1,702.65		$340.53
0055	Level I Foot Musculoskeletal Procedures	T	21.1762	$1,348.78	$355.30	$269.76
0056	Level II Foot Musculoskeletal Procedures	T	44.4710	$2,832.49		$566.50
0057	Bunion Procedures	T	29.8356	$1,900.32	$475.90	$380.06
0058	Level I Strapping and Cast Application	S	1.1272	$71.79		$14.36
0060	Manipulation Therapy	S	0.4877	$31.06		$6.21
0061	Laminectomy or Incision for Implantation of Neurostimulator Electrodes, Excluding Cranial Nerve.	S	81.3252	$5,179.85		$1,035.97
0062	Level I Treatment Fracture/Dislocation	T	26.3092	$1,675.71	$372.80	$335.14
0063	Level II Treatment Fracture/Dislocation	T	40.3466	$2,569.80	$548.30	$513.96
0064	Level III Treatment Fracture/Dislocation	T	60.0595	$3,825.37	$835.70	$765.07
0065	Level I Stereotactic Radiosurgery, MRgFUS, and MEG	S	17.1992	$1,095.47		$219.09
0066	Level II Stereotactic Radiosurgery, MRgFUS, and MEG	S	47.3767	$3,017.56		$603.51
0067	Level III Stereotactic Radiosurgery, MRgFUS, and MEG	S	61.5205	$3,918.43		$783.69
0069	Thoracoscopy	T	33.1688	$2,112.62	$591.60	$422.52
0070	Thoracentesis/Lavage Procedures	T	5.3095	$338.18		$67.64
0071	Level I Endoscopy Upper Airway	T	0.8256	$52.58	$11.20	$10.52
0072	Level II Endoscopy Upper Airway	T	1.5730	$100.19	$21.20	$20.04
0073	Level III Endoscopy Upper Airway	T	4.2060	$267.89	$69.10	$53.58
0074	Level IV Endoscopy Upper Airway	T	17.4546	$1,111.74	$292.20	$222.35
0075	Level V Endoscopy Upper Airway	T	23.2819	$1,482.89	$445.90	$296.58
0076	Level I Endoscopy Lower Airway	T	10.1732	$647.96	$189.80	$129.59
0077	Level I Pulmonary Treatment	S	0.3904	$24.87	$7.70	$4.97
0078	Level II Pulmonary Treatment	S	1.3636	$86.85		$17.37
0079	Ventilation Initiation and Management	S	2.6745	$170.35		$34.07
0080	Diagnostic Cardiac Catheterization	T	39.8631	$2,539.00	$838.90	$507.80
0082	Coronary or Non-Coronary Atherectomy	T	88.7717	$5,654.14		$1,130.83
0083	Coronary or Non-Coronary Angioplasty and Percutaneous Valvuloplasty	T	46.0685	$2,934.24		$586.85
0084	Level I Electrophysiologic Procedures	S	10.2918	$655.52		$131.10
0085	Level II Electrophysiologic Procedures	T	48.6296	$3,097.37		$619.47
0086	Level III Electrophysiologic Procedures	T	90.7639	$5,781.03		$1,156.21
0088	Thrombectomy	T	39.8001	$2,534.99	$655.20	$507.00
0089	Insertion/Replacement of Permanent Pacemaker and Electrodes	T	122.5662	$7,806.61	$1,682.20	$1,561.32
0090	Insertion/Replacement of Pacemaker Pulse Generator	T	99.8268	$6,358.27	$1,612.80	$1,271.65
0091	Level II Vascular Ligation	T	43.6609	$2,780.89		$556.18
0092	Level I Vascular Ligation	T	26.4396	$1,684.02		$336.80
0093	Vascular Reconstruction/Fistula Repair without Device	T	30.8639	$1,965.81		$393.16
0094	Level I Resuscitation and Cardioversion	S	2.5547	$162.72	$46.20	$32.54
0095	Cardiac Rehabilitation	S	0.5868	$37.38	$13.80	$7.48
0096	Non-Invasive Vascular Studies	S	1.5254	$97.16	$37.60	$19.43
0097	Prolonged Physiologic and Ambulatory Monitoring	X	1.0396	$66.22	$23.70	$13.24
0099	Electrocardiograms	S	0.3912	$24.92		$4.98
0100	Cardiac Stress Tests	X	2.8631	$182.36	$41.40	$36.47
0101	Tilt Table Evaluation	S	4.4249	$281.84	$100.20	$56.37
0103	Miscellaneous Vascular Procedures	T	15.2572	$971.78		$194.36
0104	Transcatheter Placement of Intracoronary Stents	T	89.0212	$5,670.03		$1,134.01
0105	Repair/Revision/Removal of Pacemakers, AICDs, or Vascular Devices	T	24.7274	$1,574.96	$370.40	$314.99
0106	Insertion/Replacement of Pacemaker Leads and/or Electrodes	T	75.0068	$4,777.41		$955.48
0107	Insertion of Cardioverter-Defibrillator	T	353.1242	$22,491.54		$4,498.31
0108	Insertion/Replacement/Repair of Cardioverter-Defibrillator Leads	T	403.0232	$25,669.76		$5,133.95
0109	Removal/Repair of Implanted Devices	T	6.1077	$389.02		$77.80
0110	Transfusion	S	3.4924	$222.44		$44.49
0111	Blood Product Exchange	S	12.1982	$776.94	$198.40	$155.39
0112	Apheresis and Stem Cell Procedures	S	31.9648	$2,035.93	$433.20	$407.19
0113	Excision Lymphatic System	T	23.5105	$1,497.45		$299.49
0114	Thyroid/Lymphadenectomy Procedures	T	45.1729	$2,877.20		$575.44
0115	Cannula/Access Device Procedures	T	30.5379	$1,945.05		$389.01
0121	Level I Tube changes and Repositioning	T	3.2914	$209.64	$43.80	$41.93
0125	Refilling of Infusion Pump	T	2.3262	$148.16		$29.63
0126	Level I Urinary and Anal Procedures	T	1.0850	$69.11	$16.40	$13.82
0127	Level IV Stereotactic Radiosurgery, MRgFUS, and MEG	S	123.4696	$7,864.15		$1,572.83
0130	Level I Laparoscopy	T	34.8153	$2,217.49	$659.50	$443.50
0131	Level II Laparoscopy	T	46.1201	$2,937.53	$1,001.80	$587.51
0132	Level III Laparoscopy	T	71.0022	$4,522.34	$1,239.20	$904.47
0133	Level I Skin Repair	T	1.3340	$84.97	$26.76	$16.99
0134	Level II Skin Repair	T	2.1114	$134.48	$42.36	$26.90
0135	Level III Skin Repair	T	4.6816	$298.19		$59.64
0136	Level IV Skin Repair	T	15.4399	$983.41		$196.68
0137	Level V Skin Repair	T	20.9338	$1,333.34		$266.67
0140	Esophageal Dilation without Endoscopy	T	6.0867	$387.68	$91.40	$77.54
0141	Level I Upper GI Procedures	T	8.6730	$552.41	$143.30	$110.48
0142	Small Intestine Endoscopy	T	9.6264	$613.13	$152.70	$122.63
0143	Lower GI Endoscopy	T	9.0360	$575.53	$186.00	$115.11

ADDENDUM A.—PROPOSED OPPS APCS FOR CY 2008—Continued

APC	Group Title	SI	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
0146	Level I Sigmoidoscopy and Anoscopy	T	5.1441	$327.64		$65.53
0147	Level II Sigmoidoscopy and Anoscopy	T	8.8611	$564.39		$112.88
0148	Level I Anal/Rectal Procedures	T	4.5189	$287.82		$57.56
0149	Level III Anal/Rectal Procedures	T	23.2282	$1,479.47		$295.89
0150	Level IV Anal/Rectal Procedures	T	30.5544	$1,946.10	$437.10	$389.22
0151	Endoscopic Retrograde Cholangio-Pancreatography (ERCP)	T	21.2820	$1,355.51		$271.10
0152	Level I Percutaneous Abdominal and Biliary Procedures	T	28.7304	$1,829.93		$365.99
0153	Peritoneal and Abdominal Procedures	T	25.4636	$1,621.85	$397.90	$324.37
0154	Hernia/Hydrocele Procedures	T	31.1722	$1,985.45	$464.80	$397.09
0155	Level II Anal/Rectal Procedures	T	11.6524	$742.18		$148.44
0156	Level III Urinary and Anal Procedures	T	3.0601	$194.91		$38.98
0157	Colorectal Cancer Screening: Barium Enema	S	2.2613	$144.03		$28.81
0158	Colorectal Cancer Screening: Colonoscopy	T	8.0134	$510.40		$127.60
0159	Colorectal Cancer Screening: Flexible Sigmoidoscopy	S	4.7799	$304.45		$76.11
0160	Level I Cystourethroscopy and other Genitourinary Procedures	T	6.1077	$389.02		$77.80
0161	Level II Cystourethroscopy and other Genitourinary Procedures	T	18.1376	$1,155.24	$243.72	$231.05
0162	Level III Cystourethroscopy and other Genitourinary Procedures	T	25.2775	$1,610.00		$322.00
0163	Level IV Cystourethroscopy and other Genitourinary Procedures	T	36.9175	$2,351.39		$470.28
0164	Level II Urinary and Anal Procedures	T	2.1659	$137.95		$27.59
0165	Level IV Urinary and Anal Procedures	T	19.6126	$1,249.19		$249.84
0166	Level I Urethral Procedures	T	19.6570	$1,252.01		$250.40
0168	Level II Urethral Procedures	T	30.1994	$1,923.49	$388.10	$384.70
0169	Lithotripsy	T	43.0352	$2,741.04	$1,009.40	$548.21
0170	Dialysis	S	6.7915	$432.57		$86.51
0181	Level II Male Genital Procedures	T	35.1574	$2,239.28	$621.80	$447.86
0183	Level I Male Genital Procedures	T	22.7802	$1,450.94		$290.19
0184	Prostate Biopsy	T	11.3168	$720.80		$144.16
0188	Level II Female Reproductive Proc	T	1.4138	$90.05		$18.01
0189	Level III Female Reproductive Proc	T	3.0466	$194.05		$38.81
0190	Level I Hysteroscopy	T	22.1171	$1,408.70	$424.20	$281.74
0191	Level I Female Reproductive Proc	T	0.1414	$9.01	$2.50	$1.80
0192	Level IV Female Reproductive Proc	T	7.4497	$474.49		$94.90
0193	Level V Female Reproductive Proc	T	19.2052	$1,223.24		$244.65
0195	Level VI Female Reproductive Procedures	T	32.9713	$2,100.04	$483.80	$420.01
0202	Level VII Female Reproductive Procedures	T	43.2255	$2,753.16	$981.50	$550.63
0203	Level IV Nerve Injections	T	15.5687	$991.62	$240.30	$198.32
0204	Level I Nerve Injections	T	2.3254	$148.11	$40.10	$29.62
0206	Level II Nerve Injections	T	4.1589	$264.89	$56.83	$52.98
0207	Level III Nerve Injections	T	7.1370	$454.58		$90.92
0208	Laminotomies and Laminectomies	T	47.6714	$3,036.33		$607.27
0209	Level II Extended EEG and Sleep Studies	S	11.5647	$736.59	$268.70	$147.32
0212	Nervous System Injections	T	8.6797	$552.84		$110.57
0213	Level I Extended EEG and Sleep Studies	S	2.3476	$149.53	$53.50	$29.91
0215	Level I Nerve and Muscle Tests	S	0.5746	$36.60		$7.32
0216	Level III Nerve and Muscle Tests	S	2.7680	$176.30		$35.26
0218	Level II Nerve and Muscle Tests	S	1.1861	$75.55		$15.11
0220	Level I Nerve Procedures	T	18.5069	$1,178.76		$235.75
0221	Level II Nerve Procedures	T	32.0518	$2,041.48	$463.60	$408.30
0222	Implantation of Neurological Device	T	193.3327	$12,313.94		$2,462.79
0224	Implantation of Catheter/Reservoir/Shunt	T	37.1117	$2,363.76		$472.75
0225	Implantation of Neurostimulator Electrodes, Cranial Nerve	S	221.4181	$14,102.78		$2,820.56
0227	Implantation of Drug Infusion Device	T	178.7228	$11,383.39		$2,276.68
0229	Transcatherter Placement of Intravascular Shunts	T	89.7027	$5,713.43		$1,142.69
0230	Level I Eye Tests & Treatments	S	0.7379	$47.00		$9.40
0231	Level III Eye Tests & Treatments	S	2.3117	$147.24		$29.45
0232	Level I Anterior Segment Eye Procedures	T	5.1145	$325.76	$81.59	$65.15
0233	Level II Anterior Segment Eye Procedures	T	16.5252	$1,052.54	$266.30	$210.51
0234	Level III Anterior Segment Eye Procedures	T	24.0821	$1,533.86	$511.30	$306.77
0235	Level I Posterior Segment Eye Procedures	T	4.0100	$255.41	$58.90	$51.08
0236	Level II Posterior Segment Eye Procedures	T	18.8779	$1,202.39		$240.48
0237	Level III Posterior Segment Eye Procedures	T	29.0019	$1,847.22		$369.44
0238	Level I Repair and Plastic Eye Procedures	T	2.8636	$182.39		$36.48
0239	Level II Repair and Plastic Eye Procedures	T	7.1099	$452.85		$90.57
0240	Level III Repair and Plastic Eye Procedures	T	19.2280	$1,224.69	$309.50	$244.94
0241	Level IV Repair and Plastic Eye Procedures	T	24.8916	$1,585.42	$384.40	$317.08
0242	Level V Repair and Plastic Eye Procedures	T	37.3504	$2,378.96	$597.30	$475.79
0243	Strabismus/Muscle Procedures	T	24.3920	$1,553.60	$430.30	$310.72
0244	Corneal Transplant	T	38.2919	$2,438.93	$803.20	$487.79
0245	Level I Cataract Procedures without IOL Insert	T	14.9022	$949.17	$217.00	$189.83
0246	Cataract Procedures with IOL Insert	T	24.2197	$1,542.63	$495.90	$308.53
0247	Laser Eye Procedures	T	5.2389	$333.68	$104.30	$66.74
0249	Level II Cataract Procedures without IOL Insert	T	29.7487	$1,894.78	$524.60	$378.96
0250	Nasal Cauterization/Packing	T	1.1708	$74.57	$25.30	$14.91
0251	Level I ENT Procedures	T	2.5765	$164.11		$32.82
0252	Level II ENT Procedures	T	7.6539	$487.50	$109.10	$97.50
0253	Level III ENT Procedures	T	16.6341	$1,059.48	$282.20	$211.90
0254	Level IV ENT Procedures	T	24.3535	$1,551.15	$321.30	$310.23
0256	Level V ENT Procedures	T	40.5598	$2,583.38		$516.68
0258	Tonsil and Adenoid Procedures	T	22.9075	$1,459.05	$437.20	$291.81
0259	Level VI ENT Procedures	T	404.3379	$25,753.49	$8,698.40	$5,150.70

ADDENDUM A.—PROPOSED OPPS APCS FOR CY 2008—Continued

APC	Group Title	SI	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
0260	Level I Plain Film Except Teeth	X	0.7259	$46.23		$9.25
0261	Level II Plain Film Except Teeth Including Bone Density Measurement	X	1.2024	$76.58		$15.32
0262	Plain Film of Teeth	X	0.5739	$36.55		$7.31
0263	Miscellaneous Radiology Procedures	X	1.4802	$94.28	$21.44	$18.86
0265	Level I Diagnostic and Screening Ultrasound	S	0.9925	$63.22	$23.60	$12.64
0266	Level II Diagnostic and Screening Ultrasound	S	1.5657	$99.72	$37.80	$19.94
0267	Level III Diagnostic and Screening Ultrasound	S	2.4859	$158.33	$60.50	$31.67
0269	Level II Echocardiogram Except Transesophageal	S	6.5908	$419.79		$83.96
0270	Transesophageal Echocardiogram	S	8.4200	$536.30	$141.30	$107.26
0272	Fluoroscopy	X	1.3270	$84.52	$31.60	$16.90
0274	Myelography	S	3.9008	$248.45	$62.80	$49.69
0275	Arthrography	S	2.2785	$145.12	$44.13	$29.02
0276	Level I Digestive Radiology	S	1.4387	$91.64	$34.90	$18.33
0277	Level II Digestive Radiology	S	2.2875	$145.70	$54.50	$29.14
0278	Diagnostic Urography	S	2.6114	$166.33	$59.40	$33.27
0279	Level II Angiography and Venography	S	5.9365	$378.11	$97.07	$75.62
0280	Level III Angiography and Venography	S	11.3221	$721.14	$199.34	$144.23
0282	Miscellaneous Computed Axial Tomography	S	1.6768	$106.80	$37.80	$21.36
0283	Level I Computed Tomography with Contrast	S	4.5485	$289.71	$100.30	$57.94
0284	Magnetic Resonance Imaging and Magnetic Resonance Angiography with Contrast.	S	6.7963	$432.88	$148.40	$86.58
0288	Bone Density:Axial Skeleton	S	1.1920	$75.92	$28.90	$15.18
0293	Level V Anterior Segment Eye Procedures	T	83.0605	$5,290.37	$1,128.20	$1,058.07
0299	Hyperthermia and Radiation Treatment Procedures	S	6.0275	$383.91		$76.78
0300	Level I Radiation Therapy	S	1.5000	$95.54		$19.11
0301	Level II Radiation Therapy	S	2.2933	$146.07		$29.21
0303	Treatment Device Construction	X	3.0657	$195.26	$66.90	$39.05
0304	Level I Therapeutic Radiation Treatment Preparation	X	1.6409	$104.51	$38.60	$20.90
0305	Level II Therapeutic Radiation Treatment Preparation	X	4.1775	$266.08	$91.30	$53.22
0307	Myocardial Positron Emission Tomography (PET) imaging	S	42.5674	$2,711.25		$542.25
0308	Non-Myocardial Positron Emission Tomography (PET) imaging	S	17.3837	$1,107.22		$221.44
0310	Level III Therapeutic Radiation Treatment Preparation	X	14.0797	$896.78	$325.20	$179.36
0312	Radioelement Applications	S	8.3915	$534.48		$106.90
0313	Brachytherapy	S	11.6098	$739.46		$147.89
0315	Level II Implantation of Neurostimulator	T	262.8116	$16,739.26		$3,347.85
0316	Level II Computed Tomography with Contrast	S	11.7923	$751.09	$300.26	$150.22
0320	Electroconvulsive Therapy	S	5.9448	$378.64	$80.00	$75.73
0322	Brief Individual Psychotherapy	S	1.2454	$79.32		$15.86
0323	Extended Individual Psychotherapy	S	1.6720	$106.49		$21.30
0324	Family Psychotherapy	S	2.2233	$141.61		$28.32
0325	Group Psychotherapy	S	1.0119	$64.45	$14.04	$12.89
0330	Dental Procedures	S	9.2780	$590.94		$118.19
0332	Computed Tomography without Contrast	S	3.1487	$200.55	$75.20	$40.11
0333	Computed Tomography without Contrast followed by Contrast)	S	5.3374	$339.96	$119.00	$67.99
0335	Magnetic Resonance Imaging, Miscellaneous	S	5.0067	$318.89	$111.90	$63.78
0336	Magnetic Resonance Imaging and Magnetic Resonance Angiography without Contrast.	S	5.7101	$363.69	$139.50	$72.74
0337	Magnetic Resonance Imaging and Magnetic Resonance Angiography without Contrast followed by Contrast.	S	8.6689	$552.15	$199.50	$110.43
0340	Minor Ancillary Procedures	X	0.6416	$40.87		$8.17
0341	Skin Tests	X	0.0879	$5.60	$2.20	$1.12
0342	Level I Pathology	X	0.0928	$5.91	$2.00	$1.18
0343	Level III Pathology	X	0.5372	$34.22	$10.80	$6.84
0344	Level IV Pathology	X	0.8586	$54.69	$15.60	$10.94
0345	Level I Transfusion Laboratory Procedures	X	0.2211	$14.08		$2.82
0346	Level II Transfusion Laboratory Procedures	X	0.3464	$22.06		$4.41
0347	Level III Transfusion Laboratory Procedures	X	0.8166	$52.01	$11.20	$10.40
0350	Administration of flu and PPV vaccine	S	0.4037	$25.71		$0.00
0360	Level I Alimentary Tests	X	1.6383	$104.35	$33.80	$20.87
0361	Level II Alimentary Tests	X	4.0867	$260.29	$83.20	$52.06
0363	Level I Otorhinolaryngologic Function Tests	X	0.8542	$54.41	$17.40	$10.88
0364	Level I Audiometry	X	0.4448	$28.33	$6.98	$5.67
0365	Level II Audiometry	X	1.2810	$81.59	$18.50	$16.32
0366	Level III Audiometry	X	1.8646	$118.76	$26.10	$23.75
0367	Level I Pulmonary Test	X	0.5955	$37.93	$14.38	$7.59
0368	Level II Pulmonary Tests	X	0.9541	$60.77	$22.70	$12.15
0369	Level III Pulmonary Tests	X	2.7874	$177.54	$44.10	$35.51
0370	Allergy Tests	X	1.1024	$70.22		$14.04
0373	Level I Neuropsychological Testing	X	1.8183	$115.81		$23.16
0375	Ancillary Outpatient Services When Patient Expires	S	73.4077	$4,675.56		$935.11
0377	Level II Cardiac Imaging	S	12.0147	$765.25	$158.80	$153.05
0378	Level II Pulmonary Imaging	S	5.1617	$328.76	$125.30	$65.75
0379	Injection adenosine 6 MG	K		$22.65		$4.53
0381	Single Allergy Tests	X	0.3014	$19.20		$3.84
0382	Level II Neuropsychological Testing	X	2.6763	$170.46		$34.09
0383	Cardiac Computed Tomographic Imaging	S	4.9887	$317.75	$124.17	$63.55
0384	GI Procedures with Stents	T	25.2289	$1,606.90		$321.38
0385	Level I Prosthetic Urological Procedures	S	85.3372	$5,435.38		$1,087.08
0386	Level II Prosthetic Urological Procedures	S	143.8001	$9,159.06		$1,831.81
0387	Level II Hysteroscopy	T	34.8162	$2,217.55	$655.50	$443.51

ADDENDUM A.—PROPOSED OPPS APCS FOR CY 2008—Continued

APC	Group Title	SI	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
0388	Discography	S	9.0300	$575.15	$169.68	$115.03
0389	Level I Non-imaging Nuclear Medicine	S	1.5806	$100.67	$33.80	$20.13
0390	Level I Endocrine Imaging	S	2.8272	$180.07	$57.60	$36.01
0391	Level II Endocrine Imaging	S	3.6540	$232.73	$66.10	$46.55
0392	Level II Non-imaging Nuclear Medicine	S	3.2810	$208.98	$49.30	$41.80
0393	Red Cell/Plasma Studies	S	5.5260	$351.97	$82.00	$70.39
0394	Hepatobiliary Imaging	S	4.5297	$288.51	$102.60	$57.70
0395	GI Tract Imaging	S	3.8546	$245.51	$89.70	$49.10
0396	Bone Imaging	S	3.9566	$252.01	$95.00	$50.40
0397	Vascular Imaging	S	3.0424	$193.78	$49.50	$38.76
0398	Level I Cardiac Imaging	S	5.4404	$346.52	$100.00	$69.30
0400	Hematopoietic Imaging	S	4.1916	$266.98	$93.20	$53.40
0401	Level I Pulmonary Imaging	S	3.2976	$210.03	$78.10	$42.01
0402	Level II Nervous System Imaging	S	8.8414	$563.14	$114.10	$112.63
0403	Level I Nervous System Imaging	S	3.3325	$212.26	$82.39	$42.45
0404	Renal and Genitourinary Studies	S	5.0935	$324.42	$84.10	$64.88
0406	Level I Tumor/Infection Imaging	S	4.4988	$286.54	$98.10	$57.31
0407	Level I Radionuclide Therapy	S	3.4563	$220.14	$78.10	$44.03
0408	Level III Tumor/Infection Imaging	S	16.0595	$1,022.88		$204.58
0409	Red Blood Cell Tests	X	0.1246	$7.94	$2.20	$1.59
0412	IMRT Treatment Delivery	S	5.7275	$364.80		$72.96
0413	Level II Radionuclide Therapy	S	5.4891	$349.62		$69.92
0414	Level II Tumor/Infection Imaging	S	7.4985	$477.60	$190.92	$95.52
0415	Level II Endoscopy Lower Airway	T	24.2882	$1,546.99	$459.90	$309.40
0417	Computerized Reconstruction	S	2.3401	$149.05		$29.81
0418	Insertion of Left Ventricular Pacing Elect.	T	250.5383	$15,957.54		$3,191.51
0422	Level II Upper GI Procedures	T	24.6480	$1,569.91	$445.06	$313.98
0423	Level II Percutaneous Abdominal and Biliary Procedures	T	44.1192	$2,810.08		$562.02
0425	Level II Arthroplasty with Prosthesis	T	113.6713	$7,240.07		$1,448.01
0426	Level II Strapping and Cast Application	S	2.2383	$142.56		$28.51
0427	Level II Tube Changes and Repositioning	T	14.8912	$948.47		$189.69
0428	Level III Sigmoidoscopy and Anoscopy	T	21.8923	$1,394.39		$278.88
0429	Level V Cystourethroscopy and other Genitourinary Procedures	T	45.9021	$2,923.64		$584.73
0430	Drug Preadministration-Related Services	S	0.6123	$39.00		$7.80
0432	Health and Behavior Services	S	0.3020	$19.24		$3.85
0433	Level II Pathology	X	0.2482	$15.81	$5.90	$3.16
0434	Cardiac Defect Repair	T	141.9601	$9,041.86		$1,808.37
0436	Level I Drug Administration	S	0.2201	$14.02		$2.80
0437	Level II Drug Administration	S	0.4037	$25.71		$5.14
0438	Level III Drug Administration	S	0.8310	$52.93		$10.59
0439	Level IV Drug Administration	S	1.7152	$109.25		$21.85
0440	Level V Drug Administration	S	1.8310	$116.62		$23.32
0441	Level VI Drug Administration	S	2.4378	$155.27		$31.05
0442	Dosimetric Drug Administration	S	30.2249	$1,925.11		$385.02
0604	Level 1 Hospital Clinic Visits	V	0.8381	$53.38		$10.68
0605	Level 2 Hospital Clinic Visits	V	1.0016	$63.79		$12.76
0606	Level 3 Hospital Clinic Visits	V	1.3665	$87.04		$17.41
0607	Level 4 Hospital Clinic Visits	V	1.7181	$109.43		$21.89
0608	Level 5 Hospital Clinic Visits	V	2.2077	$140.62		$28.12
0609	Level 1 Emergency Visits	V	0.8271	$52.68	$12.70	$10.54
0613	Level 2 Emergency Visits	V	1.3789	$87.83	$21.00	$17.57
0614	Level 3 Emergency Visits	V	2.1716	$138.32	$34.50	$27.66
0615	Level 4 Emergency Visits	V	3.5191	$224.14	$48.40	$44.83
0616	Level 5 Emergency Visits	V	5.4765	$348.81	$75.10	$69.76
0617	Critical Care	S	6.8478	$436.16	$111.50	$87.23
0618	Trauma Response with Critical Care	S	5.6539	$360.11	$144.04	$72.02
0621	Level I Vascular Access Procedures	T	11.0043	$700.90		$140.18
0622	Level II Vascular Access Procedures	T	24.5273	$1,562.22		$312.44
0623	Level III Vascular Access Procedures	T	29.3210	$1,867.54		$373.51
0624	Phlebotomy and Minor Vascular Access Device Procedures	X	0.5763	$36.71	$12.60	$7.34
0625	Level IV Vascular Access Procedures	T	87.3200	$5,561.67		$1,112.33
0648	Level IV Breast Surgery	T	52.9438	$3,372.15		$674.43
0651	Complex Interstitial Radiation Source Application	S	15.4158	$981.88		$196.38
0652	Insertion of Intraperitoneal and Pleural Catheters	T	31.7598	$2,022.88		$404.58
0653	Vascular Reconstruction/Fistula Repair with Device	T	41.0875	$2,616.99		$523.40
0654	Insertion/Replacement of a permanent dual chamber pacemaker	T	106.9053	$6,809.12		$1,361.82
0655	Insertion/Replacement/Conversion of a permanent dual chamber pacemaker.	T	144.2764	$9,189.40		$1,837.88
0656	Transcatheter Placement of Intracoronary Drug-Eluting Stents	T	118.8818	$7,571.94		$1,514.39
0659	Hyperbaric Oxygen	S	1.5679	$99.86		$19.97
0660	Level II Otorhinolaryngologic Function Tests	X	1.4408	$91.77	$28.00	$18.35
0661	Level V Pathology	X	2.8336	$180.48	$62.00	$36.10
0662	CT Angiography	S	5.2818	$336.41	$118.80	$67.28
0663	Level I Electronic Analysis of Neurostimulator Pulse Generators	S	1.6671	$106.18		$21.24
0664	Level I Proton Beam Radiation Therapy	S	13.2746	$845.50		$169.10
0665	Bone Density:AppendicularSkeleton	S	0.5225	$33.28	$13.31	$6.66
0667	Level II Proton Beam Radiation Therapy	S	15.8841	$1,011.71		$202.34
0668	Level I Angiography and Venography	S	3.3354	$212.44	$48.81	$42.49
0672	Level IV Posterior Segment Eye Procedures	T	38.1121	$2,427.47		$485.49
0673	Level IV Anterior Segment Eye Procedures	T	40.8481	$2,601.74	$649.50	$520.35

ADDENDUM A.—PROPOSED OPPS APCS FOR CY 2008—Continued

APC	Group Title	SI	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
0674	Prostate Cryoablation	T	123.7218	$7,880.21		$1,576.04
0676	Thrombolysis and Thrombectomy	T	2.5179	$160.37		$32.07
0678	External Counterpulsation	T	1.7081	$108.79		$21.76
0679	Level II Resuscitation and Cardioversion	S	5.5905	$356.08	$95.30	$71.22
0680	Insertion of Patient Activated Event Recorders	S	71.6463	$4,563.37		$912.67
0681	Knee Arthroplasty	T	191.2387	$12,180.57		$2,436.11
0682	Level V Debridement & Destruction	T	7.1126	$453.02	$158.60	$90.60
0683	Level II Photochemotherapy	S	2.9292	$186.57		$37.31
0685	Level III Needle Biopsy/Aspiration Except Bone Marrow	T	9.5741	$609.80		$121.96
0687	Revision/Removal of Neurostimulator Electrodes	T	24.1752	$1,539.79	$438.40	$307.96
0688	Revision/Removal of Neurostimulator Pulse Generator Receiver	T	35.7248	$2,275.42	$874.50	$455.08
0689	Electronic Analysis of Cardioverter-defibrillators	S	0.5936	$37.81		$7.56
0690	Electronic Analysis of Pacemakers and other Cardiac Devices	S	0.3590	$22.87	$8.60	$4.57
0691	Electronic Analysis of Programmable Shunts/Pumps	S	2.5849	$164.64	$56.08	$32.93
0692	Level II Electronic Analysis of Neurostimulator Pulse Generators	S	1.9206	$122.33	$30.10	$24.47
0694	Mohs Surgery	T	3.9713	$252.94	$91.60	$50.59
0697	Level I Echocardiogram Except Transesophageal	S	4.8072	$306.18		$61.24
0698	Level II Eye Tests & Treatments	S	1.1576	$73.73		$14.75
0699	Level IV Eye Tests & Treatments	T	14.2784	$909.43		$181.89
0701	Sr89 strontium	K		$610.07		$122.01
0702	Sm 153 lexidronm	K		$1,446.05		$289.21
0726	Dexrazoxane HCl injection	K		$172.43		$34.49
0728	Filgrastim 300 mcg injection	K		$187.68		$37.54
0730	Pamidronate disodium/30 MG	K		$30.49		$6.10
0731	Sargramostim injection	K		$25.08		$5.02
0732	Mesna injection	K		$8.89		$1.78
0735	Ampho b cholesteryl sulfate	K		$11.89		$2.38
0736	Amphotericin b liposome inj	K		$17.07		$3.41
0738	Rasburicase	K		$131.28		$26.26
0747	Chlorothiazide sodium inj	K		$122.67		$24.53
0748	Bleomycin sulfate injection	K		$35.52		$7.10
0750	Dolasetron mesylate	K		$6.05		$1.21
0751	Mechlorethamine hcl inj	K		$140.27		$28.05
0752	Dactinomycin actinomycin d	K		$488.78		$97.76
0759	Naltrexone, depot form	K		$1.88		$0.38
0760	Anadulafungin injection	G		$1.91		$0.38
0763	Dolasetron mesylate oral	K		$47.07		$9.41
0764	Granisetron HCl injection	K		$7.43		$1.49
0765	Granisetron HCl 1 mg oral	K		$44.44		$8.89
0767	Enfuvirtide injection	K		$22.69		$4.54
0768	Ondansetron hcl injection	K		$3.37		$0.67
0769	Ondansetron HCl 8mg oral	K		$36.21		$7.24
0800	Leuprolide acetate/3.75 MG	K		$429.83		$85.97
0802	Etoposide oral 50 MG	K		$29.32		$5.86
0804	Immune globulin subcutaneous	K		$12.60		$2.52
0805	Mecasermin injection	K		$11.81		$2.36
0806	Hyaluronidase recombinant	G		$0.40		$0.08
0807	Aldesleukin/single use vial	K		$755.78		$151.16
0808	Nabilone oral	K		$16.80		$3.36
0809	Bcg live intravesical vac	K		$109.63		$21.93
0810	Goserelin acetate implant	K		$196.81		$39.36
0811	Carboplatin injection	K		$8.38		$1.68
0812	Carmus bischl nitro inj	K		$138.52		$27.70
0814	Asparaginase injection	K		$54.20		$10.84
0820	Daunorubicin	K		$20.28		$4.06
0821	Daunorubicin citrate liposom	K		$55.40		$11.08
0823	Docetaxel	K		$303.92		$60.78
0825	Nelarabine injection	K		$82.54		$16.51
0827	Floxuridine injection	K		$50.82		$10.16
0828	Gemcitabine HCl	K		$123.98		$24.80
0830	Irinotecan injection	K		$124.81		$24.96
0831	Ifosfomide injection	K		$46.15		$9.23
0832	Idarubicin hcl injection	K		$301.74		$60.35
0834	Interferon alfa-2a inj	K		$37.53		$7.51
0835	Inj cosyntropin per 0.25 MG	K		$63.25		$12.65
0836	Interferon alfa-2b inj	K		$13.75		$2.75
0837	Non-human, non-metab tissue	K		$35.76		$7.15
0838	Interferon gamma 1-b inj	K		$287.13		$57.43
0840	Inj melphalan hydrochl 50 MG	K		$1,272.00		$254.40
0842	Fludarabine phosphate inj	K		$234.21		$46.84
0843	Pegaspargase/singl dose vial	K		$1,667.61		$333.52
0844	Pentostatin injection	K		$1,916.66		$383.33
0849	Rituximab cancer treatment	K		$491.54		$98.31
0850	Streptozocin injection	K		$152.28		$30.46
0851	Thiotepa injection	K		$40.32		$8.06
0852	Topotecan	K		$822.90		$164.58
0855	Vinorelbine tartrate/10 mg	K		$19.88		$3.98
0856	Porfimer sodium	K		$2,539.13		$507.83
0858	Inj cladribine per 1 MG	K		$35.78		$7.16
0861	Leuprolide acetate injeciton	K		$8.79		$1.76

ADDENDUM A.—PROPOSED OPPS APCS FOR CY 2008—Continued

APC	Group Title	SI	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
0862	Mitomycin 5 MG inj	K		$15.98		$3.20
0863	Paclitaxel injection	K		$12.47		$2.49
0864	Mitoxantrone hydrochl/5 MG	K		$166.64		$33.33
0865	Interferon alfa-n3 inj	K		$9.03		$1.81
0868	Oral aprepitant	K		$5.02		$1.00
0873	Hyalgan/supartz inj per dose	K		$103.86		$20.77
0874	Synvisc inj per dose	K		$184.89		$36.98
0875	Euflexxa inj per dose	K		$115.19		$23.04
0877	Orthovisc inj per dose	K		$196.47		$39.29
0878	Gallium nitrate injection	K		$1.47		$0.29
0879	Bethanechol chloride inject	K	0.5128	$32.66		$6.53
0880	Pentastarch 10% solution	K	0.3707	$23.61		$4.72
0881	Urokinase 5000 IU injection	K		$9.07		$1.81
0882	Melphalan oral 2 MG	K	0.0681	$4.34		$0.87
0883	Fondaparinux sodium	K		$5.82		$1.16
0884	Rho d immune globulin inj	K		$80.71		$16.14
0887	Azathioprine parenteral	K		$47.99		$9.60
0888	Cyclosporine oral 100 mg	K		$3.57		$0.71
0890	Lymphocyte immune globulin	K		$314.19		$62.84
0891	Tacrolimus oral per 1 MG	K		$3.63		$0.73
0898	Gamma globulin 2 CC inj	K		$22.63		$4.53
0899	Gamma globulin 3 CC inj	K		$33.93		$6.79
0900	Alglucerase injection	K		$38.85		$7.77
0901	Alpha 1 proteinase inhibitor	K		$3.24		$0.65
0902	Botulinum toxin a per unit	K		$5.05		$1.01
0903	Cytomegalovirus imm IV/vial	K		$859.86		$171.97
0904	Gamma globulin 4 CC inj	K		$45.25		$9.05
0906	RSV-ivig	K		$16.02		$3.20
0910	Interferon beta-1b/.25 MG	K		$84.12		$16.82
0911	Inj streptokinase/250000 IU	K	1.1851	$75.48		$15.10
0912	Interferon alfacon-1	K		$4.60		$0.92
0913	Ganciclovir long act implant	K		$4,707.42		$941.48
0916	Injection imiglucerase/unit	K		$3.89		$0.78
0917	Adenosine injection	K		$68.50		$13.70
0919	Gamma globulin 5 CC inj	K		$56.56		$11.31
0920	Gamma globulin 6 CC inj	K		$67.91		$13.58
0921	Gamma globulin 7 CC inj	K		$79.14		$15.83
0922	Gamma globulin 8 CC inj	K		$90.50		$18.10
0923	Gamma globulin 9 CC inj	K		$101.88		$20.38
0924	Gamma globulin 10 CC inj	K		$113.13		$22.63
0925	Factor viii	K		$0.70		$0.14
0927	Factor viii recombinant	K		$1.07		$0.21
0928	Factor ix complex	K		$0.75		$0.15
0929	Anti-inhibitor	K		$1.35		$0.27
0930	Antithrombin iii injection	K		$1.62		$0.32
0931	Factor IX non-recombinant	K		$0.89		$0.18
0932	Factor IX recombinant	K		$0.99		$0.20
0933	Gamma globulin ≤ 10 CC inj	K		$113.13		$22.63
0934	Capecitabine, oral, 500 mg	K		$13.12		$2.62
0935	Clonidine hydrochloride	K		$62.86		$12.57
0941	Mitomycin 20 MG inj	K		$63.93		$12.79
0942	Mitomycin 40 MG inj	K		$127.85		$25.57
0949	Frozen plasma, pooled, sd	K	1.1981	$76.31		$15.26
0950	Whole blood for transfusion	K	4.4374	$282.63		$56.53
0952	Cryoprecipitate each unit	K	0.6843	$43.59		$8.72
0954	RBC leukocytes reduced	K	2.9590	$188.47		$37.69
0955	Plasma, frz between 8-24hour	K	1.2456	$79.34		$15.87
0956	Plasma protein fract,5%,50ml	K	1.4392	$91.67		$18.33
0957	Platelets, each unit	K	1.0834	$69.00		$13.80
0958	Plaelet rich plasma unit	K	5.3744	$342.31		$68.46
0959	Red blood cells unit	K	2.0343	$129.57		$25.91
0960	Washed red blood cells unit	K	4.2092	$268.10		$53.62
0961	Albumin (human),5%, 50ml	K	0.3757	$23.93		$4.79
0963	Albumin (human), 5%, 250 ml	K	1.1351	$72.30		$14.46
0964	Albumin (human), 25%, 20 ml	K	0.4448	$28.33		$5.67
0965	Albumin (human), 25%, 50ml	K	1.1679	$74.39		$14.88
0966	Plasmaprotein fract,5%,250ml	K	3.9009	$248.46		$49.69
0967	Blood split unit	K	2.1237	$135.26		$27.05
0968	Platelets leukoreduced irrad	K	2.0280	$129.17		$25.83
0969	RBC leukoreduced irradiated	K	3.8191	$243.25		$48.65
1009	Cryoprecipitatereducedplasma	K	1.3131	$83.64		$16.73
1010	Blood, l/r, cmv-neg	K	2.3865	$152.00		$30.40
1011	Platelets, hla-m, l/r, unit	K	9.6766	$616.33		$123.27
1013	Platelets leukocytes reduced	K	1.7207	$109.60		$21.92
1016	Blood, l/r, froz/degly/wash	K	3.3520	$213.50		$42.70
1017	Plt, aph/pher, l/r, cmv-neg	K	7.7915	$496.26		$99.25
1018	Blood, l/r, irradiated	K	2.4372	$155.23		$31.05
1019	Plate pheres leukoredu irrad	K	10.0408	$639.53		$127.91
1020	Plt, pher, l/r cmv-neg, irr	K	10.7802	$686.62		$137.32
1021	RBC, frz/deg/wsh, l/r, irrad	K	6.4694	$412.06		$82.41

ADDENDUM A.—PROPOSED OPPS APCS FOR CY 2008—Continued

APC	Group Title	SI	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
1022	RBC, l/r, cmv-neg, irrad	K	4.6286	$294.81		$58.96
1032	Aud osseo dev, int/ext comp	H				.
1052	Injection, voriconazole	K		$4.94		$0.99
1064	I131 iodide cap, rx	K		$16.22		$3.24
1083	Adalimumab injection	K		$316.02		$63.20
1084	Denileukin diftitox, 300 mcg	K		$1,393.32		$278.66
1086	Temozolomide	K		$7.34		$1.47
1150	I131 iodide sol, rx	K		$11.74		$2.35
1166	Cytarabine liposome	K		$391.31		$78.26
1167	Inj, epirubicin hcl, 2 mg	K		$21.01		$4.20
1178	Busulfan injection	K		$8.80		$1.76
1203	Verteporfin injection	K		$8.84		$1.77
1207	Octreotide injection, depot	K		$95.86		$19.17
1280	Corticotropin injection	K		$126.52		$25.30
1436	Etidronate disodium inj	K		$70.73		$14.15
1491	New Technology—Level IA ($0–$10)	S		$5.00		$1.00
1492	New Technology—Level IB ($10–$20)	S		$15.00		$3.00
1493	New Technology—Level IC ($20–$30)	S		$25.00		$5.00
1494	New Technology—Level ID ($30–$40)	S		$35.00		$7.00
1495	New Technology—Level IE ($40–$50)	S		$45.00		$9.00
1496	New Technology—Level IA ($0–$10)	T		$5.00		$1.00
1497	New Technology—Level IB ($10–$20)	T		$15.00		$3.00
1498	New Technology—Level IC ($20–$30)	T		$25.00		$5.00
1499	New Technology—Level ID ($30–$40)	T		$35.00		$7.00
1500	New Technology—Level IE ($40–$50)	T		$45.00		$9.00
1502	New Technology—Level II ($50–$100)	S		$75.00		$15.00
1503	New Technology—Level III ($100–$200)	S		$150.00		$30.00
1504	New Technology—Level IV ($200–$300)	S		$250.00		$50.00
1505	New Technology—Level V ($300–$400)	S		$350.00		$70.00
1506	New Technology—Level VI ($400–$500)	S		$450.00		$90.00
1507	New Technology—Level VII ($500–$600)	S		$550.00		$110.00
1508	New Technology—Level VIII ($600–$700)	S		$650.00		$130.00
1509	New Technology—Level IX ($700–$800)	S		$750.00		$150.00
1510	New Technology—Level X ($800–$900)	S		$850.00		$170.00
1511	New Technology—Level XI ($900–$1000)	S		$950.00		$190.00
1512	New Technology—Level XII ($1000–$1100)	S		$1,050.00		$210.00
1513	New Technology—Level XIII ($1100–$1200)	S		$1,150.00		$230.00
1514	New Technology—Level XIV ($1200- $1300)	S		$1,250.00		$250.00
1515	New Technology—Level XV ($1300–$1400)	S		$1,350.00		$270.00
1516	New Technology—Level XVI ($1400–$1500)	S		$1,450.00		$290.00
1517	New Technology—Level XVII ($1500–$1600)	S		$1,550.00		$310.00
1518	New Technology—Level XVIII ($1600–$1700)	S		$1,650.00		$330.00
1519	New Technology—Level IXX ($1700–$1800)	S		$1,750.00		$350.00
1520	New Technology—Level XX ($1800–$1900)	S		$1,850.00		$370.00
1521	New Technology—Level XXI ($1900–$2000)	S		$1,950.00		$390.00
1522	New Technology—Level XXII ($2000–$2500)	S		$2,250.00		$450.00
1523	New Technology—Level XXIII ($2500–$3000)	S		$2,750.00		$550.00
1524	New Technology—Level 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

ADDENDUM A.—PROPOSED OPPS APCS FOR CY 2008—Continued

APC	Group Title	SI	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
1558	New Technology—Level XXI ($1900–$2000)	T		$1,950.00		$390.00
1559	New Technology—Level XXII ($2000–$2500)	T		$2,250.00		$450.00
1560	New Technology—Level XXIII ($2500–$3000)	T		$2,750.00		$550.00
1561	New Technology—Level XXIV ($3000–$3500)	T		$3,250.00		$650.00
1562	New Technology—Level XXV ($3500–$4000)	T		$3,750.00		$750.00
1563	New Technology—Level XXVI ($4000–$4500)	T		$4,250.00		$850.00
1564	New Technology—Level XXVII ($4500–$5000)	T		$4,750.00		$950.00
1565	New Technology—Level XXVIII ($5000–$5500)	T		$5,250.00		$1,050.00
1566	New Technology—Level XXIX ($5500–$6000)	T		$5,750.00		$1,150.00
1567	New Technology—Level XXX ($6000–$6500)	T		$6,250.00		$1,250.00
1568	New Technology—Level XXXI ($6500–$7000)	T		$6,750.00		$1,350.00
1569	New Technology—Level XXXII ($7000–$7500)	T		$7,250.00		$1,450.00
1570	New Technology—Level XXXIII ($7500–$8000)	T		$7,750.00		$1,550.00
1571	New Technology—Level XXXIV ($8000–$8500)	T		$8,250.00		$1,650.00
1572	New Technology—Level XXXV ($8500–$9000)	T		$8,750.00		$1,750.00
1573	New Technology—Level XXXVI ($9000–$9500)	T		$9,250.00		$1,850.00
1574	New Technology—Level XXXVII ($9500–$10000)	T		$9,750.00		$1,950.00
1605	Abciximab injection	K		$409.26		$81.85
1606	Injection anistreplase 30 u	K	42.2935	$2,693.80		$538.76
1607	Eptifibatide injection	K		$15.90		$3.18
1608	Etanercept injection	K		$160.03		$32.01
1609	Rho(D) immune globulin h, sd	K		$15.76		$3.15
1612	Daclizumab, parenteral	K		$297.03		$59.41
1613	Trastuzumab	K		$57.33		$11.47
1629	Nonmetabolic act d/e tissue	K		$18.13		$3.63
1630	Hep b ig, im	K		$132.42		$26.48
1631	Baclofen intrathecal trial	K		$70.92		$14.18
1632	Metabolic active D/E tissue	K		$28.51		$5.70
1633	Alefacept	K		$25.82		$5.16
1643	Y90 ibritumomab, rx	K		$12,030.02		$2,406.00
1645	I131 tositumomab, rx	K		$8,283.41		$1,656.68
1670	Tetanus immune globulin inj	K		$96.35		$19.27
1675	P32 Na phosphate	K		$118.02		$23.60
1676	P32 chromic phosphate	K		$122.17		$24.43
1682	Aprotonin, 10,000 kiu	K		$2.50		$0.50
1683	Basiliximab	K		$1,347.14		$269.43
1684	Corticorelin ovine triflutal	K		$4.26		$0.85
1685	Darbepoetin alfa, non-esrd	K		$3.11		$0.62
1686	Epoetin alfa, non-esrd	K		$9.36		$1.87
1687	Digoxin immune fab (ovine)	K		$511.48		$102.30
1688	Ethanolamine oleate 100 mg	K		$78.26		$15.65
1689	Fomepizole, 15 mg	K		$12.28		$2.46
1690	Hemin, 1 mg	K		$6.74		$1.35
1691	Iron dextran 165 injection	K		$11.61		$2.32
1692	Iron dextran 267 injection	K		$10.32		$2.06
1693	Lepirudin	K		$153.42		$30.68
1694	Ziconotide injection	K		$6.46		$1.29
1695	Nesiritide injection	K		$31.36		$6.27
1696	Palifermin injection	K		$11.32		$2.26
1697	Pegaptanib sodium injection	K		$1,054.70		$210.94
1700	Inj secretin synthetic human	K		$20.12		$4.02
1701	Treprostinil injection	K		$55.36		$11.07
1703	Ovine, 1000 USP units	K		$133.77		$26.75
1704	Inj Vonwillebrand factor IU	K		$0.88		$0.18
1705	Factor viia	K		$1.11		$0.22
1709	Azacitidine injection	K		$4.26		$0.85
1710	Clofarabine injection	K		$115.64		$23.13
1711	Histrelin implant	K		$1,446.98		$289.40
1712	Paclitaxel protein bound	K		$7.03		$1.41
1716	Brachytx source, Gold 198	K	0.5016	$31.95		$6.39
1717	Brachytx source, HDR Ir–192	K	2.7225	$173.40		$34.68
1719	Brachytx sour,Non-HDR Ir–192	K	0.9012	$57.40		$11.48
1738	Oxaliplatin	K		$8.89		$1.78
1739	Pegademase bovine, 25 iu	K		$176.16		$35.23
1740	Diazoxide injection	K		$113.24		$22.65
1741	Urofollitropin, 75 iu	K		$50.22		$10.04
1821	Interspinous implant	H				.
2210	Methyldopate hcl injection	K		$10.01		$2.00
2616	Brachytx source, Yttrium-90	K	187.5212	$11,943.79		$2,388.76
2632	Iodine I-125 sodium iodide	K	0.4494	$28.62		$5.72
2634	Brachytx source, HA, I–125	K	0.4699	$29.93		$5.99
2635	Brachytx source, HA, P–103	K	0.7389	$47.06		$9.41
2636	Brachytx linear source, P–103	K	0.5824	$37.09		$7.42
2731	Immune globulin, powder	K		$25.48		$5.10
2732	Immune globulin, liquid	K		$30.28		$6.06
2770	Quinupristin/dalfopristin	K		$116.70		$23.34
2940	Somatrem injection	K	1.0916	$69.53		$13.91
3030	Sumatriptan succinate/6 MG	K		$58.82		$11.76
3041	Bivalirudin	K		$1.72		$0.34
3043	Gamma globulin 1 CC inj	K		$11.31		$2.26

ADDENDUM A.—PROPOSED OPPS APCS FOR CY 2008—Continued

APC	Group Title	SI	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
3050	Sermorelin acetate injection	K		$1.74		$0.35
7000	Amifostine	K		$476.10		$95.22
7005	Gonadorelin hydroch/100 mcg	K		$178.59		$35.72
7011	Oprelvekin injection	K		$244.98		$49.00
7015	Oral busulfan	K		$2.12		$0.42
7028	Fosphenytoin, 50 mg	K		$5.50		$1.10
7034	Somatropin injection	K		$46.75		$9.35
7035	Teniposide, 50 mg	K		$261.93		$52.39
7036	Urokinase 250,000 IU inj	K		$453.41		$90.68
7038	Monoclonal antibodies	K		$886.70		$177.34
7041	Tirofiban HCl	K		$7.66		$1.53
7042	Capecitabine, oral, 150 mg	K		$3.94		$0.79
7043	Infliximab injection	K		$53.25		$10.65
7045	Inj trimetrexate glucoronate	K		$143.89		$28.78
7046	Doxorubicin hcl liposome inj	K		$385.81		$77.16
7048	Alteplase recombinant	K		$32.48		$6.50
7049	Filgrastim 480 mcg injection	K		$297.75		$59.55
7051	Leuprolide acetate implant	K		$1,696.96		$339.39
7308	Aminolevulinic acid hcl top	K		$104.43		$20.89
8000	Cardiac Electrophysiologic Evaluation and Ablation Composite	T	135.5822	$8,635.64		$1,727.13
8001	LDR Prostate Brachytherapy Composite	T	49.7153	$3,166.52		$633.30
9001	Linezolid injection	K		$24.93		$4.99
9002	Tenecteplase injection	K		$2,024.13		$404.83
9003	Palivizumab, per 50 mg	K		$677.97		$135.59
9004	Gemtuzumab ozogamicin	K		$2,334.75		$466.95
9005	Reteplase injection	K		$891.03		$178.21
9006	Tacrolimus injection	K		$139.11		$27.82
9012	Arsenic trioxide	K		$33.84		$6.77
9015	Mycophenolate mofetil oral	K		$2.60		$0.52
9018	Botulinum toxin type B	K		$8.30		$1.66
9019	Caspofungin acetate	K		$30.07		$6.01
9020	Sirolimus, oral	K		$7.15		$1.43
9022	IM inj interferon beta 1–a	K		$113.49		$22.70
9023	Rho d immune globulin 50 mcg	K		$26.41		$5.28
9024	Amphotericin b lipid complex	K		$10.28		$2.06
9032	Baclofen 10 MG injection	K		$195.18		$39.04
9033	Cidofovir injection	K		$754.62		$150.92
9038	Inj estrogen conjugate 25 MG	K		$60.32		$12.06
9042	Glucagon hydrochloride/1 MG	K		$65.64		$13.13
9044	Ibutilide fumarate injection	K		$264.40		$52.88
9046	Iron sucrose injection	K		$0.37		$0.08
9047	Itraconazole injection	K		$38.05		$7.61
9051	Urea injection	K		$73.46		$14.69
9054	Metabolically active tissue	K		$31.36		$6.27
9104	Antithymocyte globuln rabbit	K		$324.66		$64.93
9108	Thyrotropin injection	K		$758.16		$151.63
9110	Alemtuzumab injection	K		$536.10		$107.22
9115	Zoledronic acid	K		$204.09		$40.82
9119	Injection, pegfilgrastim 6mg	K		$2,142.92		$428.58
9120	Injection, Fulvestrant	K		$79.80		$15.96
9121	Injection, argatroban	K		$17.87		$3.57
9122	Triptorelin pamoate	K		$153.97		$30.79
9124	Daptomycin injection	K		$0.33		$0.07
9125	Risperidone, long acting	K		$4.80		$0.96
9126	Natalizumab injection	K		$7.45		$1.49
9133	Rabies ig, im/sc	K		$64.82		$12.96
9134	Rabies ig, heat treated	K		$69.40		$13.88
9135	Varicella-zoster ig, im	K		$121.58		$24.32
9137	Bcg vaccine, percut	K		$112.56		$22.51
9139	Rabies vaccine, im	K		$145.53		$29.11
9140	Rabies vaccine, id	K	1.9483	$124.09		$24.82
9141	Measles-rubella vaccine, sc	K	0.9593	$61.10		$12.22
9143	Meningococcal vaccine, sc	K		$88.59		$17.72
9144	Encephalitis vaccine, sc	K		$98.17		$19.63
9145	Meningococcal vaccine, im	K	1.1309	$72.03		$14.41
9156	Nonmetabolic active tissue	K		$88.37		$17.67
9167	Valrubicin, 200 mg	K	3.4445	$219.39		$43.88
9207	Bortezomib injection	K		$32.37		$6.47
9208	Agalsidase beta injection	K		$126.00		$25.20
9209	Laronidase injection	K		$23.64		$4.73
9210	Palonosetron HCl	K		$15.85		$3.17
9213	Pemetrexed injection	K		$43.38		$8.68
9214	Bevacizumab injection	K		$56.98		$11.40
9215	Cetuximab injection	K		$49.34		$9.87
9216	Abarelix injection	K		$67.97		$13.59
9217	Leuprolide acetate suspnsion	K		$227.34		$45.47
9219	Mycophenolic acid	K		$2.25		$0.45
9222	Injectable human tissue	K		$728.44		$145.69
9224	Galsulfase injection	K		$297.09		$59.42
9225	Fluocinolone acetonide implt	K		$19,162.50		$3,832.50

ADDENDUM A.—PROPOSED OPPS APCS FOR CY 2008—Continued

APC	Group Title	SI	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
9227	Micafungin sodium injection	G		$1.71		$0.34
9228	Tigecycline injection	G		$0.91		$0.18
9229	Ibandronate sodium injection	G		$138.71		$27.74
9230	Abatacept injection	G		$18.69		$3.74
9231	Decitabine injection	G	0.4157	$26.48		$5.30
9232	Injection, idursulfase	G		$455.03		$91.01
9233	Injection, ranibizumab	G		$2,030.92		$406.18
9234	Inj, alglucosidase alfa	K		$126.00		$25.20
9235	Injection, panitumumab	G		$84.80		$16.96
9300	Omalizumab injection	K		$16.79		$3.36
9350	Porous collagen tube per cm	G		$485.91		$97.18
9351	Acellular derm tissue percm2	G		$41.59		$8.32
9500	Platelets, irradiated	K	2.0742	$132.11		$26.42
9501	Platelet pheres leukoreduced	K	7.9954	$509.25		$101.85
9502	Platelet pheresis irradiated	K	7.0075	$446.33		$89.27
9503	Fr frz plasma donor retested	K	1.1632	$74.09		$14.82
9504	RBC deglycerolized	K	5.7938	$369.02		$73.80
9505	RBC irradiated	K	3.3259	$211.84		$42.37
9506	Granulocytes, pheresis unit	K	15.5519	$990.55		$198.11
9507	Platelets, pheresis	K	7.0406	$448.44		$89.69
9508	Plasma 1 donor frz w/in 8 hr	K	1.0902	$69.44		$13.89

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject to multiple procedure discounting	Comment indicator	Payment indicator	CY 2007 ASC payment rate	Proposed fully implemented payment weight	Proposed CY 2008 fully implemented payment	Proposed CY 2008 first transition year payment
0016T	Thermotx choroid vasc lesion	Y		R2		4.0100	$166.01	$166.01
0017T	Photocoagulat macular drusen	Y		R2		4.0100	$166.01	$166.01
0027T	Endoscopic epidural lysis	Y		G2		18.5069	$766.19	$766.19
0031T	Speculoscopy	N		N1				
0032T	Speculoscopy w/direct sample	N		N1				
0046T	Cath lavage, mammary duct(s)	Y		R2		16.5832	$686.54	$686.54
0047T	Cath lavage, mammary duct(s)	Y		R2		16.5832	$686.54	$686.54
0062T	Rep intradisc annulus; 1 lev	Y		G2		29.3263	$1,214.11	$1,214.11
0063T	Rep intradisc annulus; >1 lev	Y		G2		29.3263	$1,214.11	$1,214.11
0084T	Temp prostate urethral stent	Y		G2		2.1659	$89.67	$89.67
0099T*	Implant corneal ring	Y		R2		16.5252	$684.14	$684.14
0100T	Prosth retina receive&gen	Y		G2		38.1121	$1,577.84	$1,577.84
0101T	Extracorp shockwv tx,hi enrg	Y		G2		29.3263	$1,214.11	$1,214.11
0102T	Extracorp shockwv tx,anesth	Y		G2		29.3263	$1,214.11	$1,214.11
0123T	Scleral fistulization	Y		G2		24.0821	$997.00	$997.00
0124T*	Conjunctival drug placement	Y		R2		5.1145	$211.74	$211.74
0133T	Esophageal implant injexn	Y		G2		24.6480	$1,020.43	$1,020.43
0176T	Aqu canal dilat w/o retent	Y		A2	$1,339.00	40.8481	$1,691.11	$1,427.03
0177T	Aqu canal dilat w retent	Y		A2	$1,339.00	40.8481	$1,691.11	$1,427.03
10021	Fna w/o image	Y		P2		1.1915	$49.33	$49.33
10022	Fna w/image	Y		G2		4.5062	$186.56	$186.56
10040	Acne surgery	Y		P2		0.8046	$33.31	$33.31
10060	Drainage of skin abscess	Y		P3		1.1130	$46.08	$46.08
10061	Drainage of skin abscess	Y		P2		1.4630	$60.57	$60.57
10080	Drainage of pilonidal cyst	Y		P2		1.4630	$60.57	$60.57
10081	Drainage of pilonidal cyst	Y		P3		3.1002	$128.35	$128.35
10120	Remove foreign body	Y		P2		1.4630	$60.57	$60.57
10121	Remove foreign body	Y		A2	$446.00	16.5832	$686.54	$506.14
10140	Drainage of hematoma/fluid	Y		P3		1.6490	$68.27	$68.27
10160	Puncture drainage of lesion	Y	CH	P3		1.4099	$58.37	$58.37
10180	Complex drainage, wound	Y		A2	$446.00	19.0457	$788.49	$531.62
11000	Debride infected skin	Y		P3		0.5360	$22.19	$22.19
11001	Debride infected skin add-on	Y		P3		0.1896	$7.85	$7.85
11010	Debride skin, fx	Y		A2	$251.52	4.4463	$184.08	$234.66
11011	Debride skin/muscle, fx	Y		A2	$251.52	4.4463	$184.08	$234.66
11012	Debride skin/muscle/bone, fx	Y		A2	$251.52	4.4463	$184.08	$234.66
11040	Debride skin, partial	Y		P3		0.4865	$20.14	$20.14
11041	Debride skin, full	Y		P3		0.5688	$23.55	$23.55
11042	Debride skin/tissue	Y		A2	$164.42	2.7493	$113.82	$151.77
11043	Debride tissue/muscle	Y		A2	$164.42	2.7493	$113.82	$151.77
11044	Debride tissue/muscle/bone	Y		A2	$423.10	7.1126	$294.46	$390.94
11055	Trim skin lesion	Y		P3		0.5606	$23.21	$23.21
11056	Trim skin lesions, 2 to 4	Y		P3		0.6184	$25.60	$25.60
11057	Trim skin lesions, over 4	Y		P3		0.7092	$29.36	$29.36
11100	Biopsy, skin lesion	Y		P2		0.8046	$33.31	$33.31
11101	Biopsy, skin add-on	Y		P3		0.3051	$12.63	$12.63
11200	Removal of skin tags	Y	CH	P2		0.8046	$33.31	$33.31
11201	Remove skin tags add-on	Y		P3		0.1319	$5.46	$5.46
11300	Shave skin lesion	Y		P2		0.8046	$33.31	$33.31
11301	Shave skin lesion	Y		P2		0.8046	$33.31	$33.31
11302	Shave skin lesion	Y		P2		0.8046	$33.31	$33.31
11303	Shave skin lesion	Y		P3		1.4841	$61.44	$61.44
11305	Shave skin lesion	Y		P3		0.7833	$32.43	$32.43
11306	Shave skin lesion	Y	CH	P2		0.8046	$33.31	$33.31
11307	Shave skin lesion	Y		P2		0.8046	$33.31	$33.31
11308	Shave skin lesion	Y		P2		0.8046	$33.31	$33.31
11310	Shave skin lesion	Y	CH	P2		0.8046	$33.31	$33.31
11311	Shave skin lesion	Y		P2		0.8046	$33.31	$33.31
11312	Shave skin lesion	Y		P2		0.8046	$33.31	$33.31
11313	Shave skin lesion	Y	CH	P2		0.8046	$33.31	$33.31
11400	Exc tr-ext b9+marg 0.5 < cm	Y		P3		1.5913	$65.88	$65.88
11401	Exc tr-ext b9+marg 0.6–1 cm	Y		P3		1.7396	$72.02	$72.02
11402	Exc tr-ext b9+marg 1.1–2 cm	Y		P3		1.8964	$78.51	$78.51
11403	Exc tr-ext b9+marg 2.1–3 cm	Y		P3		2.0365	$84.31	$84.31
11404	Exc tr-ext b9+marg 3.1–4 cm	Y		A2	$333.00	16.5832	$686.54	$421.39
11406	Exc tr-ext b9+marg > 4.0 cm	Y		A2	$446.00	16.5832	$686.54	$506.14
11420	Exc h-f-nk-sp b9+marg 0.5 <	Y		P3		1.4758	$61.10	$61.10
11421	Exc h-f-nk-sp b9+marg 0.6–1	Y		P3		1.7563	$72.71	$72.71
11422	Exc h-f-nk-sp b9+marg 1.1–2	Y		P3		1.9210	$79.53	$79.53
11423	Exc h-f-nk-sp b9+marg 2.1–3	Y		P3		2.1601	$89.43	$89.43
11424	Exc h-f-nk-sp b9+marg 3.1–4	Y		A2	$446.00	16.5832	$686.54	$506.14
11426	Exc h-f-nk-sp b9+marg > 4 cm	Y		A2	$446.00	21.4534	$888.17	$556.54
11440	Exc face-mm b9+marg 0.5 < cm	Y		P3		1.7314	$71.68	$71.68
11441	Exc face-mm b9+marg 0.6–1 cm	Y		P3		1.9459	$80.56	$80.56
11442	Exc face-mm b9+marg 1.1–2 cm	Y		P3		2.1273	$88.07	$88.07
11443	Exc face-mm b9+marg 2.1–3 cm	Y		P3		2.3829	$98.65	$98.65

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS Code	Short Descriptor	Subject to multiple procedure discounting	Comment indicator	Payment indicator	CY 2007 ASC payment rate	Proposed fully implemented payment weight	Proposed CY 2008 fully implemented payment	Proposed CY 2008 first transition year payment
11444	Exc face-mm b9+marg 3.1–4 cm	Y		A2	$333.00	8.7155	$360.82	$339.96
11446	Exc face-mm b9+marg > 4 cm	Y		A2	$446.00	21.4534	$888.17	$556.54
11450	Removal, sweat gland lesion	Y		A2	$446.00	21.4534	$888.17	$556.54
11451	Removal, sweat gland lesion	Y		A2	$446.00	21.4534	$888.17	$556.54
11462	Removal, sweat gland lesion	Y		A2	$446.00	21.4534	$888.17	$556.54
11463	Removal, sweat gland lesion	Y		A2	$446.00	21.4534	$888.17	$556.54
11470	Removal, sweat gland lesion	Y		A2	$446.00	21.4534	$888.17	$556.54
11471	Removal, sweat gland lesion	Y		A2	$446.00	21.4534	$888.17	$556.54
11600	Exc tr-ext mlg+marg 0.5 < cm	Y		P3		2.2097	$91.48	$91.48
11601	Exc tr-ext mlg+marg 0.6–1 cm	Y		P3		2.5312	$104.79	$104.79
11602	Exc tr-ext mlg+marg 1.1–2 cm	Y		P3		2.7457	$113.67	$113.67
11603	Exc tr-ext mlg+marg 2.1–3 cm	Y		P3		2.9353	$121.52	$121.52
11604	Exc tr-ext mlg+marg 3.1–4 cm	Y		A2	$418.49	8.7155	$360.82	$404.07
11606	Exc tr-ext mlg+marg > 4 cm	Y		A2	$446.00	16.5832	$686.54	$506.14
11620	Exc h-f-nk-sp mlg+marg 0.5 <	Y		P3		2.2428	$92.85	$92.85
11621	Exc h-f-nk-sp mlg+marg 0.6–1	Y		P3		2.5560	$105.82	$105.82
11622	Exc h-f-nk-sp mlg+marg 1.1–2	Y		P3		2.8280	$117.08	$117.08
11623	Exc h-f-nk-sp mlg+marg 2.1–3	Y		P3		3.0671	$126.98	$126.98
11624	Exc h-f-nk-sp mlg+marg 3.1–4	Y		A2	$446.00	16.5832	$686.54	$506.14
11626	Exc h-f-nk-sp mlg+mar > 4 cm	Y		A2	$446.00	21.4534	$888.17	$556.54
11640	Exc face-mm malig+marg 0.5 <	Y		P3		2.3498	$97.28	$97.28
11641	Exc face-mm malig+marg 0.6–1	Y		P3		2.7457	$113.67	$113.67
11642	Exc face-mm malig+marg 1.1–2	Y		P3		3.0671	$126.98	$126.98
11643	Exc face-mm malig+marg 2.1–3	Y		P3		3.3312	$137.91	$137.91
11644	Exc face-mm malig+marg 3.1–4	Y		A2	$446.00	16.5832	$686.54	$506.14
11646	Exc face-mm mlg+marg > 4 cm	Y		A2	$446.00	21.4534	$888.17	$556.54
11719	Trim nail(s)	Y		P3		0.2556	$10.58	$10.58
11720	Debride nail, 1–5	Y		P3		0.3297	$13.65	$13.65
11721	Debride nail, 6 or more	Y		P3		0.4041	$16.73	$16.73
11730	Removal of nail plate	Y	CH	P2		0.8046	$33.31	$33.31
11732	Remove nail plate, add-on	Y		P3		0.4041	$16.73	$16.73
11740	Drain blood from under nail	Y	CH	P2		0.2682	$11.10	$11.10
11750	Removal of nail bed	Y		P3		2.0942	$86.70	$86.70
11752	Remove nail bed/finger tip	Y		P3		2.8940	$119.81	$119.81
11755	Biopsy, nail unit	Y		P3		1.4758	$61.10	$61.10
11760	Repair of nail bed	Y		G2		2.1114	$87.41	$87.41
11762	Reconstruction of nail bed	Y	CH	P3		2.6961	$111.62	$111.62
11765	Excision of nail fold, toe	Y		P2		1.5119	$62.59	$62.59
11770	Removal of pilonidal lesion	Y		A2	$510.00	21.4534	$888.17	$604.54
11771	Removal of pilonidal lesion	Y		A2	$510.00	21.4534	$888.17	$604.54
11772	Removal of pilonidal lesion	Y		A2	$510.00	21.4534	$888.17	$604.54
11900	Injection into skin lesions	Y		P3		0.6514	$26.97	$26.97
11901	Added skin lesions injection	Y		P3		0.6925	$28.67	$28.67
11920	Correct skin color defects	Y		P2		2.1114	$87.41	$87.41
11921	Correct skin color defects	Y		P2		2.1114	$87.41	$87.41
11922	Correct skin color defects	Y		P3		0.8493	$35.16	$35.16
11950	Therapy for contour defects	Y		P3		0.8329	$34.48	$34.48
11951	Therapy for contour defects	Y		P3		1.0225	$42.33	$42.33
11952	Therapy for contour defects	Y	CH	P2		1.3340	$55.23	$55.23
11954	Therapy for contour defects	Y		P2		1.3340	$55.23	$55.23
11960	Insert tissue expander(s)	Y		A2	$446.00	20.9338	$866.66	$551.17
11970	Replace tissue expander	Y		A2	$510.00	43.5953	$1,804.85	$833.71
11971	Remove tissue expander(s)	Y		A2	$333.00	21.4534	$888.17	$471.79
11976	Removal of contraceptive cap	Y		P3		1.4181	$58.71	$58.71
11980	Implant hormone pellet(s)	N		P2		0.6416	$26.56	$26.56
11981	Insert drug implant device	N		P2		0.6416	$26.56	$26.56
11982	Remove drug implant device	N		P2		0.6416	$26.56	$26.56
11983	Remove/insert drug implant	N		P2		0.6416	$26.56	$26.56
12001	Repair superficial wound(s)	Y		P2		1.3340	$55.23	$55.23
12002	Repair superficial wound(s)	Y		P2		1.3340	$55.23	$55.23
12004	Repair superficial wound(s)	Y		P2		1.3340	$55.23	$55.23
12005	Repair superficial wound(s)	Y		A2	$91.24	1.3340	$55.23	$82.24
12006	Repair superficial wound(s)	Y		A2	$91.24	1.3340	$55.23	$82.24
12007	Repair superficial wound(s)	Y		A2	$91.24	1.3340	$55.23	$82.24
12011	Repair superficial wound(s)	Y		P2		1.3340	$55.23	$55.23
12013	Repair superficial wound(s)	Y		P2		1.3340	$55.23	$55.23
12014	Repair superficial wound(s)	Y		P2		1.3340	$55.23	$55.23
12015	Repair superficial wound(s)	Y		G2		1.3340	$55.23	$55.23
12016	Repair superficial wound(s)	Y		A2	$91.24	1.3340	$55.23	$82.24
12017	Repair superficial wound(s)	Y		A2	$91.24	1.3340	$55.23	$82.24
12018	Repair superficial wound(s)	Y		A2	$91.24	1.3340	$55.23	$82.24
12020	Closure of split wound	Y		A2	$91.24	4.6816	$193.82	$116.89
12021	Closure of split wound	Y		A2	$91.24	4.6816	$193.82	$116.89
12031	Layer closure of wound(s)	Y		P2		2.1114	$87.41	$87.41
12032	Layer closure of wound(s)	Y		P2		2.1114	$87.41	$87.41
12034	Layer closure of wound(s)	Y		A2	$91.24	2.1114	$87.41	$90.28

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS Code	Short Descriptor	Subject to multiple procedure discounting	Comment indicator	Payment indicator	CY 2007 ASC payment rate	Proposed fully implemented payment weight	Proposed CY 2008 fully implemented payment	Proposed CY 2008 first transition year payment
12035	Layer closure of wound(s)	Y		A2	$91.24	2.1114	$87.41	$90.28
12036	Layer closure of wound(s)	Y		A2	$91.24	2.1114	$87.41	$90.28
12037	Layer closure of wound(s)	Y		A2	$323.28	2.1114	$87.41	$264.31
12041	Layer closure of wound(s)	Y		P2		2.1114	$87.41	$87.41
12042	Layer closure of wound(s)	Y		P2		2.1114	$87.41	$87.41
12044	Layer closure of wound(s)	Y		A2	$91.24	2.1114	$87.41	$90.28
12045	Layer closure of wound(s)	Y		A2	$91.24	2.1114	$87.41	$90.28
12046	Layer closure of wound(s)	Y		A2	$91.24	2.1114	$87.41	$90.28
12047	Layer closure of wound(s)	Y		A2	$323.28	2.1114	$87.41	$264.31
12051	Layer closure of wound(s)	Y		P2		2.1114	$87.41	$87.41
12052	Layer closure of wound(s)	Y		P2		2.1114	$87.41	$87.41
12053	Layer closure of wound(s)	Y		P2		2.1114	$87.41	$87.41
12054	Layer closure of wound(s)	Y		A2	$91.24	2.1114	$87.41	$90.28
12055	Layer closure of wound(s)	Y		A2	$91.24	2.1114	$87.41	$90.28
12056	Layer closure of wound(s)	Y		A2	$91.24	2.1114	$87.41	$90.28
12057	Layer closure of wound(s)	Y		A2	$323.28	2.1114	$87.41	$264.31
13100	Repair of wound or lesion	Y		A2	$323.28	4.6816	$193.82	$290.92
13101	Repair of wound or lesion	Y		A2	$323.28	4.6816	$193.82	$290.92
13102	Repair wound/lesion add-on	Y		A2	$91.24	4.6816	$193.82	$116.89
13120	Repair of wound or lesion	Y		A2	$91.24	2.1114	$87.41	$90.28
13121	Repair of wound or lesion	Y		A2	$91.24	4.6816	$193.82	$116.89
13122	Repair wound/lesion add-on	Y		A2	$91.24	2.1114	$87.41	$90.28
13131	Repair of wound or lesion	Y		A2	$91.24	4.6816	$193.82	$116.89
13132	Repair of wound or lesion	Y		A2	$91.24	4.6816	$193.82	$116.89
13133	Repair wound/lesion add-on	Y		A2	$91.24	4.6816	$193.82	$116.89
13150	Repair of wound or lesion	Y		A2	$323.28	4.6816	$193.82	$290.92
13151	Repair of wound or lesion	Y		A2	$323.28	4.6816	$193.82	$290.92
13152	Repair of wound or lesion	Y		A2	$323.28	4.6816	$193.82	$290.92
13153	Repair wound/lesion add-on	Y		A2	$91.24	2.1114	$87.41	$90.28
13160	Late closure of wound	Y		A2	$446.00	20.9338	$866.66	$551.17
14000	Skin tissue rearrangement	Y		A2	$446.00	15.4399	$639.21	$494.30
14001	Skin tissue rearrangement	Y		A2	$510.00	15.4399	$639.21	$542.30
14020	Skin tissue rearrangement	Y		A2	$510.00	15.4399	$639.21	$542.30
14021	Skin tissue rearrangement	Y		A2	$510.00	15.4399	$639.21	$542.30
14040	Skin tissue rearrangement	Y		A2	$446.00	15.4399	$639.21	$494.30
14041	Skin tissue rearrangement	Y		A2	$510.00	15.4399	$639.21	$542.30
14060	Skin tissue rearrangement	Y		A2	$510.00	15.4399	$639.21	$542.30
14061	Skin tissue rearrangement	Y		A2	$510.00	15.4399	$639.21	$542.30
14300	Skin tissue rearrangement	Y		A2	$630.00	20.9338	$866.66	$689.17
14350	Skin tissue rearrangement	Y		A2	$510.00	20.9338	$866.66	$599.17
15002	Wnd prep, ch/inf, trk/arm/lg	Y		A2	$323.28	4.6816	$193.82	$290.92
15003	Wnd prep, ch/inf addl 100 cm	Y		A2	$323.28	4.6816	$193.82	$290.92
15004	Wnd prep ch/inf, f/n/hf/g	Y		A2	$323.28	4.6816	$193.82	$290.92
15005	Wnd prep, f/n/hf/g, addl cm	Y		A2	$323.28	4.6816	$193.82	$290.92
15040	Harvest cultured skin graft	Y		A2	$91.24	2.1114	$87.41	$90.28
15050	Skin pinch graft	Y		A2	$323.28	4.6816	$193.82	$290.92
15100	Skin splt grft, trnk/arm/leg	Y		A2	$446.00	20.9338	$866.66	$551.17
15101	Skin splt grft t/a/l, add-on	Y		A2	$510.00	20.9338	$866.66	$599.17
15110	Epidrm autogrft trnk/arm/leg	Y		A2	$446.00	4.6816	$193.82	$382.96
15111	Epidrm autogrft t/a/l add-on	Y		A2	$333.00	4.6816	$193.82	$298.21
15115	Epidrm a-grft face/nck/hf/g	Y		A2	$446.00	4.6816	$193.82	$382.96
15116	Epidrm a-grft f/n/hf/g addl	Y		A2	$333.00	4.6816	$193.82	$298.21
15120	Skn splt a-grft fac/nck/hf/g	Y		A2	$446.00	20.9338	$866.66	$551.17
15121	Skn splt a-grft f/n/hf/g add	Y		A2	$510.00	20.9338	$866.66	$599.17
15130	Derm autograft, trnk/arm/leg	Y		A2	$446.00	15.4399	$639.21	$494.30
15131	Derm autograft t/a/l add-on	Y		A2	$333.00	15.4399	$639.21	$409.55
15135	Derm autograft face/nck/hf/g	Y		A2	$446.00	15.4399	$639.21	$494.30
15136	Derm autograft, f/n/hf/g add	Y		A2	$333.00	15.4399	$639.21	$409.55
15150	Cult epiderm grft t/arm/leg	Y		A2	$446.00	4.6816	$193.82	$382.96
15151	Cult epiderm grft t/a/l addl	Y		A2	$333.00	4.6816	$193.82	$298.21
15152	Cult epiderm graft t/a/l +%	Y		A2	$333.00	4.6816	$193.82	$298.21
15155	Cult epiderm graft, f/n/hf/g	Y		A2	$446.00	4.6816	$193.82	$382.96
15156	Cult epidrm grft f/n/hfg add	Y		A2	$333.00	4.6816	$193.82	$298.21
15157	Cult epiderm grft f/n/hfg +%	Y		A2	$333.00	4.6816	$193.82	$298.21
15200	Skin full graft, trunk	Y		A2	$510.00	15.4399	$639.21	$542.30
15201	Skin full graft trunk add-on	Y		A2	$323.28	15.4399	$639.21	$402.26
15220	Skin full graft sclp/arm/leg	Y		A2	$446.00	15.4399	$639.21	$494.30
15221	Skin full graft add-on	Y		A2	$323.28	4.6816	$193.82	$290.92
15240	Skin full grft face/genit/hf	Y		A2	$510.00	15.4399	$639.21	$542.30
15241	Skin full graft add-on	Y		A2	$323.28	4.6816	$193.82	$290.92
15260	Skin full graft een & lips	Y		A2	$446.00	15.4399	$639.21	$494.30
15261	Skin full graft add-on	Y		A2	$323.28	15.4399	$639.21	$402.26
15300	Apply skinallogrft, t/arm/lg	Y		A2	$323.28	4.6816	$193.82	$290.92
15301	Apply sknallogrft t/a/l addl	Y		A2	$323.28	4.6816	$193.82	$290.92
15320	Apply skin allogrft f/n/hf/g	Y		A2	$323.28	4.6816	$193.82	$290.92
15321	Aply sknallogrft f/n/hfg add	Y		A2	$323.28	4.6816	$193.82	$290.92

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS Code	Short Descriptor	Subject to multiple procedure discounting	Comment indicator	Payment indicator	CY 2007 ASC payment rate	Proposed fully implemented payment weight	Proposed CY 2008 fully implemented payment	Proposed CY 2008 first transition year payment
15330	Aply acell alogrft t/arm/leg	Y		A2	$323.28	4.6816	$193.82	$290.92
15331	Aply acell grft t/a/l add-on	Y		A2	$323.28	4.6816	$193.82	$290.92
15335	Apply acell graft, f/n/hf/g	Y		A2	$323.28	4.6816	$193.82	$290.92
15336	Aply acell grft f/n/hf/g add	Y		A2	$323.28	4.6816	$193.82	$290.92
15340	Apply cult skin substitute	Y		G2		2.1114	$87.41	$87.41
15341	Apply cult skin sub add-on	Y		G2		2.1114	$87.41	$87.41
15360	Apply cult derm sub, t/a/l	Y		G2		2.1114	$87.41	$87.41
15361	Aply cult derm sub t/a/l add	Y		G2		2.1114	$87.41	$87.41
15365	Apply cult derm sub f/n/hf/g	Y		G2		2.1114	$87.41	$87.41
15366	Apply cult derm f/hf/g add	Y		G2		2.1114	$87.41	$87.41
15400	Apply skin xenograft, t/a/l	Y		A2	$323.28	4.6816	$193.82	$290.92
15401	Apply skn xenogrft t/a/l add	Y		A2	$323.28	4.6816	$193.82	$290.92
15420	Apply skin xgraft, f/n/hf/g	Y		A2	$323.28	4.6816	$193.82	$290.92
15421	Apply skn xgrft f/n/hf/g add	Y		A2	$323.28	4.6816	$193.82	$290.92
15430	Apply acellular xenograft	Y		A2	$323.28	4.6816	$193.82	$290.92
15431	Apply acellular xgraft add	Y		A2	$323.28	4.6816	$193.82	$290.92
15570	Form skin pedicle flap	Y		A2	$510.00	20.9338	$866.66	$599.17
15572	Form skin pedicle flap	Y		A2	$510.00	20.9338	$866.66	$599.17
15574	Form skin pedicle flap	Y		A2	$510.00	20.9338	$866.66	$599.17
15576	Form skin pedicle flap	Y		A2	$510.00	20.9338	$866.66	$599.17
15600	Skin graft	Y		A2	$510.00	20.9338	$866.66	$599.17
15610	Skin graft	Y		A2	$510.00	20.9338	$866.66	$599.17
15620	Skin graft	Y		A2	$630.00	20.9338	$866.66	$689.17
15630	Skin graft	Y		A2	$510.00	20.9338	$866.66	$599.17
15650	Transfer skin pedicle flap	Y		A2	$717.00	20.9338	$866.66	$754.42
15731	Forehead flap w/vasc pedicle	Y		A2	$510.00	20.9338	$866.66	$599.17
15732	Muscle-skin graft, head/neck	Y		A2	$510.00	20.9338	$866.66	$599.17
15734	Muscle-skin graft, trunk	Y		A2	$510.00	20.9338	$866.66	$599.17
15736	Muscle-skin graft, arm	Y		A2	$510.00	20.9338	$866.66	$599.17
15738	Muscle-skin graft, leg	Y		A2	$510.00	20.9338	$866.66	$599.17
15740	Island pedicle flap graft	Y		A2	$446.00	15.4399	$639.21	$494.30
15750	Neurovascular pedicle graft	Y		A2	$446.00	20.9338	$866.66	$551.17
15760	Composite skin graft	Y		A2	$446.00	20.9338	$866.66	$551.17
15770	Derma-fat-fascia graft	Y		A2	$510.00	20.9338	$866.66	$599.17
15775	Hair transplant punch grafts	Y		A2	$323.28	1.3340	$55.23	$256.27
15776	Hair transplant punch grafts	Y		A2	$323.28	1.3340	$55.23	$256.27
15780	Abrasion treatment of skin	Y		P3		9.5232	$394.26	$394.26
15781	Abrasion treatment of skin	Y		P2		4.4463	$184.08	$184.08
15782	Abrasion treatment of skin	Y		P2		4.4463	$184.08	$184.08
15783	Abrasion treatment of skin	Y		P2		2.7493	$113.82	$113.82
15786	Abrasion, lesion, single	Y		P2		0.8046	$33.31	$33.31
15787	Abrasion, lesions, add-on	Y		P3		0.7915	$32.77	$32.77
15788	Chemical peel, face, epiderm	Y		P2		0.8046	$33.31	$33.31
15789	Chemical peel, face, dermal	Y		P2		1.5119	$62.59	$62.59
15792	Chemical peel, nonfacial	Y		P2		1.5119	$62.59	$62.59
15793	Chemical peel, nonfacial	Y		P2		0.8046	$33.31	$33.31
15819	Plastic surgery, neck	Y		G2		2.1114	$87.41	$87.41
15820	Revision of lower eyelid	Y		A2	$510.00	20.9338	$866.66	$599.17
15821	Revision of lower eyelid	Y		A2	$510.00	20.9338	$866.66	$599.17
15822	Revision of upper eyelid	Y		A2	$510.00	20.9338	$866.66	$599.17
15823	Revision of upper eyelid	Y		A2	$717.00	20.9338	$866.66	$754.42
15824	Removal of forehead wrinkles	Y		A2	$510.00	20.9338	$866.66	$599.17
15825	Removal of neck wrinkles	Y		A2	$510.00	20.9338	$866.66	$599.17
15826	Removal of brow wrinkles	Y		A2	$510.00	20.9338	$866.66	$599.17
15828	Removal of face wrinkles	Y		A2	$510.00	20.9338	$866.66	$599.17
15829	Removal of skin wrinkles	Y		A2	$717.00	20.9338	$866.66	$754.42
15830	Exc skin abd	Y		A2	$510.00	21.4534	$888.17	$604.54
15832	Excise excessive skin tissue	Y		A2	$510.00	21.4534	$888.17	$604.54
15833	Excise excessive skin tissue	Y		A2	$510.00	21.4534	$888.17	$604.54
15834	Excise excessive skin tissue	Y		A2	$510.00	21.4534	$888.17	$604.54
15835	Excise excessive skin tissue	Y		A2	$323.28	21.4534	$888.17	$464.50
15836	Excise excessive skin tissue	Y		A2	$510.00	16.5832	$686.54	$554.14
15837	Excise excessive skin tissue	Y		G2		16.5832	$686.54	$686.54
15838	Excise excessive skin tissue	Y		G2		16.5832	$686.54	$686.54
15839	Excise excessive skin tissue	Y		A2	$510.00	16.5832	$686.54	$554.14
15840	Graft for face nerve palsy	Y		A2	$630.00	20.9338	$866.66	$689.17
15841	Graft for face nerve palsy	Y		A2	$630.00	20.9338	$866.66	$689.17
15842	Flap for face nerve palsy	Y		G2		20.9338	$866.66	$866.66
15845	Skin and muscle repair, face	Y		A2	$630.00	20.9338	$866.66	$689.17
15847	Exc skin abd add-on	Y		A2	$510.00	21.4534	$888.17	$604.54
15850	Removal of sutures	Y		G2		2.7493	$113.82	$113.82
15851	Removal of sutures	Y		P3		1.2367	$51.20	$51.20
15852	Dressing change not for burn	N		G2		0.6416	$26.56	$26.56
15860	Test for blood flow in graft	N		G2		0.6416	$26.56	$26.56
15876	Suction assisted lipectomy	Y		A2	$510.00	20.9338	$866.66	$599.17
15877	Suction assisted lipectomy	Y		A2	$510.00	20.9338	$866.66	$599.17

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS Code	Short Descriptor	Subject to multiple procedure discounting	Comment indicator	Payment indicator	CY 2007 ASC payment rate	Proposed fully implemented payment weight	Proposed CY 2008 fully implemented payment	Proposed CY 2008 first transition year payment
15878	Suction assisted lipectomy	Y		A2	$510.00	20.9338	$866.66	$599.17
15879	Suction assisted lipectomy	Y		A2	$510.00	20.9338	$866.66	$599.17
15920	Removal of tail bone ulcer	Y		A2	$251.52	4.4463	$184.08	$234.66
15922	Removal of tail bone ulcer	Y		A2	$630.00	20.9338	$866.66	$689.17
15931	Remove sacrum pressure sore	Y		A2	$510.00	21.4534	$888.17	$604.54
15933	Remove sacrum pressure sore	Y		A2	$510.00	21.4534	$888.17	$604.54
15934	Remove sacrum pressure sore	Y		A2	$510.00	20.9338	$866.66	$599.17
15935	Remove sacrum pressure sore	Y		A2	$630.00	20.9338	$866.66	$689.17
15936	Remove sacrum pressure sore	Y		A2	$630.00	15.4399	$639.21	$632.30
15937	Remove sacrum pressure sore	Y		A2	$630.00	20.9338	$866.66	$689.17
15940	Remove hip pressure sore	Y		A2	$510.00	21.4534	$888.17	$604.54
15941	Remove hip pressure sore	Y		A2	$510.00	21.4534	$888.17	$604.54
15944	Remove hip pressure sore	Y		A2	$510.00	20.9338	$866.66	$599.17
15945	Remove hip pressure sore	Y		A2	$630.00	20.9338	$866.66	$689.17
15946	Remove hip pressure sore	Y		A2	$630.00	20.9338	$866.66	$689.17
15950	Remove thigh pressure sore	Y		A2	$510.00	21.4534	$888.17	$604.54
15951	Remove thigh pressure sore	Y		A2	$630.00	21.4534	$888.17	$694.54
15952	Remove thigh pressure sore	Y		A2	$510.00	15.4399	$639.21	$542.30
15953	Remove thigh pressure sore	Y		A2	$630.00	15.4399	$639.21	$632.30
15956	Remove thigh pressure sore	Y		A2	$510.00	15.4399	$639.21	$542.30
15958	Remove thigh pressure sore	Y		A2	$630.00	15.4399	$639.21	$632.30
16000	Initial treatment of burn(s)	Y		P3		0.6514	$26.97	$26.97
16020	Dress/debrid p-thick burn, s	Y		P3		0.9894	$40.96	$40.96
16025	Dress/debrid p-thick burn, m	Y		A2	$67.11	2.7493	$113.82	$78.79
16030	Dress/debrid p-thick burn, l	Y		A2	$99.83	2.7493	$113.82	$103.33
16035	Incision of burn scab, initi	Y		G2		2.7493	$113.82	$113.82
17000	Destruct premalg lesion	Y		P2		0.8046	$33.31	$33.31
17003	Destruct premalg les, 2–14	Y		P3		0.0906	$3.75	$3.75
17004	Destroy premlg lesions 15+	Y		P3		1.9541	$80.90	$80.90
17106	Destruction of skin lesions	Y		P2		2.7493	$113.82	$113.82
17107	Destruction of skin lesions	Y		P2		2.7493	$113.82	$113.82
17108	Destruction of skin lesions	Y		P2		2.7493	$113.82	$113.82
17110	Destruct b9 lesion, 1–14	Y		P2		0.8046	$33.31	$33.31
17111	Destruct lesion, 15 or more	Y		P2		1.5119	$62.59	$62.59
17250	Chemical cautery, tissue	Y		P3		1.0471	$43.35	$43.35
17260	Destruction of skin lesions	Y		P3		1.1130	$46.08	$46.08
17261	Destruction of skin lesions	Y		P2		1.5119	$62.59	$62.59
17262	Destruction of skin lesions	Y		P2		1.5119	$62.59	$62.59
17263	Destruction of skin lesions	Y		P2		1.5119	$62.59	$62.59
17264	Destruction of skin lesions	Y		P2		1.5119	$62.59	$62.59
17266	Destruction of skin lesions	Y		P3		2.4819	$102.75	$102.75
17270	Destruction of skin lesions	Y		P2		1.5119	$62.59	$62.59
17271	Destruction of skin lesions	Y		P2		1.5119	$62.59	$62.59
17272	Destruction of skin lesions	Y		P2		1.5119	$62.59	$62.59
17273	Destruction of skin lesions	Y	CH	P3		2.2345	$92.51	$92.51
17274	Destruction of skin lesions	Y		P3		2.5560	$105.82	$105.82
17276	Destruction of skin lesions	Y		P2		2.7493	$113.82	$113.82
17280	Destruction of skin lesions	Y	CH	P2		1.5119	$62.59	$62.59
17281	Destruction of skin lesions	Y	CH	P3		1.9210	$79.53	$79.53
17282	Destruction of skin lesions	Y	CH	P3		2.1932	$90.80	$90.80
17283	Destruction of skin lesions	Y	CH	P3		2.5229	$104.45	$104.45
17284	Destruction of skin lesions	Y		P2		2.7493	$113.82	$113.82
17286	Destruction of skin lesions	Y		P2		2.7493	$113.82	$113.82
17311	Mohs, 1 stage, h/n/hf/g	Y		P2		3.9713	$164.41	$164.41
17312	Mohs addl stage	Y		P2		3.9713	$164.41	$164.41
17313	Mohs, 1 stage, t/a/l	Y		P2		3.9713	$164.41	$164.41
17314	Mohs, addl stage, t/a/l	Y		P2		3.9713	$164.41	$164.41
17315	Mohs surg, addl block	Y		P3		0.9483	$39.26	$39.26
17340	Cryotherapy of skin	Y		P3		0.2969	$12.29	$12.29
17360	Skin peel therapy	Y		P2		0.8046	$33.31	$33.31
17380	Hair removal by electrolysis	Y		R2		0.8046	$33.31	$33.31
19000	Drainage of breast lesion	Y		P3		1.5831	$65.54	$65.54
19001	Drain breast lesion add-on	Y		P3		0.2060	$8.53	$8.53
19020	Incision of breast lesion	Y		A2	$446.00	19.0457	$788.49	$531.62
19030	Injection for breast x-ray	N		N1				
19100	Bx breast percut w/o image	Y		A2	$240.00	4.5062	$186.56	$226.64
19101	Biopsy of breast, open	Y		A2	$446.00	20.9980	$869.32	$551.83
19102	Bx breast percut w/image	Y		A2	$240.00	7.3012	$302.27	$255.57
19103	Bx breast percut w/device	Y		A2	$395.77	13.9599	$577.94	$441.31
19105	Cryosurg ablate fa, each	Y		G2		32.4940	$1,345.25	$1,345.25
19110	Nipple exploration	Y		A2	$446.00	20.9980	$869.32	$551.83
19112	Excise breast duct fistula	Y		A2	$510.00	20.9980	$869.32	$599.83
19120	Removal of breast lesion	Y		A2	$510.00	20.9980	$869.32	$599.83
19125	Excision, breast lesion	Y		A2	$510.00	20.9980	$869.32	$599.83
19126	Excision, addl breast lesion	Y		A2	$510.00	20.9980	$869.32	$599.83
19290	Place needle wire, breast	N		N1	$333.00			

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS Code	Short Descriptor	Subject to multiple procedure discounting	Comment indicator	Payment indicator	CY 2007 ASC payment rate	Proposed fully implemented payment weight	Proposed CY 2008 fully implemented payment	Proposed CY 2008 first transition year payment
19291	Place needle wire, breast	N		N1	$333.00			
19295	Place breast clip, percut	N	CH	N1	$106.76			
19296	Place po breast cath for rad	Y		A2	$1,339.00	52.9438	$2,191.87	$1,552.22
19297	Place breast cath for rad	Y		A2	$1,339.00	52.9438	$2,191.87	$1,552.22
19298	Place breast rad tube/caths	Y	CH	A2	$1,339.00	52.9438	$2,191.87	$1,552.22
19300	Removal of breast tissue	Y		A2	$630.00	20.9980	$869.32	$689.83
19301	Partical mastectomy	Y		A2	$510.00	20.9980	$869.32	$599.83
19302	P-mastectomy w/ln removal	Y		A2	$995.00	40.4634	$1,675.18	$1,165.05
19303	Mast, simple, complete	Y		A2	$630.00	32.4940	$1,345.25	$808.81
19304	Mast, subq	Y		A2	$630.00	32.4940	$1,345.25	$808.81
19316	Suspension of breast	Y		A2	$630.00	32.4940	$1,345.25	$808.81
19318	Reduction of large breast	Y		A2	$630.00	40.4634	$1,675.18	$891.30
19324	Enlarge breast	Y		A2	$630.00	40.4634	$1,675.18	$891.30
19325	Enlarge breast with implant	Y		A2	$1,339.00	52.9438	$2,191.87	$1,552.22
19328	Removal of breast implant	Y		A2	$333.00	32.4940	$1,345.25	$586.06
19330	Removal of implant material	Y		A2	$333.00	32.4940	$1,345.25	$586.06
19340	Immediate breast prosthesis	Y		A2	$446.00	40.4634	$1,675.18	$753.30
19342	Delayed breast prosthesis	Y		A2	$510.00	52.9438	$2,191.87	$930.47
19350	Breast reconstruction	Y		A2	$630.00	20.9980	$869.32	$689.83
19355	Correct inverted nipple(s)	Y		A2	$630.00	32.4940	$1,345.25	$808.81
19357	Breast reconstruction	Y		A2	$717.00	52.9438	$2,191.87	$1,085.72
19366	Breast reconstruction	Y		A2	$717.00	32.4940	$1,345.25	$874.06
19370	Surgery of breast capsule	Y		A2	$630.00	32.4940	$1,345.25	$808.81
19371	Removal of breast capsule	Y		A2	$630.00	32.4940	$1,345.25	$808.81
19380	Revise breast reconstruction	Y		A2	$717.00	40.4634	$1,675.18	$956.55
19396	Design custom breast implant	Y		G2		32.4940	$1,345.25	$1,345.25
20000	Incision of abscess	Y		P2		1.4630	$60.57	$60.57
20005	Incision of deep abscess	Y		A2	$446.00	21.5761	$893.25	$557.81
20103	Explore wound, extremity	Y		G2		9.5721	$396.28	$396.28
20150	Excise epiphyseal bar	Y		G2		43.5953	$1,804.85	$1,804.85
20200	Muscle biopsy	Y		A2	$446.00	16.5832	$686.54	$506.14
20205	Deep muscle biopsy	Y		A2	$510.00	16.5832	$686.54	$554.14
20206	Needle biopsy, muscle	Y		A2	$240.00	7.3012	$302.27	$255.57
20220	Bone biopsy, trocar/needle	Y		A2	$251.52	8.7155	$360.82	$278.85
20225	Bone biopsy, trocar/needle	Y		A2	$418.49	8.7155	$360.82	$404.07
20240	Bone biopsy, excisional	Y		A2	$446.00	21.4534	$888.17	$556.54
20245	Bone biopsy, excisional	Y		A2	$510.00	21.4534	$888.17	$604.54
20250	Open bone biopsy	Y		A2	$510.00	21.5761	$893.25	$605.81
20251	Open bone biopsy	Y		A2	$510.00	21.5761	$893.25	$605.81
20500	Injection of sinus tract	Y		P3		1.4676	$60.76	$60.76
20501	Inject sinus tract for x-ray	N		N1				
20520	Removal of foreign body	Y		P3		2.2674	$93.87	$93.87
20525	Removal of foreign body	Y		A2	$510.00	21.4534	$888.17	$604.54
20526	Ther injection, carp tunnel	Y		P3		0.7338	$30.38	$30.38
20550	Inj tendon sheath/ligament	Y		P3		0.5524	$22.87	$22.87
20551	Inj tendon origin/insertion	Y		P3		0.5442	$22.53	$22.53
20552	Inj trigger point, 1/2 muscl	Y		P3		0.5360	$22.19	$22.19
20553	Inject trigger points, =/> 3	Y		P3		0.6019	$24.92	$24.92
20600	Drain/inject, joint/bursa	Y		P3		0.5442	$22.53	$22.53
20605	Drain/inject, joint/bursa	Y		P3		0.6184	$25.60	$25.60
20610	Drain/inject, joint/bursa	Y		P3		0.8329	$34.48	$34.48
20612	Aspirate/inj ganglion cyst	Y		P3		0.5771	$23.89	$23.89
20615	Treatment of bone cyst	Y	CH	P3		2.5560	$105.82	$105.82
20650	Insert and remove bone pin	Y		A2	$510.00	21.5761	$893.25	$605.81
20662	Application of pelvis brace	Y		R2		21.5761	$893.25	$893.25
20663	Application of thigh brace	Y		R2		21.5761	$893.25	$893.25
20665	Removal of fixation device	N		G2		0.6416	$26.56	$26.56
20670	Removal of support implant	Y		A2	$333.00	16.5832	$686.54	$421.39
20680	Removal of support implant	Y		A2	$510.00	21.4534	$888.17	$604.54
20690	Apply bone fixation device	Y		A2	$446.00	29.3263	$1,214.11	$638.03
20692	Apply bone fixation device	Y		A2	$510.00	29.3263	$1,214.11	$686.03
20693	Adjust bone fixation device	Y		A2	$510.00	21.5761	$893.25	$605.81
20694	Remove bone fixation device	Y		A2	$333.00	21.5761	$893.25	$473.06
20822	Replantation digit, complete	Y		G2		26.7322	$1,106.71	$1,106.71
20900	Removal of bone for graft	Y		A2	$510.00	29.3263	$1,214.11	$686.03
20902	Removal of bone for graft	Y		A2	$630.00	29.3263	$1,214.11	$776.03
20910	Remove cartilage for graft	Y		A2	$510.00	20.9338	$866.66	$599.17
20912	Remove cartilage for graft	Y		A2	$510.00	20.9338	$866.66	$599.17
20920	Removal of fascia for graft	Y		A2	$630.00	15.4399	$639.21	$632.30
20922	Removal of fascia for graft	Y		A2	$510.00	15.4399	$639.21	$542.30
20924	Removal of tendon for graft	Y		A2	$630.00	29.3263	$1,214.11	$776.03
20926	Removal of tissue for graft	Y		A2	$630.00	4.6816	$193.82	$520.96
20950	Fluid pressure, muscle	Y		G2		1.4630	$60.57	$60.57
20972	Bone/skin graft, metatarsal	Y		G2		44.4710	$1,841.10	$1,841.10
20973	Bone/skin graft, great toe	Y		R2		44.4710	$1,841.10	$1,841.10
20975	Electrical bone stimulation	N	CH	N1	$37.51			

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS Code	Short Descriptor	Subject to multiple procedure discounting	Comment indicator	Payment indicator	CY 2007 ASC payment rate	Proposed fully implemented payment weight	Proposed CY 2008 fully implemented payment	Proposed CY 2008 first transition year payment
20979	Us bone stimulation	N		P3		0.5771	$23.89	$23.89
20982	Ablate, bone tumor(s) perq	Y		G2		43.5953	$1,804.85	$1,804.85
21010	Incision of jaw joint	Y		A2	$446.00	24.3535	$1,008.23	$586.56
21015	Resection of facial tumor	Y		A2	$510.00	16.6341	$688.65	$554.66
21025	Excision of bone, lower jaw	Y		A2	$446.00	40.5598	$1,679.18	$754.30
21026	Excision of facial bone(s)	Y		A2	$446.00	40.5598	$1,679.18	$754.30
21029	Contour of face bone lesion	Y		A2	$446.00	40.5598	$1,679.18	$754.30
21030	Excise max/zygoma b9 tumor	Y		P3		5.5737	$230.75	$230.75
21031	Remove exostosis, mandible	Y		P3		4.5761	$189.45	$189.45
21032	Remove exostosis, maxilla	Y		P3		4.6915	$194.23	$194.23
21034	Excise max/zygoma mlg tumor	Y		A2	$510.00	40.5598	$1,679.18	$802.30
21040	Excise mandible lesion	Y		A2	$446.00	24.3535	$1,008.23	$586.56
21044	Removal of jaw bone lesion	Y		A2	$446.00	40.5598	$1,679.18	$754.30
21046	Remove mandible cyst complex	Y		A2	$446.00	40.5598	$1,679.18	$754.30
21047	Excise lwr jaw cyst w/repair	Y		A2	$446.00	40.5598	$1,679.18	$754.30
21048	Remove maxilla cyst complex	Y		R2		40.5598	$1,679.18	$1,679.18
21050	Removal of jaw joint	Y		A2	$510.00	40.5598	$1,679.18	$802.30
21060	Remove jaw joint cartilage	Y		A2	$446.00	40.5598	$1,679.18	$754.30
21070	Remove coronoid process	Y		A2	$510.00	40.5598	$1,679.18	$802.30
21076	Prepare face/oral prosthesis	Y		P3		8.3442	$345.45	$345.45
21077	Prepare face/oral prosthesis	Y		P3		20.4563	$846.89	$846.89
21079	Prepare face/oral prosthesis	Y		P3		14.5198	$601.12	$601.12
21080	Prepare face/oral prosthesis	Y		P3		16.6471	$689.19	$689.19
21081	Prepare face/oral prosthesis	Y		P3		15.2783	$632.52	$632.52
21082	Prepare face/oral prosthesis	Y		P3		14.0993	$583.71	$583.71
21083	Prepare face/oral prosthesis	Y		P3		13.7860	$570.74	$570.74
21084	Prepare face/oral prosthesis	Y		P3		16.0370	$663.93	$663.93
21085	Prepare face/oral prosthesis	Y		P3		6.2333	$258.06	$258.06
21086	Prepare face/oral prosthesis	Y		P3		15.0391	$622.62	$622.62
21087	Prepare face/oral prosthesis	Y		P3		14.9237	$617.84	$617.84
21088	Prepare face/oral prosthesis	Y		R2		40.5598	$1,679.18	$1,679.18
21100	Maxillofacial fixation	Y		A2	$446.00	40.5598	$1,679.18	$754.30
21110	Interdental fixation	Y		P2		7.6539	$316.87	$316.87
21116	Injection, jaw joint x-ray	N		N1				
21120	Reconstruction of chin	Y		A2	$995.00	24.3535	$1,008.23	$998.31
21121	Reconstruction of chin	Y		A2	$995.00	24.3535	$1,008.23	$998.31
21122	Reconstruction of chin	Y		A2	$995.00	24.3535	$1,008.23	$998.31
21123	Reconstruction of chin	Y		A2	$995.00	24.3535	$1,008.23	$998.31
21125	Augmentation, lower jaw bone	Y		A2	$995.00	24.3535	$1,008.23	$998.31
21127	Augmentation, lower jaw bone	Y		A2	$1,339.00	40.5598	$1,679.18	$1,424.05
21137	Reduction of forehead	Y		G2		24.3535	$1,008.23	$1,008.23
21138	Reduction of forehead	Y		G2		40.5598	$1,679.18	$1,679.18
21139	Reduction of forehead	Y		G2		40.5598	$1,679.18	$1,679.18
21150	Reconstruct midface, lefort	Y		G2		40.5598	$1,679.18	$1,679.18
21181	Contour cranial bone lesion	Y		A2	$995.00	24.3535	$1,008.23	$998.31
21198	Reconstr lwr jaw segment	Y		G2		40.5598	$1,679.18	$1,679.18
21199	Reconstr lwr jaw w/advance	Y		G2		40.5598	$1,679.18	$1,679.18
21206	Reconstruct upper jaw bone	Y		A2	$717.00	40.5598	$1,679.18	$957.55
21208	Augmentation of facial bones	Y		A2	$995.00	40.5598	$1,679.18	$1,166.05
21209	Reduction of facial bones	Y		A2	$717.00	40.5598	$1,679.18	$957.55
21210	Face bone graft	Y		A2	$995.00	40.5598	$1,679.18	$1,166.05
21215	Lower jaw bone graft	Y		A2	$995.00	40.5598	$1,679.18	$1,166.05
21230	Rib cartilage graft	Y		A2	$995.00	40.5598	$1,679.18	$1,166.05
21235	Ear cartilage graft	Y		A2	$995.00	24.3535	$1,008.23	$998.31
21240	Reconstruction of jaw joint	Y		A2	$630.00	40.5598	$1,679.18	$892.30
21242	Reconstruction of jaw joint	Y		A2	$717.00	40.5598	$1,679.18	$957.55
21243	Reconstruction of jaw joint	Y		A2	$717.00	40.5598	$1,679.18	$957.55
21244	Reconstruction of lower jaw	Y		A2	$995.00	40.5598	$1,679.18	$1,166.05
21245	Reconstruction of jaw	Y		A2	$995.00	40.5598	$1,679.18	$1,166.05
21246	Reconstruction of jaw	Y		A2	$995.00	40.5598	$1,679.18	$1,166.05
21248	Reconstruction of jaw	Y		A2	$995.00	40.5598	$1,679.18	$1,166.05
21249	Reconstruction of jaw	Y		A2	$995.00	40.5598	$1,679.18	$1,166.05
21260	Revise eye sockets	Y		G2		40.5598	$1,679.18	$1,679.18
21267	Revise eye sockets	Y		A2	$995.00	40.5598	$1,679.18	$1,166.05
21270	Augmentation, cheek bone	Y		A2	$717.00	40.5598	$1,679.18	$957.55
21275	Revision, orbitofacial bones	Y		A2	$995.00	40.5598	$1,679.18	$1,166.05
21280	Revision of eyelid	Y		A2	$717.00	40.5598	$1,679.18	$957.55
21282	Revision of eyelid	Y		A2	$717.00	16.6341	$688.65	$709.91
21295	Revision of jaw muscle/bone	Y		A2	$333.00	7.6539	$316.87	$328.97
21296	Revision of jaw muscle/bone	Y		A2	$333.00	24.3535	$1,008.23	$501.81
21310	Treatment of nose fracture	Y		A2	$150.72	2.5765	$106.67	$139.71
21315	Treatment of nose fracture	Y		A2	$150.72	2.5765	$106.67	$139.71
21320	Treatment of nose fracture	Y		A2	$446.00	16.6341	$688.65	$506.66
21325	Treatment of nose fracture	Y		A2	$630.00	24.3535	$1,008.23	$724.56
21330	Treatment of nose fracture	Y		A2	$717.00	24.3535	$1,008.23	$789.81
21335	Treatment of nose fracture	Y		A2	$995.00	24.3535	$1,008.23	$998.31

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS Code	Short Descriptor	Subject to multiple procedure discounting	Comment indicator	Payment indicator	CY 2007 ASC payment rate	Proposed fully implemented payment weight	Proposed CY 2008 fully implemented payment	Proposed CY 2008 first transition year payment
21336	Treat nasal septal fracture	Y		A2	$630.00	40.3466	$1,670.35	$890.09
21337	Treat nasal septal fracture	Y		A2	$446.00	16.6341	$688.65	$506.66
21338	Treat nasoethmoid fracture	Y		A2	$630.00	24.3535	$1,008.23	$724.56
21339	Treat nasoethmoid fracture	Y		A2	$717.00	24.3535	$1,008.23	$789.81
21340	Treatment of nose fracture	Y		A2	$630.00	40.5598	$1,679.18	$892.30
21345	Treat nose/jaw fracture	Y		A2	$995.00	24.3535	$1,008.23	$998.31
21355	Treat cheek bone fracture	Y		A2	$510.00	40.5598	$1,679.18	$802.30
21356	Treat cheek bone fracture	Y		A2	$510.00	24.3535	$1,008.23	$634.56
21390	Treat eye socket fracture	Y		G2		40.5598	$1,679.18	$1,679.18
21400	Treat eye socket fracture	Y		A2	$446.00	7.6539	$316.87	$413.72
21401	Treat eye socket fracture	Y		A2	$510.00	16.6341	$688.65	$554.66
21406	Treat eye socket fracture	Y		G2		40.5598	$1,679.18	$1,679.18
21407	Treat eye socket fracture	Y		G2		40.5598	$1,679.18	$1,679.18
21421	Treat mouth roof fracture	Y		A2	$630.00	24.3535	$1,008.23	$724.56
21440	Treat dental ridge fracture	Y		P3		7.0990	$293.90	$293.90
21445	Treat dental ridge fracture	Y		A2	$630.00	24.3535	$1,008.23	$724.56
21450	Treat lower jaw fracture	Y		A2	$150.72	2.5765	$106.67	$139.71
21451	Treat lower jaw fracture	Y		A2	$464.15	7.6539	$316.87	$427.33
21452	Treat lower jaw fracture	Y		A2	$446.00	16.6341	$688.65	$506.66
21453	Treat lower jaw fracture	Y		A2	$510.00	40.5598	$1,679.18	$802.30
21454	Treat lower jaw fracture	Y		A2	$717.00	24.3535	$1,008.23	$789.81
21461	Treat lower jaw fracture	Y		A2	$630.00	40.5598	$1,679.18	$892.30
21462	Treat lower jaw fracture	Y		A2	$717.00	40.5598	$1,679.18	$957.55
21465	Treat lower jaw fracture	Y		A2	$630.00	40.5598	$1,679.18	$892.30
21480	Reset dislocated jaw	Y		A2	$150.72	2.5765	$106.67	$139.71
21485	Reset dislocated jaw	Y		A2	$446.00	16.6341	$688.65	$506.66
21490	Repair dislocated jaw	Y		A2	$510.00	40.5598	$1,679.18	$802.30
21495	Treat hyoid bone fracture	Y		G2		16.6341	$688.65	$688.65
21497	Interdental wiring	Y		A2	$446.00	16.6341	$688.65	$506.66
21501	Drain neck/chest lesion	Y		A2	$446.00	19.0457	$788.49	$531.62
21502	Drain chest lesion	Y		A2	$446.00	21.5761	$893.25	$557.81
21550	Biopsy of neck/chest	Y		G2		8.7155	$360.82	$360.82
21555	Remove lesion, neck/chest	Y		A2	$446.00	21.4534	$888.17	$556.54
21556	Remove lesion, neck/chest	Y		A2	$446.00	21.4534	$888.17	$556.54
21557	Remove tumor, neck/chest	Y		G2		21.4534	$888.17	$888.17
21600	Partial removal of rib	Y		A2	$446.00	29.3263	$1,214.11	$638.03
21610	Partial removal of rib	Y		A2	$446.00	29.3263	$1,214.11	$638.03
21685	Hyoid myotomy & suspension	Y		G2		7.6539	$316.87	$316.87
21700	Revision of neck muscle	Y		A2	$446.00	21.5761	$893.25	$557.81
21720	Revision of neck muscle	Y		A2	$510.00	21.5761	$893.25	$605.81
21725	Revision of neck muscle	Y		A2	$88.46	1.4630	$60.57	$81.49
21800	Treatment of rib fracture	Y		A2	$103.62	1.8742	$77.59	$97.11
21805	Treatment of rib fracture	Y		A2	$446.00	26.3092	$1,089.20	$606.80
21820	Treat sternum fracture	Y		A2	$103.62	1.8742	$77.59	$97.11
21920	Biopsy soft tissue of back	Y		P3		3.1744	$131.42	$131.42
21925	Biopsy soft tissue of back	Y		A2	$446.00	21.4534	$888.17	$556.54
21930	Remove lesion, back or flank	Y		A2	$446.00	21.4534	$888.17	$556.54
21935	Remove tumor, back	Y		A2	$510.00	21.4534	$888.17	$604.54
22102	Remove part, lumbar vertebra	Y		G2		47.6714	$1,973.60	$1,973.60
22103	Remove extra spine segment	Y		G2		47.6714	$1,973.60	$1,973.60
22305	Treat spine process fracture	Y		A2	$103.62	1.8742	$77.59	$97.11
22310	Treat spine fracture	Y		A2	$103.62	1.8742	$77.59	$97.11
22315	Treat spine fracture	Y		A2	$103.62	1.8742	$77.59	$97.11
22505	Manipulation of spine	Y		A2	$446.00	15.0176	$621.73	$489.93
22520	Percut vertebroplasty thor	Y		A2	$1,339.00	29.3263	$1,214.11	$1,307.78
22521	Percut vertebroplasty lumb	Y		A2	$1,339.00	29.3263	$1,214.11	$1,307.78
22522	Percut vertebroplasty add'l	Y		A2	$1,339.00	29.3263	$1,214.11	$1,307.78
22523	Percut kyphoplasty, thor	Y		G2		78.6518	$3,256.18	$3,256.18
22524	Percut kyphoplasty, lumbar	Y		G2		78.6518	$3,256.18	$3,256.18
22525	Percut kyphoplasty, add-on	Y		G2		78.6518	$3,256.18	$3,256.18
22900	Remove abdominal wall lesion	Y		A2	$630.00	21.4534	$888.17	$694.54
23000	Removal of calcium deposits	Y		A2	$446.00	16.5832	$686.54	$506.14
23020	Release shoulder joint	Y		A2	$446.00	43.5953	$1,804.85	$785.71
23030	Drain shoulder lesion	Y		A2	$333.00	19.0457	$788.49	$446.87
23031	Drain shoulder bursa	Y		A2	$510.00	19.0457	$788.49	$579.62
23035	Drain shoulder bone lesion	Y		A2	$510.00	21.5761	$893.25	$605.81
23040	Exploratory shoulder surgery	Y		A2	$510.00	29.3263	$1,214.11	$686.03
23044	Exploratory shoulder surgery	Y		A2	$630.00	29.3263	$1,214.11	$776.03
23065	Biopsy shoulder tissues	Y		P3		2.2428	$92.85	$92.85
23066	Biopsy shoulder tissues	Y		A2	$446.00	21.4534	$888.17	$556.54
23075	Removal of shoulder lesion	Y		A2	$446.00	16.5832	$686.54	$506.14
23076	Removal of shoulder lesion	Y		A2	$446.00	21.4534	$888.17	$556.54
23077	Remove tumor of shoulder	Y		A2	$510.00	21.4534	$888.17	$604.54
23100	Biopsy of shoulder joint	Y		A2	$446.00	21.5761	$893.25	$557.81
23101	Shoulder joint surgery	Y		A2	$995.00	29.3263	$1,214.11	$1,049.78
23105	Remove shoulder joint lining	Y		A2	$630.00	29.3263	$1,214.11	$776.03

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS Code	Short Descriptor	Subject to multiple procedure discounting	Comment indicator	Payment indicator	CY 2007 ASC payment rate	Proposed fully implemented payment weight	Proposed CY 2008 fully implemented payment	Proposed CY 2008 first transition year payment
23106	Incision of collarbone joint	Y		A2	$630.00	29.3263	$1,214.11	$776.03
23107	Explore treat shoulder joint	Y		A2	$630.00	29.3263	$1,214.11	$776.03
23120	Partial removal, collar bone	Y		A2	$717.00	29.3263	$1,214.11	$841.28
23125	Removal of collar bone	Y		A2	$717.00	29.3263	$1,214.11	$841.28
23130	Remove shoulder bone, part	Y		A2	$717.00	43.5953	$1,804.85	$988.96
23140	Removal of bone lesion	Y		A2	$630.00	21.5761	$893.25	$695.81
23145	Removal of bone lesion	Y		A2	$717.00	29.3263	$1,214.11	$841.28
23146	Removal of bone lesion	Y		A2	$717.00	29.3263	$1,214.11	$841.28
23150	Removal of humerus lesion	Y		A2	$630.00	29.3263	$1,214.11	$776.03
23155	Removal of humerus lesion	Y		A2	$717.00	29.3263	$1,214.11	$841.28
23156	Removal of humerus lesion	Y		A2	$717.00	29.3263	$1,214.11	$841.28
23170	Remove collar bone lesion	Y		A2	$446.00	29.3263	$1,214.11	$638.03
23172	Remove shoulder blade lesion	Y		A2	$446.00	29.3263	$1,214.11	$638.03
23174	Remove humerus lesion	Y		A2	$446.00	29.3263	$1,214.11	$638.03
23180	Remove collar bone lesion	Y		A2	$630.00	29.3263	$1,214.11	$776.03
23182	Remove shoulder blade lesion	Y		A2	$630.00	29.3263	$1,214.11	$776.03
23184	Remove humerus lesion	Y		A2	$630.00	29.3263	$1,214.11	$776.03
23190	Partial removal of scapula	Y		A2	$630.00	29.3263	$1,214.11	$776.03
23195	Removal of head of humerus	Y		A2	$717.00	29.3263	$1,214.11	$841.28
23330	Remove shoulder foreign body	Y		A2	$333.00	8.7155	$360.82	$339.96
23331	Remove shoulder foreign body	Y		A2	$333.00	21.4534	$888.17	$471.79
23350	Injection for shoulder x-ray	N		N1				
23395	Muscle transfer,shoulder/arm	Y		A2	$717.00	43.5953	$1,804.85	$988.96
23397	Muscle transfers	Y		A2	$995.00	78.6518	$3,256.18	$1,560.30
23400	Fixation of shoulder blade	Y		A2	$995.00	29.3263	$1,214.11	$1,049.78
23405	Incision of tendon & muscle	Y		A2	$446.00	29.3263	$1,214.11	$638.03
23406	Incise tendon(s) & muscle(s)	Y		A2	$446.00	29.3263	$1,214.11	$638.03
23410	Repair rotator cuff, acute	Y		A2	$717.00	43.5953	$1,804.85	$988.96
23412	Repair rotator cuff, chronic	Y		A2	$995.00	43.5953	$1,804.85	$1,197.46
23415	Release of shoulder ligament	Y		A2	$717.00	43.5953	$1,804.85	$988.96
23420	Repair of shoulder	Y		A2	$995.00	43.5953	$1,804.85	$1,197.46
23430	Repair biceps tendon	Y		A2	$630.00	43.5953	$1,804.85	$923.71
23440	Remove/transplant tendon	Y		A2	$630.00	43.5953	$1,804.85	$923.71
23450	Repair shoulder capsule	Y		A2	$717.00	78.6518	$3,256.18	$1,351.80
23455	Repair shoulder capsule	Y		A2	$995.00	78.6518	$3,256.18	$1,560.30
23460	Repair shoulder capsule	Y		A2	$717.00	78.6518	$3,256.18	$1,351.80
23462	Repair shoulder capsule	Y		A2	$995.00	43.5953	$1,804.85	$1,197.46
23465	Repair shoulder capsule	Y		A2	$717.00	78.6518	$3,256.18	$1,351.80
23466	Repair shoulder capsule	Y		A2	$995.00	43.5953	$1,804.85	$1,197.46
23480	Revision of collar bone	Y		A2	$630.00	43.5953	$1,804.85	$923.71
23485	Revision of collar bone	Y		A2	$995.00	78.6518	$3,256.18	$1,560.30
23490	Reinforce clavicle	Y		A2	$510.00	43.5953	$1,804.85	$833.71
23491	Reinforce shoulder bones	Y		A2	$510.00	78.6518	$3,256.18	$1,196.55
23500	Treat clavicle fracture	Y		A2	$103.62	1.8742	$77.59	$97.11
23505	Treat clavicle fracture	Y		A2	$103.62	1.8742	$77.59	$97.11
23515	Treat clavicle fracture	Y		A2	$510.00	60.0595	$2,486.46	$1,004.12
23520	Treat clavicle dislocation	Y		A2	$103.62	1.8742	$77.59	$97.11
23525	Treat clavicle dislocation	Y		A2	$103.62	1.8742	$77.59	$97.11
23530	Treat clavicle dislocation	Y		A2	$510.00	40.3466	$1,670.35	$800.09
23532	Treat clavicle dislocation	Y		A2	$630.00	26.3092	$1,089.20	$744.80
23540	Treat clavicle dislocation	Y		A2	$103.62	1.8742	$77.59	$97.11
23545	Treat clavicle dislocation	Y		A2	$103.62	1.8742	$77.59	$97.11
23550	Treat clavicle dislocation	Y		A2	$510.00	40.3466	$1,670.35	$800.09
23552	Treat clavicle dislocation	Y		A2	$630.00	40.3466	$1,670.35	$890.09
23570	Treat shoulder blade fx	Y		A2	$103.62	1.8742	$77.59	$97.11
23575	Treat shoulder blade fx	Y		A2	$103.62	1.8742	$77.59	$97.11
23585	Treat scapula fracture	Y		A2	$510.00	60.0595	$2,486.46	$1,004.12
23600	Treat humerus fracture	Y		P2		1.8742	$77.59	$77.59
23605	Treat humerus fracture	Y		A2	$103.62	1.8742	$77.59	$97.11
23615	Treat humerus fracture	Y		A2	$630.00	60.0595	$2,486.46	$1,094.12
23616	Treat humerus fracture	Y		A2	$630.00	60.0595	$2,486.46	$1,094.12
23620	Treat humerus fracture	Y		P2		1.8742	$77.59	$77.59
23625	Treat humerus fracture	Y		A2	$103.62	1.8742	$77.59	$97.11
23630	Treat humerus fracture	Y		A2	$717.00	60.0595	$2,486.46	$1,159.37
23650	Treat shoulder dislocation	Y		A2	$103.62	1.8742	$77.59	$97.11
23655	Treat shoulder dislocation	Y		A2	$333.00	15.0176	$621.73	$405.18
23660	Treat shoulder dislocation	Y		A2	$510.00	40.3466	$1,670.35	$800.09
23665	Treat dislocation/fracture	Y		A2	$103.62	1.8742	$77.59	$97.11
23670	Treat dislocation/fracture	Y		A2	$510.00	60.0595	$2,486.46	$1,004.12
23675	Treat dislocation/fracture	Y		A2	$103.62	1.8742	$77.59	$97.11
23680	Treat dislocation/fracture	Y		A2	$510.00	40.3466	$1,670.35	$800.09
23700	Fixation of shoulder	Y		A2	$333.00	15.0176	$621.73	$405.18
23800	Fusion of shoulder joint	Y		A2	$630.00	78.6518	$3,256.18	$1,286.55
23802	Fusion of shoulder joint	Y		A2	$995.00	43.5953	$1,804.85	$1,197.46
23921	Amputation follow-up surgery	Y		A2	$323.28	15.4399	$639.21	$402.26
23930	Drainage of arm lesion	Y		A2	$333.00	19.0457	$788.49	$446.87

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS Code	Short Descriptor	Subject to multiple procedure discounting	Comment indicator	Payment indicator	CY 2007 ASC payment rate	Proposed fully implemented payment weight	Proposed CY 2008 fully implemented payment	Proposed CY 2008 first transition year payment
23931	Drainage of arm bursa	Y		A2	$446.00	19.0457	$788.49	$531.62
23935	Drain arm/elbow bone lesion	Y		A2	$446.00	21.5761	$893.25	$557.81
24000	Exploratory elbow surgery	Y		A2	$630.00	29.3263	$1,214.11	$776.03
24006	Release elbow joint	Y		A2	$630.00	29.3263	$1,214.11	$776.03
24065	Biopsy arm/elbow soft tissue	Y		P3		3.0343	$125.62	$125.62
24066	Biopsy arm/elbow soft tissue	Y		A2	$446.00	16.5832	$686.54	$506.14
24075	Remove arm/elbow lesion	Y		A2	$446.00	16.5832	$686.54	$506.14
24076	Remove arm/elbow lesion	Y		A2	$446.00	21.4534	$888.17	$556.54
24077	Remove tumor of arm/elbow	Y		A2	$510.00	21.4534	$888.17	$604.54
24100	Biopsy elbow joint lining	Y		A2	$333.00	21.5761	$893.25	$473.06
24101	Explore/treat elbow joint	Y		A2	$630.00	29.3263	$1,214.11	$776.03
24102	Remove elbow joint lining	Y		A2	$630.00	29.3263	$1,214.11	$776.03
24105	Removal of elbow bursa	Y		A2	$510.00	21.5761	$893.25	$605.81
24110	Remove humerus lesion	Y		A2	$446.00	21.5761	$893.25	$557.81
24115	Remove/graft bone lesion	Y		A2	$510.00	29.3263	$1,214.11	$686.03
24116	Remove/graft bone lesion	Y		A2	$510.00	29.3263	$1,214.11	$686.03
24120	Remove elbow lesion	Y		A2	$510.00	21.5761	$893.25	$605.81
24125	Remove/graft bone lesion	Y		A2	$510.00	29.3263	$1,214.11	$686.03
24126	Remove/graft bone lesion	Y		A2	$510.00	29.3263	$1,214.11	$686.03
24130	Removal of head of radius	Y		A2	$510.00	29.3263	$1,214.11	$686.03
24134	Removal of arm bone lesion	Y		A2	$446.00	29.3263	$1,214.11	$638.03
24136	Remove radius bone lesion	Y		A2	$446.00	29.3263	$1,214.11	$638.03
24138	Remove elbow bone lesion	Y		A2	$446.00	29.3263	$1,214.11	$638.03
24140	Partial removal of arm bone	Y		A2	$510.00	29.3263	$1,214.11	$686.03
24145	Partial removal of radius	Y		A2	$510.00	29.3263	$1,214.11	$686.03
24147	Partial removal of elbow	Y		A2	$446.00	29.3263	$1,214.11	$638.03
24149	Radical resection of elbow	Y		G2		29.3263	$1,214.11	$1,214.11
24152	Extensive radius surgery	Y		G2		43.5953	$1,804.85	$1,804.85
24153	Extensive radius surgery	Y		G2		78.6518	$3,256.18	$3,256.18
24155	Removal of elbow joint	Y		A2	$510.00	43.5953	$1,804.85	$833.71
24160	Remove elbow joint implant	Y		A2	$446.00	29.3263	$1,214.11	$638.03
24164	Remove radius head implant	Y		A2	$510.00	29.3263	$1,214.11	$686.03
24200	Removal of arm foreign body	Y		P3		2.5312	$104.79	$104.79
24201	Removal of arm foreign body	Y		A2	$446.00	16.5832	$686.54	$506.14
24220	Injection for elbow x-ray	N		N1				
24300	Manipulate elbow w/anesth	Y		G2		15.0176	$621.73	$621.73
24301	Muscle/tendon transfer	Y		A2	$630.00	29.3263	$1,214.11	$776.03
24305	Arm tendon lengthening	Y		A2	$630.00	29.3263	$1,214.11	$776.03
24310	Revision of arm tendon	Y		A2	$510.00	21.5761	$893.25	$605.81
24320	Repair of arm tendon	Y		A2	$510.00	43.5953	$1,804.85	$833.71
24330	Revision of arm muscles	Y		A2	$510.00	78.6518	$3,256.18	$1,196.55
24331	Revision of arm muscles	Y		A2	$510.00	43.5953	$1,804.85	$833.71
24332	Tenolysis, triceps	Y		G2		21.5761	$893.25	$893.25
24340	Repair of biceps tendon	Y		A2	$510.00	43.5953	$1,804.85	$833.71
24341	Repair arm tendon/muscle	Y		A2	$510.00	43.5953	$1,804.85	$833.71
24342	Repair of ruptured tendon	Y		A2	$510.00	43.5953	$1,804.85	$833.71
24343	Repr elbow lat ligmnt w/tiss	Y		G2		29.3263	$1,214.11	$1,214.11
24344	Reconstruct elbow lat ligmnt	Y		G2		78.6518	$3,256.18	$3,256.18
24345	Repr elbw med ligmnt w/tissu	Y		A2	$446.00	29.3263	$1,214.11	$638.03
24346	Reconstruct elbow med ligmnt	Y		G2		43.5953	$1,804.85	$1,804.85
24350	Repair of tennis elbow	Y		A2	$510.00	29.3263	$1,214.11	$686.03
24351	Repair of tennis elbow	Y		A2	$510.00	29.3263	$1,214.11	$686.03
24352	Repair of tennis elbow	Y		A2	$510.00	29.3263	$1,214.11	$686.03
24354	Repair of tennis elbow	Y		A2	$510.00	29.3263	$1,214.11	$686.03
24356	Revision of tennis elbow	Y		A2	$510.00	29.3263	$1,214.11	$686.03
24360	Reconstruct elbow joint	Y		A2	$717.00	35.9249	$1,487.29	$909.57
24361	Reconstruct elbow joint	Y		A2	$717.00	113.6713	$4,705.99	$1,714.25
24362	Reconstruct elbow joint	Y		A2	$717.00	51.0431	$2,113.18	$1,066.05
24363	Replace elbow joint	Y		A2	$995.00	113.6713	$4,705.99	$1,922.75
24365	Reconstruct head of radius	Y		A2	$717.00	35.9249	$1,487.29	$909.57
24366	Reconstruct head of radius	Y		A2	$717.00	113.6713	$4,705.99	$1,714.25
24400	Revision of humerus	Y		A2	$630.00	29.3263	$1,214.11	$776.03
24410	Revision of humerus	Y		A2	$630.00	29.3263	$1,214.11	$776.03
24420	Revision of humerus	Y		A2	$510.00	43.5953	$1,804.85	$833.71
24430	Repair of humerus	Y		A2	$510.00	78.6518	$3,256.18	$1,196.55
24435	Repair humerus with graft	Y		A2	$630.00	78.6518	$3,256.18	$1,286.55
24470	Revision of elbow joint	Y		A2	$510.00	43.5953	$1,804.85	$833.71
24495	Decompression of forearm	Y		A2	$446.00	29.3263	$1,214.11	$638.03
24498	Reinforce humerus	Y		A2	$510.00	78.6518	$3,256.18	$1,196.55
24500	Treat humerus fracture	Y		A2	$103.62	1.8742	$77.59	$97.11
24505	Treat humerus fracture	Y		A2	$103.62	1.8742	$77.59	$97.11
24515	Treat humerus fracture	Y		A2	$630.00	60.0595	$2,486.46	$1,094.12
24516	Treat humerus fracture	Y		A2	$630.00	60.0595	$2,486.46	$1,094.12
24530	Treat humerus fracture	Y		A2	$103.62	1.8742	$77.59	$97.11
24535	Treat humerus fracture	Y		A2	$103.62	1.8742	$77.59	$97.11
24538	Treat humerus fracture	Y		A2	$446.00	26.3092	$1,089.20	$606.80

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS Code	Short Descriptor	Subject to multiple procedure discounting	Comment indicator	Payment indicator	CY 2007 ASC payment rate	Proposed fully implemented payment weight	Proposed CY 2008 fully implemented payment	Proposed CY 2008 first transition year payment
24545	Treat humerus fracture	Y		A2	$630.00	60.0595	$2,486.46	$1,094.12
24546	Treat humerus fracture	Y		A2	$717.00	60.0595	$2,486.46	$1,159.37
24560	Treat humerus fracture	Y		A2	$103.62	1.8742	$77.59	$97.11
24565	Treat humerus fracture	Y		A2	$103.62	1.8742	$77.59	$97.11
24566	Treat humerus fracture	Y		A2	$446.00	26.3092	$1,089.20	$606.80
24575	Treat humerus fracture	Y		A2	$510.00	60.0595	$2,486.46	$1,004.12
24576	Treat humerus fracture	Y		A2	$103.62	1.8742	$77.59	$97.11
24577	Treat humerus fracture	Y		A2	$103.62	1.8742	$77.59	$97.11
24579	Treat humerus fracture	Y		A2	$510.00	60.0595	$2,486.46	$1,004.12
24582	Treat humerus fracture	Y		A2	$446.00	26.3092	$1,089.20	$606.80
24586	Treat elbow fracture	Y		A2	$630.00	60.0595	$2,486.46	$1,094.12
24587	Treat elbow fracture	Y		A2	$717.00	60.0595	$2,486.46	$1,159.37
24600	Treat elbow dislocation	Y		A2	$103.62	1.8742	$77.59	$97.11
24605	Treat elbow dislocation	Y		A2	$446.00	15.0176	$621.73	$489.93
24615	Treat elbow dislocation	Y		A2	$510.00	60.0595	$2,486.46	$1,004.12
24620	Treat elbow fracture	Y		A2	$103.62	1.8742	$77.59	$97.11
24635	Treat elbow fracture	Y		A2	$510.00	60.0595	$2,486.46	$1,004.12
24640	Treat elbow dislocation	Y	CH	P3		1.3771	$57.01	$57.01
24650	Treat radius fracture	Y		P2		1.8742	$77.59	$77.59
24655	Treat radius fracture	Y		A2	$103.62	1.8742	$77.59	$97.11
24665	Treat radius fracture	Y		A2	$630.00	40.3466	$1,670.35	$890.09
24666	Treat radius fracture	Y		A2	$630.00	60.0595	$2,486.46	$1,094.12
24670	Treat ulnar fracture	Y		A2	$103.62	1.8742	$77.59	$97.11
24675	Treat ulnar fracture	Y		A2	$103.62	1.8742	$77.59	$97.11
24685	Treat ulnar fracture	Y		A2	$510.00	40.3466	$1,670.35	$800.09
24800	Fusion of elbow joint	Y		A2	$630.00	43.5953	$1,804.85	$923.71
24802	Fusion/graft of elbow joint	Y		A2	$717.00	43.5953	$1,804.85	$988.96
24925	Amputation follow-up surgery	Y		A2	$510.00	21.5761	$893.25	$605.81
25000	Incision of tendon sheath	Y		A2	$510.00	21.5761	$893.25	$605.81
25001	Incise flexor carpi radialis	Y		G2		21.5761	$893.25	$893.25
25020	Decompress forearm 1 space	Y		A2	$510.00	21.5761	$893.25	$605.81
25023	Decompress forearm 1 space	Y		A2	$510.00	29.3263	$1,214.11	$686.03
25024	Decompress forearm 2 spaces	Y		A2	$510.00	29.3263	$1,214.11	$686.03
25025	Decompress forearm 2 spaces	Y		A2	$510.00	29.3263	$1,214.11	$686.03
25028	Drainage of forearm lesion	Y		A2	$333.00	21.5761	$893.25	$473.06
25031	Drainage of forearm bursa	Y		A2	$446.00	21.5761	$893.25	$557.81
25035	Treat forearm bone lesion	Y		A2	$446.00	21.5761	$893.25	$557.81
25040	Explore/treat wrist joint	Y		A2	$717.00	29.3263	$1,214.11	$841.28
25065	Biopsy forearm soft tissues	Y		P3		3.1085	$128.69	$128.69
25066	Biopsy forearm soft tissues	Y		A2	$446.00	21.4534	$888.17	$556.54
25075	Removal forearm lesion subcu	Y		A2	$446.00	16.5832	$686.54	$506.14
25076	Removal forearm lesion deep	Y		A2	$510.00	21.4534	$888.17	$604.54
25077	Remove tumor, forearm/wrist	Y		A2	$510.00	21.4534	$888.17	$604.54
25085	Incision of wrist capsule	Y		A2	$510.00	21.5761	$893.25	$605.81
25100	Biopsy of wrist joint	Y		A2	$446.00	21.5761	$893.25	$557.81
25101	Explore/treat wrist joint	Y		A2	$510.00	29.3263	$1,214.11	$686.03
25105	Remove wrist joint lining	Y		A2	$630.00	29.3263	$1,214.11	$776.03
25107	Remove wrist joint cartilage	Y		A2	$510.00	29.3263	$1,214.11	$686.03
25109	Excise tendon forearm/wrist	Y		G2		21.5761	$893.25	$893.25
25110	Remove wrist tendon lesion	Y		A2	$510.00	21.5761	$893.25	$605.81
25111	Remove wrist tendon lesion	Y		A2	$510.00	16.8220	$696.43	$556.61
25112	Reremove wrist tendon lesion	Y		A2	$630.00	16.8220	$696.43	$646.61
25115	Remove wrist/forearm lesion	Y		A2	$630.00	21.5761	$893.25	$695.81
25116	Remove wrist/forearm lesion	Y		A2	$630.00	21.5761	$893.25	$695.81
25118	Excise wrist tendon sheath	Y		A2	$446.00	29.3263	$1,214.11	$638.03
25119	Partial removal of ulna	Y		A2	$510.00	29.3263	$1,214.11	$686.03
25120	Removal of forearm lesion	Y		A2	$510.00	29.3263	$1,214.11	$686.03
25125	Remove/graft forearm lesion	Y		A2	$510.00	29.3263	$1,214.11	$686.03
25126	Remove/graft forearm lesion	Y		A2	$510.00	29.3263	$1,214.11	$686.03
25130	Removal of wrist lesion	Y		A2	$510.00	29.3263	$1,214.11	$686.03
25135	Remove & graft wrist lesion	Y		A2	$510.00	29.3263	$1,214.11	$686.03
25136	Remove & graft wrist lesion	Y		A2	$510.00	29.3263	$1,214.11	$686.03
25145	Remove forearm bone lesion	Y		A2	$446.00	29.3263	$1,214.11	$638.03
25150	Partial removal of ulna	Y		A2	$446.00	29.3263	$1,214.11	$638.03
25151	Partial removal of radius	Y		A2	$446.00	29.3263	$1,214.11	$638.03
25210	Removal of wrist bone	Y		A2	$510.00	26.7322	$1,106.71	$659.18
25215	Removal of wrist bones	Y		A2	$630.00	26.7322	$1,106.71	$749.18
25230	Partial removal of radius	Y		A2	$630.00	29.3263	$1,214.11	$776.03
25240	Partial removal of ulna	Y		A2	$630.00	29.3263	$1,214.11	$776.03
25246	Injection for wrist x-ray	N		N1				
25248	Remove forearm foreign body	Y		A2	$446.00	21.5761	$893.25	$557.81
25250	Removal of wrist prosthesis	Y		A2	$333.00	29.3263	$1,214.11	$553.28
25251	Removal of wrist prosthesis	Y		A2	$333.00	29.3263	$1,214.11	$553.28
25259	Manipulate wrist w/anesthes	Y		G2		1.8742	$77.59	$77.59
25260	Repair forearm tendon/muscle	Y		A2	$630.00	29.3263	$1,214.11	$776.03
25263	Repair forearm tendon/muscle	Y		A2	$446.00	29.3263	$1,214.11	$638.03

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS Code	Short Descriptor	Subject to multiple procedure discounting	Comment indicator	Payment indicator	CY 2007 ASC payment rate	Proposed fully implemented payment weight	Proposed CY 2008 fully implemented payment	Proposed CY 2008 first transition year payment
25265	Repair forearm tendon/muscle	Y		A2	$510.00	29.3263	$1,214.11	$686.03
25270	Repair forearm tendon/muscle	Y		A2	$630.00	29.3263	$1,214.11	$776.03
25272	Repair forearm tendon/muscle	Y		A2	$510.00	29.3263	$1,214.11	$686.03
25274	Repair forearm tendon/muscle	Y		A2	$630.00	29.3263	$1,214.11	$776.03
25275	Repair forearm tendon sheath	Y		A2	$630.00	29.3263	$1,214.11	$776.03
25280	Revise wrist/forearm tendon	Y		A2	$630.00	29.3263	$1,214.11	$776.03
25290	Incise wrist/forearm tendon	Y		A2	$510.00	29.3263	$1,214.11	$686.03
25295	Release wrist/forearm tendon	Y		A2	$510.00	21.5761	$893.25	$605.81
25300	Fusion of tendons at wrist	Y		A2	$510.00	29.3263	$1,214.11	$686.03
25301	Fusion of tendons at wrist	Y		A2	$510.00	29.3263	$1,214.11	$686.03
25310	Transplant forearm tendon	Y		A2	$510.00	43.5953	$1,804.85	$833.71
25312	Transplant forearm tendon	Y		A2	$630.00	43.5953	$1,804.85	$923.71
25315	Revise palsy hand tendon(s)	Y		A2	$510.00	43.5953	$1,804.85	$833.71
25316	Revise palsy hand tendon(s)	Y		A2	$510.00	78.6518	$3,256.18	$1,196.55
25320	Repair/revise wrist joint	Y		A2	$510.00	43.5953	$1,804.85	$833.71
25332	Revise wrist joint	Y		A2	$717.00	35.9249	$1,487.29	$909.57
25335	Realignment of hand	Y		A2	$510.00	43.5953	$1,804.85	$833.71
25337	Reconstruct ulna/radioulnar	Y		A2	$717.00	43.5953	$1,804.85	$988.96
25350	Revision of radius	Y		A2	$510.00	78.6518	$3,256.18	$1,196.55
25355	Revision of radius	Y		A2	$510.00	43.5953	$1,804.85	$833.71
25360	Revision of ulna	Y		A2	$510.00	29.3263	$1,214.11	$686.03
25365	Revise radius & ulna	Y		A2	$510.00	29.3263	$1,214.11	$686.03
25370	Revise radius or ulna	Y		A2	$510.00	43.5953	$1,804.85	$833.71
25375	Revise radius & ulna	Y		A2	$630.00	43.5953	$1,804.85	$923.71
25390	Shorten radius or ulna	Y		A2	$510.00	29.3263	$1,214.11	$686.03
25391	Lengthen radius or ulna	Y		A2	$630.00	43.5953	$1,804.85	$923.71
25392	Shorten radius & ulna	Y		A2	$510.00	29.3263	$1,214.11	$686.03
25393	Lengthen radius & ulna	Y		A2	$630.00	43.5953	$1,804.85	$923.71
25394	Repair carpal bone, shorten	Y		G2		16.8220	$696.43	$696.43
25400	Repair radius or ulna	Y		A2	$510.00	78.6518	$3,256.18	$1,196.55
25405	Repair/graft radius or ulna	Y		A2	$630.00	78.6518	$3,256.18	$1,286.55
25415	Repair radius & ulna	Y		A2	$510.00	78.6518	$3,256.18	$1,196.55
25420	Repair/graft radius & ulna	Y		A2	$630.00	78.6518	$3,256.18	$1,286.55
25425	Repair/graft radius or ulna	Y		A2	$510.00	43.5953	$1,804.85	$833.71
25426	Repair/graft radius & ulna	Y		A2	$630.00	43.5953	$1,804.85	$923.71
25430	Vasc graft into carpal bone	Y		G2		26.7322	$1,106.71	$1,106.71
25431	Repair nonunion carpal bone	Y		G2		26.7322	$1,106.71	$1,106.71
25440	Repair/graft wrist bone	Y		A2	$630.00	78.6518	$3,256.18	$1,286.55
25441	Reconstruct wrist joint	Y		A2	$717.00	113.6713	$4,705.99	$1,714.25
25442	Reconstruct wrist joint	Y		A2	$717.00	113.6713	$4,705.99	$1,714.25
25443	Reconstruct wrist joint	Y		A2	$717.00	51.0431	$2,113.18	$1,066.05
25444	Reconstruct wrist joint	Y		A2	$717.00	51.0431	$2,113.18	$1,066.05
25445	Reconstruct wrist joint	Y		A2	$717.00	51.0431	$2,113.18	$1,066.05
25446	Wrist replacement	Y		A2	$995.00	113.6713	$4,705.99	$1,922.75
25447	Repair wrist joint(s)	Y		A2	$717.00	35.9249	$1,487.29	$909.57
25449	Remove wrist joint implant	Y		A2	$717.00	35.9249	$1,487.29	$909.57
25450	Revision of wrist joint	Y		A2	$510.00	43.5953	$1,804.85	$833.71
25455	Revision of wrist joint	Y		A2	$510.00	43.5953	$1,804.85	$833.71
25490	Reinforce radius	Y		A2	$510.00	43.5953	$1,804.85	$833.71
25491	Reinforce ulna	Y		A2	$510.00	43.5953	$1,804.85	$833.71
25492	Reinforce radius and ulna	Y		A2	$510.00	43.5953	$1,804.85	$833.71
25500	Treat fracture of radius	Y		P2		1.8742	$77.59	$77.59
25505	Treat fracture of radius	Y		A2	$103.62	1.8742	$77.59	$97.11
25515	Treat fracture of radius	Y		A2	$510.00	40.3466	$1,670.35	$800.09
25520	Treat fracture of radius	Y		A2	$103.62	1.8742	$77.59	$97.11
25525	Treat fracture of radius	Y		A2	$630.00	40.3466	$1,670.35	$890.09
25526	Treat fracture of radius	Y		A2	$717.00	40.3466	$1,670.35	$955.34
25530	Treat fracture of ulna	Y		P2		1.8742	$77.59	$77.59
25535	Treat fracture of ulna	Y		A2	$103.62	1.8742	$77.59	$97.11
25545	Treat fracture of ulna	Y		A2	$510.00	40.3466	$1,670.35	$800.09
25560	Treat fracture radius & ulna	Y		P2		1.8742	$77.59	$77.59
25565	Treat fracture radius & ulna	Y		A2	$103.62	1.8742	$77.59	$97.11
25574	Treat fracture radius & ulna	Y		A2	$510.00	60.0595	$2,486.46	$1,004.12
25575	Treat fracture radius/ulna	Y		A2	$510.00	60.0595	$2,486.46	$1,004.12
25600	Treat fracture radius/ulna	Y		P2		1.8742	$77.59	$77.59
25605	Treat fracture radius/ulna	Y		A2	$103.62	1.8742	$77.59	$97.11
25606	Treat fx distal radial	Y		A2	$510.00	26.3092	$1,089.20	$654.80
25607	Treat fx rad extra-articul	Y		A2	$717.00	60.0595	$2,486.46	$1,159.37
25608	Treat fx rad intra-articul	Y		A2	$717.00	60.0595	$2,486.46	$1,159.37
25609	Treat fx radial 3+ frag	Y		A2	$717.00	60.0595	$2,486.46	$1,159.37
25622	Treat wrist bone fracture	Y		P2		1.8742	$77.59	$77.59
25624	Treat wrist bone fracture	Y		A2	$103.62	1.8742	$77.59	$97.11
25628	Treat wrist bone fracture	Y		A2	$510.00	40.3466	$1,670.35	$800.09
25630	Treat wrist bone fracture	Y		P2		1.8742	$77.59	$77.59
25635	Treat wrist bone fracture	Y		A2	$103.62	1.8742	$77.59	$97.11
25645	Treat wrist bone fracture	Y		A2	$510.00	40.3466	$1,670.35	$800.09

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS Code	Short Descriptor	Subject to multiple procedure discounting	Comment indicator	Payment indicator	CY 2007 ASC payment rate	Proposed fully implemented payment weight	Proposed CY 2008 fully implemented payment	Proposed CY 2008 first transition year payment
25650	Treat wrist bone fracture	Y		P2		1.8742	$77.59	$77.59
25651	Pin ulnar styloid fracture	Y		G2		26.3092	$1,089.20	$1,089.20
25652	Treat fracture ulnar styloid	Y		G2		40.3466	$1,670.35	$1,670.35
25660	Treat wrist dislocation	Y		A2	$103.62	1.8742	$77.59	$97.11
25670	Treat wrist dislocation	Y		A2	$510.00	26.3092	$1,089.20	$654.80
25671	Pin radioulnar dislocation	Y		A2	$333.00	26.3092	$1,089.20	$522.05
25675	Treat wrist dislocation	Y		A2	$103.62	1.8742	$77.59	$97.11
25676	Treat wrist dislocation	Y		A2	$446.00	26.3092	$1,089.20	$606.80
25680	Treat wrist fracture	Y		A2	$103.62	1.8742	$77.59	$97.11
25685	Treat wrist fracture	Y		A2	$510.00	26.3092	$1,089.20	$654.80
25690	Treat wrist dislocation	Y		A2	$103.62	1.8742	$77.59	$97.11
25695	Treat wrist dislocation	Y		A2	$446.00	26.3092	$1,089.20	$606.80
25800	Fusion of wrist joint	Y		A2	$630.00	78.6518	$3,256.18	$1,286.55
25805	Fusion/graft of wrist joint	Y		A2	$717.00	43.5953	$1,804.85	$988.96
25810	Fusion/graft of wrist joint	Y		A2	$717.00	78.6518	$3,256.18	$1,351.80
25820	Fusion of hand bones	Y		A2	$630.00	16.8220	$696.43	$646.61
25825	Fuse hand bones with graft	Y		A2	$717.00	78.6518	$3,256.18	$1,351.80
25830	Fusion, radioulnar jnt/ulna	Y		A2	$717.00	78.6518	$3,256.18	$1,351.80
25907	Amputation follow-up surgery	Y		A2	$510.00	21.5761	$893.25	$605.81
25922	Amputate hand at wrist	Y		A2	$510.00	21.5761	$893.25	$605.81
25929	Amputation follow-up surgery	Y		A2	$510.00	15.4399	$639.21	$542.30
25931	Amputation follow-up surgery	Y	CH	G2		21.5761	$893.25	$893.25
26010	Drainage of finger abscess	Y		P2		1.4630	$60.57	$60.57
26011	Drainage of finger abscess	Y		A2	$333.00	12.5792	$520.78	$379.95
26020	Drain hand tendon sheath	Y		A2	$446.00	16.8220	$696.43	$508.61
26025	Drainage of palm bursa	Y		A2	$333.00	16.8220	$696.43	$423.86
26030	Drainage of palm bursa(s)	Y		A2	$446.00	16.8220	$696.43	$508.61
26034	Treat hand bone lesion	Y		A2	$446.00	16.8220	$696.43	$508.61
26035	Decompress fingers/hand	Y		G2		16.8220	$696.43	$696.43
26040	Release palm contracture	Y		A2	$630.00	26.7322	$1,106.71	$749.18
26045	Release palm contracture	Y		A2	$510.00	26.7322	$1,106.71	$659.18
26055	Incise finger tendon sheath	Y		A2	$446.00	16.8220	$696.43	$508.61
26060	Incision of finger tendon	Y		A2	$446.00	16.8220	$696.43	$508.61
26070	Explore/treat hand joint	Y		A2	$446.00	16.8220	$696.43	$508.61
26075	Explore/treat finger joint	Y		A2	$630.00	16.8220	$696.43	$646.61
26080	Explore/treat finger joint	Y		A2	$630.00	16.8220	$696.43	$646.61
26100	Biopsy hand joint lining	Y		A2	$446.00	16.8220	$696.43	$508.61
26105	Biopsy finger joint lining	Y		A2	$333.00	16.8220	$696.43	$423.86
26110	Biopsy finger joint lining	Y		A2	$333.00	16.8220	$696.43	$423.86
26115	Removal hand lesion subcut	Y		A2	$446.00	21.4534	$888.17	$556.54
26116	Removal hand lesion, deep	Y		A2	$446.00	21.4534	$888.17	$556.54
26117	Remove tumor, hand/finger	Y		A2	$510.00	21.4534	$888.17	$604.54
26121	Release palm contracture	Y		A2	$630.00	26.7322	$1,106.71	$749.18
26123	Release palm contracture	Y		A2	$630.00	26.7322	$1,106.71	$749.18
26125	Release palm contracture	Y		A2	$630.00	16.8220	$696.43	$646.61
26130	Remove wrist joint lining	Y		A2	$510.00	16.8220	$696.43	$556.61
26135	Revise finger joint, each	Y		A2	$630.00	26.7322	$1,106.71	$749.18
26140	Revise finger joint, each	Y		A2	$446.00	16.8220	$696.43	$508.61
26145	Tendon excision, palm/finger	Y		A2	$510.00	16.8220	$696.43	$556.61
26160	Remove tendon sheath lesion	Y		A2	$510.00	16.8220	$696.43	$556.61
26170	Removal of palm tendon, each	Y		A2	$510.00	16.8220	$696.43	$556.61
26180	Removal of finger tendon	Y		A2	$510.00	16.8220	$696.43	$556.61
26185	Remove finger bone	Y		A2	$630.00	16.8220	$696.43	$646.61
26200	Remove hand bone lesion	Y		A2	$446.00	16.8220	$696.43	$508.61
26205	Remove/graft bone lesion	Y		A2	$510.00	26.7322	$1,106.71	$659.18
26210	Removal of finger lesion	Y		A2	$446.00	16.8220	$696.43	$508.61
26215	Remove/graft finger lesion	Y		A2	$510.00	16.8220	$696.43	$556.61
26230	Partial removal of hand bone	Y		A2	$992.95	16.8220	$696.43	$918.82
26235	Partial removal, finger bone	Y		A2	$510.00	16.8220	$696.43	$556.61
26236	Partial removal, finger bone	Y		A2	$510.00	16.8220	$696.43	$556.61
26250	Extensive hand surgery	Y		A2	$510.00	16.8220	$696.43	$556.61
26255	Extensive hand surgery	Y		A2	$510.00	26.7322	$1,106.71	$659.18
26260	Extensive finger surgery	Y		A2	$510.00	16.8220	$696.43	$556.61
26261	Extensive finger surgery	Y		A2	$510.00	16.8220	$696.43	$556.61
26262	Partial removal of finger	Y		A2	$446.00	16.8220	$696.43	$508.61
26320	Removal of implant from hand	Y		A2	$446.00	16.5832	$686.54	$506.14
26340	Manipulate finger w/anesth	Y		G2		1.8742	$77.59	$77.59
26350	Repair finger/hand tendon	Y		A2	$333.00	26.7322	$1,106.71	$526.43
26352	Repair/graft hand tendon	Y		A2	$630.00	26.7322	$1,106.71	$749.18
26356	Repair finger/hand tendon	Y		A2	$630.00	26.7322	$1,106.71	$749.18
26357	Repair finger/hand tendon	Y		A2	$630.00	26.7322	$1,106.71	$749.18
26358	Repair/graft hand tendon	Y		A2	$630.00	26.7322	$1,106.71	$749.18
26370	Repair finger/hand tendon	Y		A2	$630.00	26.7322	$1,106.71	$749.18
26372	Repair/graft hand tendon	Y		A2	$630.00	26.7322	$1,106.71	$749.18
26373	Repair finger/hand tendon	Y		A2	$510.00	26.7322	$1,106.71	$659.18
26390	Revise hand/finger tendon	Y		A2	$630.00	26.7322	$1,106.71	$749.18

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS Code	Short Descriptor	Subject to multiple procedure discounting	Comment indicator	Payment indicator	CY 2007 ASC payment rate	Proposed fully implemented payment weight	Proposed CY 2008 fully implemented payment	Proposed CY 2008 first transition year payment
26392	Repair/graft hand tendon	Y		A2	$510.00	26.7322	$1,106.71	$659.18
26410	Repair hand tendon	Y		A2	$510.00	16.8220	$696.43	$556.61
26412	Repair/graft hand tendon	Y		A2	$510.00	26.7322	$1,106.71	$659.18
26415	Excision, hand/finger tendon	Y		A2	$630.00	26.7322	$1,106.71	$749.18
26416	Graft hand or finger tendon	Y		A2	$510.00	26.7322	$1,106.71	$659.18
26418	Repair finger tendon	Y		A2	$630.00	16.8220	$696.43	$646.61
26420	Repair/graft finger tendon	Y		A2	$630.00	26.7322	$1,106.71	$749.18
26426	Repair finger/hand tendon	Y		A2	$510.00	26.7322	$1,106.71	$659.18
26428	Repair/graft finger tendon	Y		A2	$510.00	26.7322	$1,106.71	$659.18
26432	Repair finger tendon	Y		A2	$510.00	16.8220	$696.43	$556.61
26433	Repair finger tendon	Y		A2	$510.00	16.8220	$696.43	$556.61
26434	Repair/graft finger tendon	Y		A2	$510.00	26.7322	$1,106.71	$659.18
26437	Realignment of tendons	Y		A2	$510.00	16.8220	$696.43	$556.61
26440	Release palm/finger tendon	Y		A2	$510.00	16.8220	$696.43	$556.61
26442	Release palm & finger tendon	Y		A2	$510.00	26.7322	$1,106.71	$659.18
26445	Release hand/finger tendon	Y		A2	$510.00	16.8220	$696.43	$556.61
26449	Release forearm/hand tendon	Y		A2	$510.00	26.7322	$1,106.71	$659.18
26450	Incision of palm tendon	Y		A2	$510.00	16.8220	$696.43	$556.61
26455	Incision of finger tendon	Y		A2	$510.00	16.8220	$696.43	$556.61
26460	Incise hand/finger tendon	Y		A2	$510.00	16.8220	$696.43	$556.61
26471	Fusion of finger tendons	Y		A2	$446.00	16.8220	$696.43	$508.61
26474	Fusion of finger tendons	Y		A2	$446.00	16.8220	$696.43	$508.61
26476	Tendon lengthening	Y		A2	$333.00	16.8220	$696.43	$423.86
26477	Tendon shortening	Y		A2	$333.00	16.8220	$696.43	$423.86
26478	Lengthening of hand tendon	Y		A2	$333.00	16.8220	$696.43	$423.86
26479	Shortening of hand tendon	Y		A2	$333.00	16.8220	$696.43	$423.86
26480	Transplant hand tendon	Y		A2	$510.00	26.7322	$1,106.71	$659.18
26483	Transplant/graft hand tendon	Y		A2	$510.00	26.7322	$1,106.71	$659.18
26485	Transplant palm tendon	Y		A2	$446.00	26.7322	$1,106.71	$611.18
26489	Transplant/graft palm tendon	Y		A2	$510.00	26.7322	$1,106.71	$659.18
26490	Revise thumb tendon	Y		A2	$510.00	26.7322	$1,106.71	$659.18
26492	Tendon transfer with graft	Y		A2	$510.00	26.7322	$1,106.71	$659.18
26494	Hand tendon/muscle transfer	Y		A2	$510.00	26.7322	$1,106.71	$659.18
26496	Revise thumb tendon	Y		A2	$510.00	26.7322	$1,106.71	$659.18
26497	Finger tendon transfer	Y		A2	$510.00	26.7322	$1,106.71	$659.18
26498	Finger tendon transfer	Y		A2	$630.00	26.7322	$1,106.71	$749.18
26499	Revision of finger	Y		A2	$510.00	26.7322	$1,106.71	$659.18
26500	Hand tendon reconstruction	Y		A2	$630.00	16.8220	$696.43	$646.61
26502	Hand tendon reconstruction	Y		A2	$630.00	26.7322	$1,106.71	$749.18
26508	Release thumb contracture	Y		A2	$510.00	16.8220	$696.43	$556.61
26510	Thumb tendon transfer	Y		A2	$510.00	26.7322	$1,106.71	$659.18
26516	Fusion of knuckle joint	Y		A2	$333.00	26.7322	$1,106.71	$526.43
26517	Fusion of knuckle joints	Y		A2	$510.00	26.7322	$1,106.71	$659.18
26518	Fusion of knuckle joints	Y		A2	$510.00	26.7322	$1,106.71	$659.18
26520	Release knuckle contracture	Y		A2	$510.00	16.8220	$696.43	$556.61
26525	Release finger contracture	Y		A2	$510.00	16.8220	$696.43	$556.61
26530	Revise knuckle joint	Y		A2	$510.00	35.9249	$1,487.29	$754.32
26531	Revise knuckle with implant	Y		A2	$995.00	51.0431	$2,113.18	$1,274.55
26535	Revise finger joint	Y		A2	$717.00	35.9249	$1,487.29	$909.57
26536	Revise/implant finger joint	Y		A2	$717.00	51.0431	$2,113.18	$1,066.05
26540	Repair hand joint	Y		A2	$630.00	16.8220	$696.43	$646.61
26541	Repair hand joint with graft	Y		A2	$995.00	26.7322	$1,106.71	$1,022.93
26542	Repair hand joint with graft	Y		A2	$630.00	16.8220	$696.43	$646.61
26545	Reconstruct finger joint	Y		A2	$630.00	26.7322	$1,106.71	$749.18
26546	Repair nonunion hand	Y		A2	$630.00	26.7322	$1,106.71	$749.18
26548	Reconstruct finger joint	Y		A2	$630.00	26.7322	$1,106.71	$749.18
26550	Construct thumb replacement	Y		A2	$446.00	26.7322	$1,106.71	$611.18
26555	Positional change of finger	Y		A2	$510.00	26.7322	$1,106.71	$659.18
26560	Repair of web finger	Y		A2	$446.00	16.8220	$696.43	$508.61
26561	Repair of web finger	Y		A2	$510.00	26.7322	$1,106.71	$659.18
26562	Repair of web finger	Y		A2	$630.00	26.7322	$1,106.71	$749.18
26565	Correct metacarpal flaw	Y		A2	$717.00	26.7322	$1,106.71	$814.43
26567	Correct finger deformity	Y		A2	$717.00	26.7322	$1,106.71	$814.43
26568	Lengthen metacarpal/finger	Y		A2	$510.00	26.7322	$1,106.71	$659.18
26580	Repair hand deformity	Y		A2	$717.00	16.8220	$696.43	$711.86
26587	Reconstruct extra finger	Y		A2	$717.00	16.8220	$696.43	$711.86
26590	Repair finger deformity	Y		A2	$717.00	16.8220	$696.43	$711.86
26591	Repair muscles of hand	Y		A2	$510.00	26.7322	$1,106.71	$659.18
26593	Release muscles of hand	Y		A2	$510.00	16.8220	$696.43	$556.61
26596	Excision constricting tissue	Y		A2	$446.00	16.8220	$696.43	$508.61
26600	Treat metacarpal fracture	Y		P2		1.8742	$77.59	$77.59
26605	Treat metacarpal fracture	Y		A2	$103.62	1.8742	$77.59	$97.11
26607	Treat metacarpal fracture	Y		A2	$103.62	1.8742	$77.59	$97.11
26608	Treat metacarpal fracture	Y		A2	$630.00	26.3092	$1,089.20	$744.80
26615	Treat metacarpal fracture	Y		A2	$630.00	40.3466	$1,670.35	$890.09
26641	Treat thumb dislocation	Y	CH	P2		1.8742	$77.59	$77.59

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS Code	Short Descriptor	Subject to multiple procedure discounting	Comment indicator	Payment indicator	CY 2007 ASC payment rate	Proposed fully implemented payment weight	Proposed CY 2008 fully implemented payment	Proposed CY 2008 first transition year payment
26645	Treat thumb fracture	Y		A2	$103.62	1.8742	$77.59	$97.11
26650	Treat thumb fracture	Y		A2	$446.00	26.3092	$1,089.20	$606.80
26665	Treat thumb fracture	Y		A2	$630.00	40.3466	$1,670.35	$890.09
26670	Treat hand dislocation	Y	CH	P2		1.8742	$77.59	$77.59
26675	Treat hand dislocation	Y		A2	$103.62	1.8742	$77.59	$97.11
26676	Pin hand dislocation	Y		A2	$446.00	26.3092	$1,089.20	$606.80
26685	Treat hand dislocation	Y		A2	$510.00	40.3466	$1,670.35	$800.09
26686	Treat hand dislocation	Y		A2	$510.00	60.0595	$2,486.46	$1,004.12
26700	Treat knuckle dislocation	Y	CH	P2		1.8742	$77.59	$77.59
26705	Treat knuckle dislocation	Y		A2	$103.62	1.8742	$77.59	$97.11
26706	Pin knuckle dislocation	Y		A2	$103.62	1.8742	$77.59	$97.11
26715	Treat knuckle dislocation	Y		A2	$630.00	40.3466	$1,670.35	$890.09
26720	Treat finger fracture, each	Y		P2		1.8742	$77.59	$77.59
26725	Treat finger fracture, each	Y		P2		1.8742	$77.59	$77.59
26727	Treat finger fracture, each	Y		A2	$995.00	26.3092	$1,089.20	$1,018.55
26735	Treat finger fracture, each	Y		A2	$630.00	40.3466	$1,670.35	$890.09
26740	Treat finger fracture, each	Y		P2		1.8742	$77.59	$77.59
26742	Treat finger fracture, each	Y		A2	$103.62	1.8742	$77.59	$97.11
26746	Treat finger fracture, each	Y		A2	$717.00	40.3466	$1,670.35	$955.34
26750	Treat finger fracture, each	Y		P2		1.8742	$77.59	$77.59
26755	Treat finger fracture, each	Y		G2		1.8742	$77.59	$77.59
26756	Pin finger fracture, each	Y		A2	$446.00	26.3092	$1,089.20	$606.80
26765	Treat finger fracture, each	Y		A2	$630.00	40.3466	$1,670.35	$890.09
26770	Treat finger dislocation	Y		G2		1.8742	$77.59	$77.59
26775	Treat finger dislocation	Y	CH	P3		4.0319	$166.92	$166.92
26776	Pin finger dislocation	Y		A2	$446.00	26.3092	$1,089.20	$606.80
26785	Treat finger dislocation	Y		A2	$446.00	26.3092	$1,089.20	$606.80
26820	Thumb fusion with graft	Y		A2	$717.00	26.7322	$1,106.71	$814.43
26841	Fusion of thumb	Y		A2	$630.00	26.7322	$1,106.71	$749.18
26842	Thumb fusion with graft	Y		A2	$630.00	26.7322	$1,106.71	$749.18
26843	Fusion of hand joint	Y		A2	$510.00	26.7322	$1,106.71	$659.18
26844	Fusion/graft of hand joint	Y		A2	$510.00	26.7322	$1,106.71	$659.18
26850	Fusion of knuckle	Y		A2	$630.00	26.7322	$1,106.71	$749.18
26852	Fusion of knuckle with graft	Y		A2	$630.00	26.7322	$1,106.71	$749.18
26860	Fusion of finger joint	Y		A2	$510.00	26.7322	$1,106.71	$659.18
26861	Fusion of finger jnt, add-on	Y		A2	$446.00	26.7322	$1,106.71	$611.18
26862	Fusion/graft of finger joint	Y		A2	$630.00	26.7322	$1,106.71	$749.18
26863	Fuse/graft added joint	Y		A2	$510.00	26.7322	$1,106.71	$659.18
26910	Amputate metacarpal bone	Y		A2	$510.00	26.7322	$1,106.71	$659.18
26951	Amputation of finger/thumb	Y		A2	$446.00	16.8220	$696.43	$508.61
26952	Amputation of finger/thumb	Y		A2	$630.00	16.8220	$696.43	$646.61
26990	Drainage of pelvis lesion	Y		A2	$333.00	21.5761	$893.25	$473.06
26991	Drainage of pelvis bursa	Y		A2	$333.00	21.5761	$893.25	$473.06
27000	Incision of hip tendon	Y		A2	$446.00	21.5761	$893.25	$557.81
27001	Incision of hip tendon	Y		A2	$510.00	29.3263	$1,214.11	$686.03
27003	Incision of hip tendon	Y		A2	$510.00	29.3263	$1,214.11	$686.03
27033	Exploration of hip joint	Y		A2	$510.00	43.5953	$1,804.85	$833.71
27035	Denervation of hip joint	Y		A2	$630.00	43.5953	$1,804.85	$923.71
27040	Biopsy of soft tissues	Y		A2	$333.00	8.7155	$360.82	$339.96
27041	Biopsy of soft tissues	Y		A2	$418.49	8.7155	$360.82	$404.07
27047	Remove hip/pelvis lesion	Y		A2	$446.00	21.4534	$888.17	$556.54
27048	Remove hip/pelvis lesion	Y		A2	$510.00	21.4534	$888.17	$604.54
27049	Remove tumor, hip/pelvis	Y		A2	$510.00	21.4534	$888.17	$604.54
27050	Biopsy of sacroiliac joint	Y		A2	$510.00	21.5761	$893.25	$605.81
27052	Biopsy of hip joint	Y		A2	$510.00	21.5761	$893.25	$605.81
27060	Removal of ischial bursa	Y		A2	$717.00	21.5761	$893.25	$761.06
27062	Remove femur lesion/bursa	Y		A2	$717.00	21.5761	$893.25	$761.06
27065	Removal of hip bone lesion	Y		A2	$717.00	21.5761	$893.25	$761.06
27066	Removal of hip bone lesion	Y		A2	$717.00	29.3263	$1,214.11	$841.28
27067	Remove/graft hip bone lesion	Y		A2	$717.00	29.3263	$1,214.11	$841.28
27080	Removal of tail bone	Y		A2	$446.00	29.3263	$1,214.11	$638.03
27086	Remove hip foreign body	Y		A2	$333.00	8.7155	$360.82	$339.96
27087	Remove hip foreign body	Y		A2	$510.00	21.5761	$893.25	$605.81
27093	Injection for hip x-ray	N		N1				
27095	Injection for hip x-ray	N		N1				
27097	Revision of hip tendon	Y		A2	$510.00	29.3263	$1,214.11	$686.03
27098	Transfer tendon to pelvis	Y		A2	$510.00	29.3263	$1,214.11	$686.03
27100	Transfer of abdominal muscle	Y		A2	$630.00	43.5953	$1,804.85	$923.71
27105	Transfer of spinal muscle	Y		A2	$630.00	43.5953	$1,804.85	$923.71
27110	Transfer of iliopsoas muscle	Y		A2	$630.00	43.5953	$1,804.85	$923.71
27111	Transfer of iliopsoas muscle	Y		A2	$630.00	43.5953	$1,804.85	$923.71
27193	Treat pelvic ring fracture	Y		A2	$103.62	1.8742	$77.59	$97.11
27194	Treat pelvic ring fracture	Y		A2	$446.00	15.0176	$621.73	$489.93
27200	Treat tail bone fracture	Y		P3		1.7727	$73.39	$73.39
27202	Treat tail bone fracture	Y		A2	$446.00	40.3466	$1,670.35	$752.09
27220	Treat hip socket fracture	Y		G2		1.8742	$77.59	$77.59

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS Code	Short Descriptor	Subject to multiple procedure discounting	Comment indicator	Payment indicator	CY 2007 ASC payment rate	Proposed fully implemented payment weight	Proposed CY 2008 fully implemented payment	Proposed CY 2008 first transition year payment
27230	Treat thigh fracture	Y		A2	$103.62	1.8742	$77.59	$97.11
27238	Treat thigh fracture	Y		A2	$103.62	1.8742	$77.59	$97.11
27246	Treat thigh fracture	Y		A2	$103.62	1.8742	$77.59	$97.11
27250	Treat hip dislocation	Y		A2	$103.62	1.8742	$77.59	$97.11
27252	Treat hip dislocation	Y		A2	$446.00	15.0176	$621.73	$489.93
27256	Treat hip dislocation	Y		G2		1.8742	$77.59	$77.59
27257	Treat hip dislocation	Y		A2	$510.00	15.0176	$621.73	$537.93
27265	Treat hip dislocation	Y		A2	$103.62	1.8742	$77.59	$97.11
27266	Treat hip dislocation	Y		A2	$446.00	15.0176	$621.73	$489.93
27275	Manipulation of hip joint	Y		A2	$446.00	15.0176	$621.73	$489.93
27301	Drain thigh/knee lesion	Y		A2	$510.00	19.0457	$788.49	$579.62
27305	Incise thigh tendon & fascia	Y		A2	$446.00	21.5761	$893.25	$557.81
27306	Incision of thigh tendon	Y		A2	$510.00	21.5761	$893.25	$605.81
27307	Incision of thigh tendons	Y		A2	$510.00	21.5761	$893.25	$605.81
27310	Exploration of knee joint	Y		A2	$630.00	29.3263	$1,214.11	$776.03
27323	Biopsy, thigh soft tissues	Y		A2	$333.00	8.7155	$360.82	$339.96
27324	Biopsy, thigh soft tissues	Y		A2	$333.00	21.4534	$888.17	$471.79
27325	Neurectomy, hamstring	Y		A2	$446.00	18.5069	$766.19	$526.05
27326	Neurectomy, popliteal	Y		A2	$446.00	18.5069	$766.19	$526.05
27327	Removal of thigh lesion	Y		A2	$446.00	21.4534	$888.17	$556.54
27328	Removal of thigh lesion	Y		A2	$510.00	21.4534	$888.17	$604.54
27329	Remove tumor, thigh/knee	Y		A2	$630.00	21.4534	$888.17	$694.54
27330	Biopsy, knee joint lining	Y		A2	$630.00	29.3263	$1,214.11	$776.03
27331	Explore/treat knee joint	Y		A2	$630.00	29.3263	$1,214.11	$776.03
27332	Removal of knee cartilage	Y		A2	$630.00	29.3263	$1,214.11	$776.03
27333	Removal of knee cartilage	Y		A2	$630.00	29.3263	$1,214.11	$776.03
27334	Remove knee joint lining	Y		A2	$630.00	29.3263	$1,214.11	$776.03
27335	Remove knee joint lining	Y		A2	$630.00	29.3263	$1,214.11	$776.03
27340	Removal of kneecap bursa	Y		A2	$510.00	21.5761	$893.25	$605.81
27345	Removal of knee cyst	Y		A2	$630.00	21.5761	$893.25	$695.81
27347	Remove knee cyst	Y		A2	$630.00	21.5761	$893.25	$695.81
27350	Removal of kneecap	Y		A2	$630.00	29.3263	$1,214.11	$776.03
27355	Remove femur lesion	Y		A2	$510.00	29.3263	$1,214.11	$686.03
27356	Remove femur lesion/graft	Y		A2	$630.00	29.3263	$1,214.11	$776.03
27357	Remove femur lesion/graft	Y		A2	$717.00	29.3263	$1,214.11	$841.28
27358	Remove femur lesion/fixation	Y		A2	$717.00	29.3263	$1,214.11	$841.28
27360	Partial removal, leg bone(s)	Y		A2	$717.00	29.3263	$1,214.11	$841.28
27370	Injection for knee x-ray	N		N1				
27372	Removal of foreign body	Y		A2	$995.00	21.4534	$888.17	$968.29
27380	Repair of kneecap tendon	Y		A2	$333.00	21.5761	$893.25	$473.06
27381	Repair/graft kneecap tendon	Y		A2	$510.00	21.5761	$893.25	$605.81
27385	Repair of thigh muscle	Y		A2	$510.00	21.5761	$893.25	$605.81
27386	Repair/graft of thigh muscle	Y		A2	$510.00	21.5761	$893.25	$605.81
27390	Incision of thigh tendon	Y		A2	$333.00	21.5761	$893.25	$473.06
27391	Incision of thigh tendons	Y		A2	$446.00	21.5761	$893.25	$557.81
27392	Incision of thigh tendons	Y		A2	$510.00	21.5761	$893.25	$605.81
27393	Lengthening of thigh tendon	Y		A2	$446.00	29.3263	$1,214.11	$638.03
27394	Lengthening of thigh tendons	Y		A2	$510.00	29.3263	$1,214.11	$686.03
27395	Lengthening of thigh tendons	Y		A2	$510.00	43.5953	$1,804.85	$833.71
27396	Transplant of thigh tendon	Y		A2	$510.00	29.3263	$1,214.11	$686.03
27397	Transplants of thigh tendons	Y		A2	$510.00	43.5953	$1,804.85	$833.71
27400	Revise thigh muscles/tendons	Y		A2	$510.00	43.5953	$1,804.85	$833.71
27403	Repair of knee cartilage	Y		A2	$630.00	29.3263	$1,214.11	$776.03
27405	Repair of knee ligament	Y		A2	$630.00	43.5953	$1,804.85	$923.71
27407	Repair of knee ligament	Y		A2	$630.00	78.6518	$3,256.18	$1,286.55
27409	Repair of knee ligaments	Y		A2	$630.00	43.5953	$1,804.85	$923.71
27418	Repair degenerated kneecap	Y		A2	$510.00	43.5953	$1,804.85	$833.71
27420	Revision of unstable kneecap	Y		A2	$510.00	43.5953	$1,804.85	$833.71
27422	Revision of unstable kneecap	Y		A2	$995.00	43.5953	$1,804.85	$1,197.46
27424	Revision/removal of kneecap	Y		A2	$510.00	43.5953	$1,804.85	$833.71
27425	Lat retinacular release open	Y		A2	$995.00	29.3263	$1,214.11	$1,049.78
27427	Reconstruction, knee	Y		A2	$510.00	43.5953	$1,804.85	$833.71
27428	Reconstruction, knee	Y		A2	$630.00	78.6518	$3,256.18	$1,286.55
27429	Reconstruction, knee	Y		A2	$630.00	78.6518	$3,256.18	$1,286.55
27430	Revision of thigh muscles	Y		A2	$630.00	43.5953	$1,804.85	$923.71
27435	Incision of knee joint	Y		A2	$630.00	43.5953	$1,804.85	$923.71
27437	Revise kneecap	Y		A2	$630.00	35.9249	$1,487.29	$844.32
27438	Revise kneecap with implant	Y		A2	$717.00	51.0431	$2,113.18	$1,066.05
27440	Revision of knee joint	Y		G2		35.9249	$1,487.29	$1,487.29
27441	Revision of knee joint	Y		A2	$717.00	35.9249	$1,487.29	$909.57
27442	Revision of knee joint	Y		A2	$717.00	35.9249	$1,487.29	$909.57
27443	Revision of knee joint	Y		A2	$717.00	35.9249	$1,487.29	$909.57
27446	Revision of knee joint	Y		G2		191.2387	$7,917.28	$7,917.28
27496	Decompression of thigh/knee	Y		A2	$717.00	21.5761	$893.25	$761.06
27497	Decompression of thigh/knee	Y		A2	$510.00	21.5761	$893.25	$605.81
27498	Decompression of thigh/knee	Y		A2	$510.00	21.5761	$893.25	$605.81

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS Code	Short Descriptor	Subject to multiple procedure discounting	Comment indicator	Payment indicator	CY 2007 ASC payment rate	Proposed fully implemented payment weight	Proposed CY 2008 fully implemented payment	Proposed CY 2008 first transition year payment
27499	Decompression of thigh/knee	Y		A2	$510.00	21.5761	$893.25	$605.81
27500	Treatment of thigh fracture	Y		A2	$103.62	1.8742	$77.59	$97.11
27501	Treatment of thigh fracture	Y		A2	$103.62	1.8742	$77.59	$97.11
27502	Treatment of thigh fracture	Y		A2	$103.62	1.8742	$77.59	$97.11
27503	Treatment of thigh fracture	Y		A2	$103.62	1.8742	$77.59	$97.11
27508	Treatment of thigh fracture	Y		A2	$103.62	1.8742	$77.59	$97.11
27509	Treatment of thigh fracture	Y		A2	$510.00	26.3092	$1,089.20	$654.80
27510	Treatment of thigh fracture	Y		A2	$103.62	1.8742	$77.59	$97.11
27516	Treat thigh fx growth plate	Y		A2	$103.62	1.8742	$77.59	$97.11
27517	Treat thigh fx growth plate	Y		A2	$103.62	1.8742	$77.59	$97.11
27520	Treat kneecap fracture	Y		A2	$103.62	1.8742	$77.59	$97.11
27530	Treat knee fracture	Y		A2	$103.62	1.8742	$77.59	$97.11
27532	Treat knee fracture	Y		A2	$103.62	1.8742	$77.59	$97.11
27538	Treat knee fracture(s)	Y		A2	$103.62	1.8742	$77.59	$97.11
27550	Treat knee dislocation	Y		A2	$103.62	1.8742	$77.59	$97.11
27552	Treat knee dislocation	Y		A2	$333.00	15.0176	$621.73	$405.18
27560	Treat kneecap dislocation	Y		A2	$103.62	1.8742	$77.59	$97.11
27562	Treat kneecap dislocation	Y		A2	$333.00	15.0176	$621.73	$405.18
27566	Treat kneecap dislocation	Y		A2	$446.00	40.3466	$1,670.35	$752.09
27570	Fixation of knee joint	Y		A2	$333.00	15.0176	$621.73	$405.18
27594	Amputation follow-up surgery	Y		A2	$510.00	21.5761	$893.25	$605.81
27600	Decompression of lower leg	Y		A2	$510.00	21.5761	$893.25	$605.81
27601	Decompression of lower leg	Y		A2	$510.00	21.5761	$893.25	$605.81
27602	Decompression of lower leg	Y		A2	$510.00	21.5761	$893.25	$605.81
27603	Drain lower leg lesion	Y		A2	$446.00	19.0457	$788.49	$531.62
27604	Drain lower leg bursa	Y		A2	$446.00	21.5761	$893.25	$557.81
27605	Incision of achilles tendon	Y		A2	$333.00	21.1762	$876.69	$468.92
27606	Incision of achilles tendon	Y		A2	$333.00	21.5761	$893.25	$473.06
27607	Treat lower leg bone lesion	Y		A2	$446.00	21.5761	$893.25	$557.81
27610	Explore/treat ankle joint	Y		A2	$446.00	29.3263	$1,214.11	$638.03
27612	Exploration of ankle joint	Y		A2	$510.00	29.3263	$1,214.11	$686.03
27613	Biopsy lower leg soft tissue	Y		P3		2.9271	$121.18	$121.18
27614	Biopsy lower leg soft tissue	Y		A2	$446.00	21.4534	$888.17	$556.54
27615	Remove tumor, lower leg	Y		A2	$510.00	29.3263	$1,214.11	$686.03
27618	Remove lower leg lesion	Y		A2	$446.00	16.5832	$686.54	$506.14
27619	Remove lower leg lesion	Y		A2	$510.00	21.4534	$888.17	$604.54
27620	Explore/treat ankle joint	Y		A2	$630.00	29.3263	$1,214.11	$776.03
27625	Remove ankle joint lining	Y		A2	$630.00	29.3263	$1,214.11	$776.03
27626	Remove ankle joint lining	Y		A2	$630.00	29.3263	$1,214.11	$776.03
27630	Removal of tendon lesion	Y		A2	$510.00	21.5761	$893.25	$605.81
27635	Remove lower leg bone lesion	Y		A2	$510.00	29.3263	$1,214.11	$686.03
27637	Remove/graft leg bone lesion	Y		A2	$510.00	29.3263	$1,214.11	$686.03
27638	Remove/graft leg bone lesion	Y		A2	$510.00	29.3263	$1,214.11	$686.03
27640	Partial removal of tibia	Y		A2	$446.00	43.5953	$1,804.85	$785.71
27641	Partial removal of fibula	Y		A2	$446.00	29.3263	$1,214.11	$638.03
27647	Extensive ankle/heel surgery	Y		A2	$510.00	43.5953	$1,804.85	$833.71
27648	Injection for ankle x-ray	N		N1				
27650	Repair achilles tendon	Y		A2	$510.00	43.5953	$1,804.85	$833.71
27652	Repair/graft achilles tendon	Y		A2	$510.00	78.6518	$3,256.18	$1,196.55
27654	Repair of achilles tendon	Y		A2	$510.00	43.5953	$1,804.85	$833.71
27656	Repair leg fascia defect	Y		A2	$446.00	21.5761	$893.25	$557.81
27658	Repair of leg tendon, each	Y		A2	$333.00	21.5761	$893.25	$473.06
27659	Repair of leg tendon, each	Y		A2	$446.00	21.5761	$893.25	$557.81
27664	Repair of leg tendon, each	Y		A2	$446.00	21.5761	$893.25	$557.81
27665	Repair of leg tendon, each	Y		A2	$446.00	29.3263	$1,214.11	$638.03
27675	Repair lower leg tendons	Y		A2	$446.00	21.5761	$893.25	$557.81
27676	Repair lower leg tendons	Y		A2	$510.00	29.3263	$1,214.11	$686.03
27680	Release of lower leg tendon	Y		A2	$510.00	29.3263	$1,214.11	$686.03
27681	Release of lower leg tendons	Y		A2	$446.00	29.3263	$1,214.11	$638.03
27685	Revision of lower leg tendon	Y		A2	$510.00	29.3263	$1,214.11	$686.03
27686	Revise lower leg tendons	Y		A2	$510.00	29.3263	$1,214.11	$686.03
27687	Revision of calf tendon	Y		A2	$510.00	29.3263	$1,214.11	$686.03
27690	Revise lower leg tendon	Y		A2	$630.00	43.5953	$1,804.85	$923.71
27691	Revise lower leg tendon	Y		A2	$630.00	43.5953	$1,804.85	$923.71
27692	Revise additional leg tendon	Y		A2	$510.00	43.5953	$1,804.85	$833.71
27695	Repair of ankle ligament	Y		A2	$446.00	29.3263	$1,214.11	$638.03
27696	Repair of ankle ligaments	Y		A2	$446.00	29.3263	$1,214.11	$638.03
27698	Repair of ankle ligament	Y		A2	$446.00	29.3263	$1,214.11	$638.03
27700	Revision of ankle joint	Y		A2	$717.00	35.9249	$1,487.29	$909.57
27704	Removal of ankle implant	Y		A2	$446.00	21.5761	$893.25	$557.81
27705	Incision of tibia	Y		A2	$446.00	43.5953	$1,804.85	$785.71
27707	Incision of fibula	Y		A2	$446.00	21.5761	$893.25	$557.81
27709	Incision of tibia & fibula	Y		A2	$446.00	29.3263	$1,214.11	$638.03
27730	Repair of tibia epiphysis	Y		A2	$446.00	29.3263	$1,214.11	$638.03
27732	Repair of fibula epiphysis	Y		A2	$446.00	29.3263	$1,214.11	$638.03
27734	Repair lower leg epiphyses	Y		A2	$446.00	29.3263	$1,214.11	$638.03

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS Code	Short Descriptor	Subject to multiple procedure discounting	Comment indicator	Payment indicator	CY 2007 ASC payment rate	Proposed fully implemented payment weight	Proposed CY 2008 fully implemented payment	Proposed CY 2008 first transition year payment
27740	Repair of leg epiphyses	Y		A2	$446.00	29.3263	$1,214.11	$638.03
27742	Repair of leg epiphyses	Y		A2	$446.00	43.5953	$1,804.85	$785.71
27745	Reinforce tibia	Y		A2	$510.00	78.6518	$3,256.18	$1,196.55
27750	Treatment of tibia fracture	Y		A2	$103.62	1.8742	$77.59	$97.11
27752	Treatment of tibia fracture	Y		A2	$103.62	1.8742	$77.59	$97.11
27756	Treatment of tibia fracture	Y		A2	$510.00	26.3092	$1,089.20	$654.80
27758	Treatment of tibia fracture	Y		A2	$630.00	40.3466	$1,670.35	$890.09
27759	Treatment of tibia fracture	Y		A2	$630.00	60.0595	$2,486.46	$1,094.12
27760	Treatment of ankle fracture	Y		A2	$103.62	1.8742	$77.59	$97.11
27762	Treatment of ankle fracture	Y		A2	$103.62	1.8742	$77.59	$97.11
27766	Treatment of ankle fracture	Y		A2	$510.00	40.3466	$1,670.35	$800.09
27780	Treatment of fibula fracture	Y		A2	$103.62	1.8742	$77.59	$97.11
27781	Treatment of fibula fracture	Y		A2	$103.62	1.8742	$77.59	$97.11
27784	Treatment of fibula fracture	Y		A2	$510.00	40.3466	$1,670.35	$800.09
27786	Treatment of ankle fracture	Y		A2	$103.62	1.8742	$77.59	$97.11
27788	Treatment of ankle fracture	Y		A2	$103.62	1.8742	$77.59	$97.11
27792	Treatment of ankle fracture	Y		A2	$510.00	40.3466	$1,670.35	$800.09
27808	Treatment of ankle fracture	Y		A2	$103.62	1.8742	$77.59	$97.11
27810	Treatment of ankle fracture	Y		A2	$103.62	1.8742	$77.59	$97.11
27814	Treatment of ankle fracture	Y		A2	$510.00	40.3466	$1,670.35	$800.09
27816	Treatment of ankle fracture	Y		A2	$103.62	1.8742	$77.59	$97.11
27818	Treatment of ankle fracture	Y		A2	$103.62	1.8742	$77.59	$97.11
27822	Treatment of ankle fracture	Y		A2	$510.00	40.3466	$1,670.35	$800.09
27823	Treatment of ankle fracture	Y		A2	$510.00	60.0595	$2,486.46	$1,004.12
27824	Treat lower leg fracture	Y		A2	$103.62	1.8742	$77.59	$97.11
27825	Treat lower leg fracture	Y		A2	$103.62	1.8742	$77.59	$97.11
27826	Treat lower leg fracture	Y		A2	$510.00	40.3466	$1,670.35	$800.09
27827	Treat lower leg fracture	Y		A2	$510.00	60.0595	$2,486.46	$1,004.12
27828	Treat lower leg fracture	Y		A2	$630.00	60.0595	$2,486.46	$1,094.12
27829	Treat lower leg joint	Y		A2	$446.00	40.3466	$1,670.35	$752.09
27830	Treat lower leg dislocation	Y		A2	$103.62	1.8742	$77.59	$97.11
27831	Treat lower leg dislocation	Y		A2	$103.62	1.8742	$77.59	$97.11
27832	Treat lower leg dislocation	Y		A2	$446.00	40.3466	$1,670.35	$752.09
27840	Treat ankle dislocation	Y		A2	$103.62	1.8742	$77.59	$97.11
27842	Treat ankle dislocation	Y		A2	$333.00	15.0176	$621.73	$405.18
27846	Treat ankle dislocation	Y		A2	$510.00	40.3466	$1,670.35	$800.09
27848	Treat ankle dislocation	Y		A2	$510.00	40.3466	$1,670.35	$800.09
27860	Fixation of ankle joint	Y		A2	$333.00	15.0176	$621.73	$405.18
27870	Fusion of ankle joint, open	Y		A2	$630.00	78.6518	$3,256.18	$1,286.55
27871	Fusion of tibiofibular joint	Y		A2	$630.00	78.6518	$3,256.18	$1,286.55
27884	Amputation follow-up surgery	Y		A2	$510.00	21.5761	$893.25	$605.81
27889	Amputation of foot at ankle	Y		A2	$510.00	29.3263	$1,214.11	$686.03
27892	Decompression of leg	Y		A2	$510.00	21.5761	$893.25	$605.81
27893	Decompression of leg	Y		A2	$510.00	21.5761	$893.25	$605.81
27894	Decompression of leg	Y		A2	$510.00	21.5761	$893.25	$605.81
28001	Drainage of bursa of foot	Y		P3		2.8529	$118.11	$118.11
28002	Treatment of foot infection	Y		A2	$510.00	21.5761	$893.25	$605.81
28003	Treatment of foot infection	Y		A2	$510.00	21.5761	$893.25	$605.81
28005	Treat foot bone lesion	Y		A2	$510.00	21.1762	$876.69	$601.67
28008	Incision of foot fascia	Y		A2	$510.00	21.1762	$876.69	$601.67
28010	Incision of toe tendon	Y		P3		2.1437	$88.75	$88.75
28011	Incision of toe tendons	Y		A2	$510.00	21.1762	$876.69	$601.67
28020	Exploration of foot joint	Y		A2	$446.00	21.1762	$876.69	$553.67
28022	Exploration of foot joint	Y		A2	$446.00	21.1762	$876.69	$553.67
28024	Exploration of toe joint	Y		A2	$446.00	21.1762	$876.69	$553.67
28035	Decompression of tibia nerve	Y		A2	$630.00	18.5069	$766.19	$664.05
28043	Excision of foot lesion	Y		A2	$446.00	21.4534	$888.17	$556.54
28045	Excision of foot lesion	Y		A2	$510.00	21.1762	$876.69	$601.67
28046	Resection of tumor, foot	Y		A2	$510.00	21.1762	$876.69	$601.67
28050	Biopsy of foot joint lining	Y		A2	$446.00	21.1762	$876.69	$553.67
28052	Biopsy of foot joint lining	Y		A2	$446.00	21.1762	$876.69	$553.67
28054	Biopsy of toe joint lining	Y		A2	$446.00	21.1762	$876.69	$553.67
28055	Neurectomy, foot	Y		A2	$630.00	18.5069	$766.19	$664.05
28060	Partial removal, foot fascia	Y		A2	$446.00	21.1762	$876.69	$553.67
28062	Removal of foot fascia	Y		A2	$510.00	21.1762	$876.69	$601.67
28070	Removal of foot joint lining	Y		A2	$510.00	21.1762	$876.69	$601.67
28072	Removal of foot joint lining	Y		A2	$510.00	21.1762	$876.69	$601.67
28080	Removal of foot lesion	Y		A2	$510.00	21.1762	$876.69	$601.67
28086	Excise foot tendon sheath	Y		A2	$446.00	21.1762	$876.69	$553.67
28088	Excise foot tendon sheath	Y		A2	$446.00	21.1762	$876.69	$553.67
28090	Removal of foot lesion	Y		A2	$510.00	21.1762	$876.69	$601.67
28092	Removal of toe lesions	Y		A2	$510.00	21.1762	$876.69	$601.67
28100	Removal of ankle/heel lesion	Y		A2	$446.00	21.1762	$876.69	$553.67
28102	Remove/graft foot lesion	Y		A2	$510.00	44.4710	$1,841.10	$842.78
28103	Remove/graft foot lesion	Y		A2	$510.00	44.4710	$1,841.10	$842.78
28104	Removal of foot lesion	Y		A2	$446.00	21.1762	$876.69	$553.67

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS Code	Short Descriptor	Subject to multiple procedure discounting	Comment indicator	Payment indicator	CY 2007 ASC payment rate	Proposed fully implemented payment weight	Proposed CY 2008 fully implemented payment	Proposed CY 2008 first transition year payment
28106	Remove/graft foot lesion	Y		A2	$510.00	44.4710	$1,841.10	$842.78
28107	Remove/graft foot lesion	Y		A2	$510.00	44.4710	$1,841.10	$842.78
28108	Removal of toe lesions	Y		A2	$446.00	21.1762	$876.69	$553.67
28110	Part removal of metatarsal	Y		A2	$510.00	21.1762	$876.69	$601.67
28111	Part removal of metatarsal	Y		A2	$510.00	21.1762	$876.69	$601.67
28112	Part removal of metatarsal	Y		A2	$510.00	21.1762	$876.69	$601.67
28113	Part removal of metatarsal	Y		A2	$510.00	21.1762	$876.69	$601.67
28114	Removal of metatarsal heads	Y		A2	$510.00	21.1762	$876.69	$601.67
28116	Revision of foot	Y		A2	$510.00	21.1762	$876.69	$601.67
28118	Removal of heel bone	Y		A2	$630.00	21.1762	$876.69	$691.67
28119	Removal of heel spur	Y		A2	$630.00	21.1762	$876.69	$691.67
28120	Part removal of ankle/heel	Y		A2	$995.00	21.1762	$876.69	$965.42
28122	Partial removal of foot bone	Y		A2	$510.00	21.1762	$876.69	$601.67
28124	Partial removal of toe	Y		P3		4.8152	$199.35	$199.35
28126	Partial removal of toe	Y		A2	$510.00	21.1762	$876.69	$601.67
28130	Removal of ankle bone	Y		A2	$510.00	21.1762	$876.69	$601.67
28140	Removal of metatarsal	Y		A2	$510.00	21.1762	$876.69	$601.67
28150	Removal of toe	Y		A2	$510.00	21.1762	$876.69	$601.67
28153	Partial removal of toe	Y		A2	$510.00	21.1762	$876.69	$601.67
28160	Partial removal of toe	Y		A2	$510.00	21.1762	$876.69	$601.67
28171	Extensive foot surgery	Y		A2	$510.00	21.1762	$876.69	$601.67
28173	Extensive foot surgery	Y		A2	$510.00	21.1762	$876.69	$601.67
28175	Extensive foot surgery	Y		A2	$510.00	21.1762	$876.69	$601.67
28190	Removal of foot foreign body	Y		P3		3.0261	$125.28	$125.28
28192	Removal of foot foreign body	Y		A2	$446.00	16.5832	$686.54	$506.14
28193	Removal of foot foreign body	Y		A2	$418.49	8.7155	$360.82	$404.07
28200	Repair of foot tendon	Y		A2	$510.00	21.1762	$876.69	$601.67
28202	Repair/graft of foot tendon	Y		A2	$510.00	21.1762	$876.69	$601.67
28208	Repair of foot tendon	Y		A2	$510.00	21.1762	$876.69	$601.67
28210	Repair/graft of foot tendon	Y		A2	$510.00	44.4710	$1,841.10	$842.78
28220	Release of foot tendon	Y		P3		4.5266	$187.40	$187.40
28222	Release of foot tendons	Y		A2	$333.00	21.1762	$876.69	$468.92
28225	Release of foot tendon	Y		A2	$333.00	21.1762	$876.69	$468.92
28226	Release of foot tendons	Y		A2	$333.00	21.1762	$876.69	$468.92
28230	Incision of foot tendon(s)	Y		P3		4.4771	$185.35	$185.35
28232	Incision of toe tendon	Y		P3		4.2710	$176.82	$176.82
28234	Incision of foot tendon	Y		A2	$446.00	21.1762	$876.69	$553.67
28238	Revision of foot tendon	Y		A2	$510.00	44.4710	$1,841.10	$842.78
28240	Release of big toe	Y		A2	$446.00	21.1762	$876.69	$553.67
28250	Revision of foot fascia	Y		A2	$510.00	21.1762	$876.69	$601.67
28260	Release of midfoot joint	Y		A2	$510.00	21.1762	$876.69	$601.67
28261	Revision of foot tendon	Y		A2	$510.00	21.1762	$876.69	$601.67
28262	Revision of foot and ankle	Y		A2	$630.00	21.1762	$876.69	$691.67
28264	Release of midfoot joint	Y		A2	$333.00	44.4710	$1,841.10	$710.03
28270	Release of foot contracture	Y		A2	$510.00	21.1762	$876.69	$601.67
28272	Release of toe joint, each	Y		P3		4.0896	$169.31	$169.31
28280	Fusion of toes	Y		A2	$446.00	21.1762	$876.69	$553.67
28285	Repair of hammertoe	Y		A2	$510.00	21.1762	$876.69	$601.67
28286	Repair of hammertoe	Y		A2	$630.00	21.1762	$876.69	$691.67
28288	Partial removal of foot bone	Y		A2	$510.00	21.1762	$876.69	$601.67
28289	Repair hallux rigidus	Y		A2	$510.00	21.1762	$876.69	$601.67
28290	Correction of bunion	Y		A2	$446.00	29.8356	$1,235.19	$643.30
28292	Correction of bunion	Y		A2	$446.00	29.8356	$1,235.19	$643.30
28293	Correction of bunion	Y		A2	$510.00	29.8356	$1,235.19	$691.30
28294	Correction of bunion	Y		A2	$510.00	29.8356	$1,235.19	$691.30
28296	Correction of bunion	Y		A2	$510.00	29.8356	$1,235.19	$691.30
28297	Correction of bunion	Y		A2	$510.00	29.8356	$1,235.19	$691.30
28298	Correction of bunion	Y		A2	$510.00	29.8356	$1,235.19	$691.30
28299	Correction of bunion	Y		A2	$717.00	29.8356	$1,235.19	$846.55
28300	Incision of heel bone	Y		A2	$446.00	44.4710	$1,841.10	$794.78
28302	Incision of ankle bone	Y		A2	$446.00	21.1762	$876.69	$553.67
28304	Incision of midfoot bones	Y		A2	$446.00	44.4710	$1,841.10	$794.78
28305	Incise/graft midfoot bones	Y		A2	$510.00	44.4710	$1,841.10	$842.78
28306	Incision of metatarsal	Y		A2	$630.00	21.1762	$876.69	$691.67
28307	Incision of metatarsal	Y		A2	$630.00	21.1762	$876.69	$691.67
28308	Incision of metatarsal	Y		A2	$446.00	21.1762	$876.69	$553.67
28309	Incision of metatarsals	Y		A2	$630.00	44.4710	$1,841.10	$932.78
28310	Revision of big toe	Y		A2	$510.00	21.1762	$876.69	$601.67
28312	Revision of toe	Y		A2	$510.00	21.1762	$876.69	$601.67
28313	Repair deformity of toe	Y		A2	$446.00	21.1762	$876.69	$553.67
28315	Removal of sesamoid bone	Y		A2	$630.00	21.1762	$876.69	$691.67
28320	Repair of foot bones	Y		A2	$630.00	44.4710	$1,841.10	$932.78
28322	Repair of metatarsals	Y		A2	$630.00	44.4710	$1,841.10	$932.78
28340	Resect enlarged toe tissue	Y		A2	$630.00	21.1762	$876.69	$691.67
28341	Resect enlarged toe	Y		A2	$630.00	21.1762	$876.69	$691.67
28344	Repair extra toe(s)	Y		A2	$630.00	21.1762	$876.69	$691.67

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS Code	Short Descriptor	Subject to multiple procedure discounting	Comment indicator	Payment indicator	CY 2007 ASC payment rate	Proposed fully implemented payment weight	Proposed CY 2008 fully implemented payment	Proposed CY 2008 first transition year payment
28345	Repair webbed toe(s)	Y		A2	$630.00	21.1762	$876.69	$691.67
28400	Treatment of heel fracture	Y		A2	$103.62	1.8742	$77.59	$97.11
28405	Treatment of heel fracture	Y		A2	$103.62	1.8742	$77.59	$97.11
28406	Treatment of heel fracture	Y		A2	$446.00	26.3092	$1,089.20	$606.80
28415	Treat heel fracture	Y		A2	$510.00	40.3466	$1,670.35	$800.09
28420	Treat/graft heel fracture	Y		A2	$630.00	40.3466	$1,670.35	$890.09
28430	Treatment of ankle fracture	Y		P2		1.8742	$77.59	$77.59
28435	Treatment of ankle fracture	Y		A2	$103.62	1.8742	$77.59	$97.11
28436	Treatment of ankle fracture	Y		A2	$446.00	26.3092	$1,089.20	$606.80
28445	Treat ankle fracture	Y		A2	$510.00	40.3466	$1,670.35	$800.09
28450	Treat midfoot fracture, each	Y		P2		1.8742	$77.59	$77.59
28455	Treat midfoot fracture, each	Y		P2		1.8742	$77.59	$77.59
28456	Treat midfoot fracture	Y		A2	$446.00	26.3092	$1,089.20	$606.80
28465	Treat midfoot fracture, each	Y		A2	$510.00	40.3466	$1,670.35	$800.09
28470	Treat metatarsal fracture	Y		P2		1.8742	$77.59	$77.59
28475	Treat metatarsal fracture	Y		P2		1.8742	$77.59	$77.59
28476	Treat metatarsal fracture	Y		A2	$446.00	26.3092	$1,089.20	$606.80
28485	Treat metatarsal fracture	Y		A2	$630.00	40.3466	$1,670.35	$890.09
28490	Treat big toe fracture	Y		P3		1.6821	$69.64	$69.64
28495	Treat big toe fracture	Y		P2		1.8742	$77.59	$77.59
28496	Treat big toe fracture	Y		A2	$446.00	26.3092	$1,089.20	$606.80
28505	Treat big toe fracture	Y		A2	$510.00	40.3466	$1,670.35	$800.09
28510	Treatment of toe fracture	Y		P3		1.3193	$54.62	$54.62
28515	Treatment of toe fracture	Y		P3		1.6821	$69.64	$69.64
28525	Treat toe fracture	Y		A2	$510.00	40.3466	$1,670.35	$800.09
28530	Treat sesamoid bone fracture	Y		P3		1.2534	$51.89	$51.89
28531	Treat sesamoid bone fracture	Y		A2	$510.00	40.3466	$1,670.35	$800.09
28540	Treat foot dislocation	Y		P2		1.8742	$77.59	$77.59
28545	Treat foot dislocation	Y		A2	$333.00	26.3092	$1,089.20	$522.05
28546	Treat foot dislocation	Y		A2	$446.00	26.3092	$1,089.20	$606.80
28555	Repair foot dislocation	Y		A2	$446.00	40.3466	$1,670.35	$752.09
28570	Treat foot dislocation	Y		P2		1.8742	$77.59	$77.59
28575	Treat foot dislocation	Y		A2	$103.62	1.8742	$77.59	$97.11
28576	Treat foot dislocation	Y		A2	$510.00	26.3092	$1,089.20	$654.80
28585	Repair foot dislocation	Y		A2	$510.00	40.3466	$1,670.35	$800.09
28600	Treat foot dislocation	Y		P2		1.8742	$77.59	$77.59
28605	Treat foot dislocation	Y		A2	$103.62	1.8742	$77.59	$97.11
28606	Treat foot dislocation	Y		A2	$446.00	26.3092	$1,089.20	$606.80
28615	Repair foot dislocation	Y		A2	$510.00	40.3466	$1,670.35	$800.09
28630	Treat toe dislocation	Y	CH	P3		1.4181	$58.71	$58.71
28635	Treat toe dislocation	Y		A2	$333.00	15.0176	$621.73	$405.18
28636	Treat toe dislocation	Y		A2	$510.00	26.3092	$1,089.20	$654.80
28645	Repair toe dislocation	Y		A2	$510.00	40.3466	$1,670.35	$800.09
28660	Treat toe dislocation	Y	CH	P3		1.0471	$43.35	$43.35
28665	Treat toe dislocation	Y		A2	$333.00	15.0176	$621.73	$405.18
28666	Treat toe dislocation	Y		A2	$510.00	26.3092	$1,089.20	$654.80
28675	Repair of toe dislocation	Y		A2	$510.00	40.3466	$1,670.35	$800.09
28705	Fusion of foot bones	Y		A2	$630.00	44.4710	$1,841.10	$932.78
28715	Fusion of foot bones	Y		A2	$630.00	78.6518	$3,256.18	$1,286.55
28725	Fusion of foot bones	Y		A2	$630.00	44.4710	$1,841.10	$932.78
28730	Fusion of foot bones	Y		A2	$630.00	44.4710	$1,841.10	$932.78
28735	Fusion of foot bones	Y		A2	$630.00	44.4710	$1,841.10	$932.78
28737	Revision of foot bones	Y		A2	$717.00	44.4710	$1,841.10	$998.03
28740	Fusion of foot bones	Y		A2	$630.00	44.4710	$1,841.10	$932.78
28750	Fusion of big toe joint	Y		A2	$630.00	44.4710	$1,841.10	$932.78
28755	Fusion of big toe joint	Y		A2	$630.00	21.1762	$876.69	$691.67
28760	Fusion of big toe joint	Y		A2	$630.00	44.4710	$1,841.10	$932.78
28810	Amputation toe & metatarsal	Y		A2	$446.00	21.1762	$876.69	$553.67
28820	Amputation of toe	Y		A2	$446.00	21.1762	$876.69	$553.67
28825	Partial amputation of toe	Y		A2	$446.00	21.1762	$876.69	$553.67
28890	High energy eswt, plantar f	Y	CH	P3		4.2297	$175.11	$175.11
29000	Application of body cast	N		G2		1.1272	$46.67	$46.67
29010	Application of body cast	N		P2		2.2383	$92.67	$92.67
29015	Application of body cast	N		P2		2.2383	$92.67	$92.67
29020	Application of body cast	N		G2		1.1272	$46.67	$46.67
29025	Application of body cast	N		P2		1.1272	$46.67	$46.67
29035	Application of body cast	N	CH	P2		2.2383	$92.67	$92.67
29040	Application of body cast	N		G2		1.1272	$46.67	$46.67
29044	Application of body cast	N		P2		2.2383	$92.67	$92.67
29046	Application of body cast	N		G2		2.2383	$92.67	$92.67
29049	Application of figure eight	N		P3		0.9976	$41.30	$41.30
29055	Application of shoulder cast	N		P2		2.2383	$92.67	$92.67
29058	Application of shoulder cast	N		P2		1.1272	$46.67	$46.67
29065	Application of long arm cast	N		P3		1.0720	$44.38	$44.38
29075	Application of forearm cast	N		P3		1.0225	$42.33	$42.33
29085	Apply hand/wrist cast	N		P3		1.0471	$43.35	$43.35

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS Code	Short Descriptor	Subject to multiple procedure discounting	Comment indicator	Payment indicator	CY 2007 ASC payment rate	Proposed fully implemented payment weight	Proposed CY 2008 fully implemented payment	Proposed CY 2008 first transition year payment
29086	Apply finger cast	N		P3		0.8329	$34.48	$34.48
29105	Apply long arm splint	N		P3		0.9565	$39.60	$39.60
29125	Apply forearm splint	N		P3		0.8162	$33.79	$33.79
29126	Apply forearm splint	N		P3		0.9152	$37.89	$37.89
29130	Application of finger splint	N		P3		0.3710	$15.36	$15.36
29131	Application of finger splint	N		P3		0.5524	$22.87	$22.87
29200	Strapping of chest	N		P3		0.5442	$22.53	$22.53
29220	Strapping of low back	N		P3		0.5524	$22.87	$22.87
29240	Strapping of shoulder	N		P3		0.6348	$26.28	$26.28
29260	Strapping of elbow or wrist	N		P3		0.5771	$23.89	$23.89
29280	Strapping of hand or finger	N		P3		0.6019	$24.92	$24.92
29305	Application of hip cast	N	CH	P2		2.2383	$92.67	$92.67
29325	Application of hip casts	N	CH	P2		2.2383	$92.67	$92.67
29345	Application of long leg cast	N		P3		1.4099	$58.37	$58.37
29355	Application of long leg cast	N		P3		1.3686	$56.66	$56.66
29358	Apply long leg cast brace	N		P3		1.6821	$69.64	$69.64
29365	Application of long leg cast	N		P3		1.3357	$55.30	$55.30
29405	Apply short leg cast	N		P3		0.9976	$41.30	$41.30
29425	Apply short leg cast	N		P3		1.0058	$41.64	$41.64
29435	Apply short leg cast	N		P3		1.2698	$52.57	$52.57
29440	Addition of walker to cast	N		P3		0.5442	$22.53	$22.53
29445	Apply rigid leg cast	N		P3		1.3935	$57.69	$57.69
29450	Application of leg cast	N		P2		1.1272	$46.67	$46.67
29505	Application, long leg splint	N	CH	P3		0.9234	$38.23	$38.23
29515	Application lower leg splint	N	CH	P3		0.7502	$31.06	$31.06
29520	Strapping of hip	N		P3		0.6266	$25.94	$25.94
29530	Strapping of knee	N		P3		0.5937	$24.58	$24.58
29540	Strapping of ankle and/or ft	N		P3		0.3957	$16.38	$16.38
29550	Strapping of toes	N		P3		0.4041	$16.73	$16.73
29580	Application of paste boot	N		P3		0.5606	$23.21	$23.21
29590	Application of foot splint	N		P3		0.4534	$18.77	$18.77
29700	Removal/revision of cast	N		P3		0.7585	$31.40	$31.40
29705	Removal/revision of cast	N		P3		0.6514	$26.97	$26.97
29710	Removal/revision of cast	N		P3		1.1872	$49.15	$49.15
29715	Removal/revision of cast	N		P3		0.9729	$40.28	$40.28
29720	Repair of body cast	N		P3		0.9565	$39.60	$39.60
29730	Windowing of cast	N		P3		0.6432	$26.63	$26.63
29740	Wedging of cast	N		P3		0.9070	$37.55	$37.55
29750	Wedging of clubfoot cast	N		P3		0.8575	$35.50	$35.50
29800	Jaw arthroscopy/surgery	Y		A2	$510.00	29.4467	$1,219.09	$687.27
29804	Jaw arthroscopy/surgery	Y		A2	$510.00	29.4467	$1,219.09	$687.27
29805	Shoulder arthroscopy, dx	Y		A2	$510.00	29.4467	$1,219.09	$687.27
29806	Shoulder arthroscopy/surgery	Y		A2	$510.00	47.7765	$1,977.95	$876.99
29807	Shoulder arthroscopy/surgery	Y		A2	$510.00	47.7765	$1,977.95	$876.99
29819	Shoulder arthroscopy/surgery	Y		A2	$510.00	29.4467	$1,219.09	$687.27
29820	Shoulder arthroscopy/surgery	Y		A2	$510.00	29.4467	$1,219.09	$687.27
29821	Shoulder arthroscopy/surgery	Y		A2	$510.00	29.4467	$1,219.09	$687.27
29822	Shoulder arthroscopy/surgery	Y		A2	$510.00	29.4467	$1,219.09	$687.27
29823	Shoulder arthroscopy/surgery	Y		A2	$510.00	29.4467	$1,219.09	$687.27
29824	Shoulder arthroscopy/surgery	Y		A2	$717.00	29.4467	$1,219.09	$842.52
29825	Shoulder arthroscopy/surgery	Y		A2	$510.00	29.4467	$1,219.09	$687.27
29826	Shoulder arthroscopy/surgery	Y		A2	$510.00	47.7765	$1,977.95	$876.99
29827	Arthroscop rotator cuff repr	Y		A2	$717.00	47.7765	$1,977.95	$1,032.24
29830	Elbow arthroscopy	Y		A2	$510.00	29.4467	$1,219.09	$687.27
29834	Elbow arthroscopy/surgery	Y		A2	$510.00	29.4467	$1,219.09	$687.27
29835	Elbow arthroscopy/surgery	Y		A2	$510.00	29.4467	$1,219.09	$687.27
29836	Elbow arthroscopy/surgery	Y		A2	$510.00	29.4467	$1,219.09	$687.27
29837	Elbow arthroscopy/surgery	Y		A2	$510.00	29.4467	$1,219.09	$687.27
29838	Elbow arthroscopy/surgery	Y		A2	$510.00	29.4467	$1,219.09	$687.27
29840	Wrist arthroscopy	Y		A2	$510.00	29.4467	$1,219.09	$687.27
29843	Wrist arthroscopy/surgery	Y		A2	$510.00	29.4467	$1,219.09	$687.27
29844	Wrist arthroscopy/surgery	Y		A2	$510.00	29.4467	$1,219.09	$687.27
29845	Wrist arthroscopy/surgery	Y		A2	$510.00	29.4467	$1,219.09	$687.27
29846	Wrist arthroscopy/surgery	Y		A2	$510.00	29.4467	$1,219.09	$687.27
29847	Wrist arthroscopy/surgery	Y		A2	$510.00	29.4467	$1,219.09	$687.27
29848	Wrist endoscopy/surgery	Y		A2	$1,339.00	29.4467	$1,219.09	$1,309.02
29850	Knee arthroscopy/surgery	Y		A2	$630.00	29.4467	$1,219.09	$777.27
29851	Knee arthroscopy/surgery	Y		A2	$630.00	47.7765	$1,977.95	$966.99
29855	Tibial arthroscopy/surgery	Y		A2	$630.00	47.7765	$1,977.95	$966.99
29856	Tibial arthroscopy/surgery	Y		A2	$630.00	29.4467	$1,219.09	$777.27
29860	Hip arthroscopy, dx	Y		A2	$630.00	29.4467	$1,219.09	$777.27
29861	Hip arthroscopy/surgery	Y		A2	$630.00	29.4467	$1,219.09	$777.27
29862	Hip arthroscopy/surgery	Y		A2	$1,339.00	47.7765	$1,977.95	$1,498.74
29863	Hip arthroscopy/surgery	Y		A2	$630.00	47.7765	$1,977.95	$966.99
29870	Knee arthroscopy, dx	Y		A2	$510.00	29.4467	$1,219.09	$687.27
29871	Knee arthroscopy/drainage	Y		A2	$510.00	29.4467	$1,219.09	$687.27

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS Code	Short Descriptor	Subject to multiple procedure discounting	Comment indicator	Payment indicator	CY 2007 ASC payment rate	Proposed fully implemented payment weight	Proposed CY 2008 fully implemented payment	Proposed CY 2008 first transition year payment
29873	Knee arthroscopy/surgery	Y		A2	$510.00	29.4467	$1,219.09	$687.27
29874	Knee arthroscopy/surgery	Y		A2	$510.00	29.4467	$1,219.09	$687.27
29875	Knee arthroscopy/surgery	Y		A2	$630.00	29.4467	$1,219.09	$777.27
29876	Knee arthroscopy/surgery	Y		A2	$630.00	29.4467	$1,219.09	$777.27
29877	Knee arthroscopy/surgery	Y		A2	$630.00	29.4467	$1,219.09	$777.27
29879	Knee arthroscopy/surgery	Y		A2	$510.00	29.4467	$1,219.09	$687.27
29880	Knee arthroscopy/surgery	Y		A2	$630.00	29.4467	$1,219.09	$777.27
29881	Knee arthroscopy/surgery	Y		A2	$630.00	29.4467	$1,219.09	$777.27
29882	Knee arthroscopy/surgery	Y		A2	$510.00	29.4467	$1,219.09	$687.27
29883	Knee arthroscopy/surgery	Y		A2	$510.00	29.4467	$1,219.09	$687.27
29884	Knee arthroscopy/surgery	Y		A2	$510.00	29.4467	$1,219.09	$687.27
29885	Knee arthroscopy/surgery	Y		A2	$510.00	47.7765	$1,977.95	$876.99
29886	Knee arthroscopy/surgery	Y		A2	$510.00	29.4467	$1,219.09	$687.27
29887	Knee arthroscopy/surgery	Y		A2	$510.00	29.4467	$1,219.09	$687.27
29888	Knee arthroscopy/surgery	Y		A2	$510.00	47.7765	$1,977.95	$876.99
29889	Knee arthroscopy/surgery	Y		A2	$510.00	47.7765	$1,977.95	$876.99
29891	Ankle arthroscopy/surgery	Y		A2	$510.00	29.4467	$1,219.09	$687.27
29892	Ankle arthroscopy/surgery	Y		A2	$510.00	29.4467	$1,219.09	$687.27
29893	Scope, plantar fasciotomy	Y		A2	$1,255.56	21.1762	$876.69	$1,160.84
29894	Ankle arthroscopy/surgery	Y		A2	$510.00	29.4467	$1,219.09	$687.27
29895	Ankle arthroscopy/surgery	Y		A2	$510.00	29.4467	$1,219.09	$687.27
29897	Ankle arthroscopy/surgery	Y		A2	$510.00	29.4467	$1,219.09	$687.27
29898	Ankle arthroscopy/surgery	Y		A2	$510.00	29.4467	$1,219.09	$687.27
29899	Ankle arthroscopy/surgery	Y		A2	$510.00	47.7765	$1,977.95	$876.99
29900	Mcp joint arthroscopy, dx	Y		A2	$510.00	16.8220	$696.43	$556.61
29901	Mcp joint arthroscopy, surg	Y		A2	$510.00	16.8220	$696.43	$556.61
29902	Mcp joint arthroscopy, surg	Y		A2	$510.00	16.8220	$696.43	$556.61
30000	Drainage of nose lesion	Y		P2		2.5765	$106.67	$106.67
30020	Drainage of nose lesion	Y		P2		2.5765	$106.67	$106.67
30100	Intranasal biopsy	Y		P3		1.8469	$76.46	$76.46
30110	Removal of nose polyp(s)	Y		P3		2.9024	$120.16	$120.16
30115	Removal of nose polyp(s)	Y		A2	$446.00	16.6341	$688.65	$506.66
30117	Removal of intranasal lesion	Y		A2	$510.00	16.6341	$688.65	$554.66
30118	Removal of intranasal lesion	Y		A2	$510.00	24.3535	$1,008.23	$634.56
30120	Revision of nose	Y		A2	$333.00	16.6341	$688.65	$421.91
30124	Removal of nose lesion	Y		R2		7.6539	$316.87	$316.87
30125	Removal of nose lesion	Y		A2	$446.00	40.5598	$1,679.18	$754.30
30130	Excise inferior turbinate	Y		A2	$510.00	16.6341	$688.65	$554.66
30140	Resect inferior turbinate	Y		A2	$446.00	24.3535	$1,008.23	$586.56
30150	Partial removal of nose	Y		A2	$510.00	40.5598	$1,679.18	$802.30
30160	Removal of nose	Y		A2	$630.00	40.5598	$1,679.18	$892.30
30200	Injection treatment of nose	Y		P3		1.4841	$61.44	$61.44
30210	Nasal sinus therapy	Y		P3		1.8717	$77.49	$77.49
30220	Insert nasal septal button	Y		A2	$464.15	7.6539	$316.87	$427.33
30300	Remove nasal foreign body	N		P2		0.6416	$26.56	$26.56
30310	Remove nasal foreign body	Y		A2	$333.00	16.6341	$688.65	$421.91
30320	Remove nasal foreign body	Y		A2	$446.00	16.6341	$688.65	$506.66
30400	Reconstruction of nose	Y		A2	$630.00	40.5598	$1,679.18	$892.30
30410	Reconstruction of nose	Y		A2	$717.00	40.5598	$1,679.18	$957.55
30420	Reconstruction of nose	Y		A2	$717.00	40.5598	$1,679.18	$957.55
30430	Revision of nose	Y		A2	$510.00	24.3535	$1,008.23	$634.56
30435	Revision of nose	Y		A2	$717.00	40.5598	$1,679.18	$957.55
30450	Revision of nose	Y		A2	$995.00	40.5598	$1,679.18	$1,166.05
30460	Revision of nose	Y		A2	$995.00	40.5598	$1,679.18	$1,166.05
30462	Revision of nose	Y		A2	$1,339.00	40.5598	$1,679.18	$1,424.05
30465	Repair nasal stenosis	Y		A2	$1,339.00	40.5598	$1,679.18	$1,424.05
30520	Repair of nasal septum	Y		A2	$630.00	24.3535	$1,008.23	$724.56
30540	Repair nasal defect	Y		A2	$717.00	40.5598	$1,679.18	$957.55
30545	Repair nasal defect	Y		A2	$717.00	40.5598	$1,679.18	$957.55
30560	Release of nasal adhesions	Y		A2	$150.72	2.5765	$106.67	$139.71
30580	Repair upper jaw fistula	Y		A2	$630.00	40.5598	$1,679.18	$892.30
30600	Repair mouth/nose fistula	Y		A2	$630.00	40.5598	$1,679.18	$892.30
30620	Intranasal reconstruction	Y		A2	$995.00	40.5598	$1,679.18	$1,166.05
30630	Repair nasal septum defect	Y		A2	$995.00	24.3535	$1,008.23	$998.31
30801	Ablate inf turbinate, superf	Y		A2	$333.00	7.6539	$316.87	$328.97
30802	Cauterization, inner nose	Y		A2	$333.00	7.6539	$316.87	$328.97
30901	Control of nosebleed	Y		P3		1.0720	$44.38	$44.38
30903	Control of nosebleed	Y		A2	$72.48	1.1708	$48.47	$66.48
30905	Control of nosebleed	Y		A2	$72.48	1.1708	$48.47	$66.48
30906	Repeat control of nosebleed	Y		A2	$72.48	1.1708	$48.47	$66.48
30915	Ligation, nasal sinus artery	Y		A2	$446.00	26.4396	$1,094.60	$608.15
30920	Ligation, upper jaw artery	Y		A2	$510.00	26.4396	$1,094.60	$656.15
30930	Ther fx, nasal inf turbinate	Y		A2	$630.00	16.6341	$688.65	$644.66
31000	Irrigation, maxillary sinus	Y		P3		2.4570	$101.72	$101.72
31002	Irrigation, sphenoid sinus	Y		R2		7.6539	$316.87	$316.87
31020	Exploration, maxillary sinus	Y		A2	$446.00	24.3535	$1,008.23	$586.56

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS Code	Short Descriptor	Subject to multiple procedure discounting	Comment indicator	Payment indicator	CY 2007 ASC payment rate	Proposed fully implemented payment weight	Proposed CY 2008 fully implemented payment	Proposed CY 2008 first transition year payment
31030	Exploration, maxillary sinus	Y		A2	$510.00	40.5598	$1,679.18	$802.30
31032	Explore sinus, remove polyps	Y		A2	$630.00	40.5598	$1,679.18	$892.30
31040	Exploration behind upper jaw	Y		R2		24.3535	$1,008.23	$1,008.23
31050	Exploration, sphenoid sinus	Y		A2	$446.00	40.5598	$1,679.18	$754.30
31051	Sphenoid sinus surgery	Y		A2	$630.00	40.5598	$1,679.18	$892.30
31070	Exploration of frontal sinus	Y		A2	$446.00	24.3535	$1,008.23	$586.56
31075	Exploration of frontal sinus	Y		A2	$630.00	40.5598	$1,679.18	$892.30
31080	Removal of frontal sinus	Y		A2	$630.00	40.5598	$1,679.18	$892.30
31081	Removal of frontal sinus	Y		A2	$630.00	40.5598	$1,679.18	$892.30
31084	Removal of frontal sinus	Y		A2	$630.00	40.5598	$1,679.18	$892.30
31085	Removal of frontal sinus	Y		A2	$630.00	40.5598	$1,679.18	$892.30
31086	Removal of frontal sinus	Y		A2	$630.00	40.5598	$1,679.18	$892.30
31087	Removal of frontal sinus	Y		A2	$630.00	40.5598	$1,679.18	$892.30
31090	Exploration of sinuses	Y		A2	$717.00	40.5598	$1,679.18	$957.55
31200	Removal of ethmoid sinus	Y		A2	$446.00	40.5598	$1,679.18	$754.30
31201	Removal of ethmoid sinus	Y		A2	$717.00	40.5598	$1,679.18	$957.55
31205	Removal of ethmoid sinus	Y		A2	$510.00	40.5598	$1,679.18	$802.30
31231	Nasal endoscopy, dx	Y		P2		1.5730	$65.12	$65.12
31233	Nasal/sinus endoscopy, dx	Y		A2	$86.39	1.5730	$65.12	$81.07
31235	Nasal/sinus endoscopy, dx	Y		A2	$333.00	17.4546	$722.62	$430.41
31237	Nasal/sinus endoscopy, surg	Y		A2	$446.00	17.4546	$722.62	$515.16
31238	Nasal/sinus endoscopy, surg	Y		A2	$333.00	17.4546	$722.62	$430.41
31239	Nasal/sinus endoscopy, surg	Y		A2	$630.00	23.2819	$963.87	$713.47
31240	Nasal/sinus endoscopy, surg	Y		A2	$446.00	17.4546	$722.62	$515.16
31254	Revision of ethmoid sinus	Y		A2	$510.00	23.2819	$963.87	$623.47
31255	Removal of ethmoid sinus	Y		A2	$717.00	23.2819	$963.87	$778.72
31256	Exploration maxillary sinus	Y		A2	$510.00	23.2819	$963.87	$623.47
31267	Endoscopy, maxillary sinus	Y		A2	$510.00	23.2819	$963.87	$623.47
31276	Sinus endoscopy, surgical	Y		A2	$510.00	23.2819	$963.87	$623.47
31287	Nasal/sinus endoscopy, surg	Y		A2	$510.00	23.2819	$963.87	$623.47
31288	Nasal/sinus endoscopy, surg	Y		A2	$510.00	23.2819	$963.87	$623.47
31300	Removal of larynx lesion	Y		A2	$717.00	24.3535	$1,008.23	$789.81
31320	Diagnostic incision, larynx	Y		A2	$446.00	40.5598	$1,679.18	$754.30
31400	Revision of larynx	Y		A2	$446.00	40.5598	$1,679.18	$754.30
31420	Removal of epiglottis	Y		A2	$446.00	40.5598	$1,679.18	$754.30
31500	Insert emergency airway	N		G2		2.5547	$105.76	$105.76
31502	Change of windpipe airway	N	CH	G2		1.3636	$56.45	$56.45
31505	Diagnostic laryngoscopy	Y		P2		0.8256	$34.18	$34.18
31510	Laryngoscopy with biopsy	Y		A2	$446.00	17.4546	$722.62	$515.16
31511	Remove foreign body, larynx	Y		A2	$86.39	1.5730	$65.12	$81.07
31512	Removal of larynx lesion	Y		A2	$446.00	17.4546	$722.62	$515.16
31513	Injection into vocal cord	Y		A2	$86.39	1.5730	$65.12	$81.07
31515	Laryngoscopy for aspiration	Y		A2	$333.00	17.4546	$722.62	$430.41
31520	Dx laryngoscopy, newborn	Y		G2		1.5730	$65.12	$65.12
31525	Dx laryngoscopy excl nb	Y		A2	$333.00	17.4546	$722.62	$430.41
31526	Dx laryngoscopy w/oper scope	Y		A2	$446.00	23.2819	$963.87	$575.47
31527	Laryngoscopy for treatment	Y		A2	$333.00	23.2819	$963.87	$490.72
31528	Laryngoscopy and dilation	Y		A2	$446.00	17.4546	$722.62	$515.16
31529	Laryngoscopy and dilation	Y		A2	$446.00	17.4546	$722.62	$515.16
31530	Laryngoscopy w/fb removal	Y		A2	$446.00	23.2819	$963.87	$575.47
31531	Laryngoscopy w/fb & op scope	Y		A2	$510.00	23.2819	$963.87	$623.47
31535	Laryngoscopy w/biopsy	Y		A2	$446.00	23.2819	$963.87	$575.47
31536	Laryngoscopy w/bx & op scope	Y		A2	$510.00	23.2819	$963.87	$623.47
31540	Laryngoscopy w/exc of tumor	Y		A2	$510.00	23.2819	$963.87	$623.47
31541	Larynscop w/tumr exc + scope	Y		A2	$630.00	23.2819	$963.87	$713.47
31545	Remove vc lesion w/scope	Y		A2	$630.00	23.2819	$963.87	$713.47
31546	Remove vc lesion scope/graft	Y		A2	$630.00	23.2819	$963.87	$713.47
31560	Laryngoscop w/arytenoidectom	Y		A2	$717.00	23.2819	$963.87	$778.72
31561	Larynscop, remve cart + scop	Y		A2	$717.00	23.2819	$963.87	$778.72
31570	Laryngoscope w/vc inj	Y		A2	$446.00	17.4546	$722.62	$515.16
31571	Laryngoscop w/vc inj + scope	Y		A2	$446.00	23.2819	$963.87	$575.47
31575	Diagnostic laryngoscopy	Y		P3		1.4676	$60.76	$60.76
31576	Laryngoscopy with biopsy	Y		A2	$446.00	23.2819	$963.87	$575.47
31577	Remove foreign body, larynx	Y		A2	$236.42	4.2060	$174.13	$220.85
31578	Removal of larynx lesion	Y		A2	$446.00	23.2819	$963.87	$575.47
31579	Diagnostic laryngoscopy	Y		P3		2.7126	$112.30	$112.30
31580	Revision of larynx	Y		A2	$717.00	40.5598	$1,679.18	$957.55
31582	Revision of larynx	Y		A2	$717.00	40.5598	$1,679.18	$957.55
31588	Revision of larynx	Y		A2	$717.00	40.5598	$1,679.18	$957.55
31590	Reinnervate larynx	Y		A2	$717.00	40.5598	$1,679.18	$957.55
31595	Larynx nerve surgery	Y		A2	$446.00	40.5598	$1,679.18	$754.30
31603	Incision of windpipe	Y		A2	$333.00	7.6539	$316.87	$328.97
31605	Incision of windpipe	Y		G2		7.6539	$316.87	$316.87
31611	Surgery/speech prosthesis	Y		A2	$510.00	24.3535	$1,008.23	$634.56
31612	Puncture/clear windpipe	Y		A2	$333.00	24.3535	$1,008.23	$501.81
31613	Repair windpipe opening	Y		A2	$446.00	24.3535	$1,008.23	$586.56

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS Code	Short Descriptor	Subject to multiple procedure discounting	Comment indicator	Payment indicator	CY 2007 ASC payment rate	Proposed fully implemented payment weight	Proposed CY 2008 fully implemented payment	Proposed CY 2008 first transition year payment
31614	Repair windpipe opening	Y		A2	$446.00	40.5598	$1,679.18	$754.30
31615	Visualization of windpipe	Y		A2	$333.00	10.1732	$421.17	$355.04
31620	Endobronchial us add-on	N	CH	N1	$333.00			
31622	Dx bronchoscope/wash	Y		A2	$333.00	10.1732	$421.17	$355.04
31623	Dx bronchoscope/brush	Y		A2	$446.00	10.1732	$421.17	$439.79
31624	Dx bronchoscope/lavage	Y		A2	$446.00	10.1732	$421.17	$439.79
31625	Bronchoscopy w/biopsy(s)	Y		A2	$446.00	10.1732	$421.17	$439.79
31628	Bronchoscopy/lung bx, each	Y		A2	$446.00	10.1732	$421.17	$439.79
31629	Bronchoscopy/needle bx, each	Y		A2	$446.00	10.1732	$421.17	$439.79
31630	Bronchoscopy dilate/fx repr	Y		A2	$446.00	24.2882	$1,005.53	$585.88
31631	Bronchoscopy, dilate w/stent	Y		A2	$446.00	24.2882	$1,005.53	$585.88
31632	Bronchoscopy/lung bx, add'l	Y		G2		10.1732	$421.17	$421.17
31633	Bronchoscopy/needle bx add'l	Y		G2		10.1732	$421.17	$421.17
31635	Bronchoscopy w/fb removal	Y		A2	$446.00	10.1732	$421.17	$439.79
31636	Bronchoscopy, bronch stents	Y		A2	$446.00	24.2882	$1,005.53	$585.88
31637	Bronchoscopy, stent add-on	Y		A2	$333.00	10.1732	$421.17	$355.04
31638	Bronchoscopy, revise stent	Y		A2	$446.00	24.2882	$1,005.53	$585.88
31640	Bronchoscopy w/tumor excise	Y		A2	$446.00	24.2882	$1,005.53	$585.88
31641	Bronchoscopy, treat blockage	Y		A2	$446.00	24.2882	$1,005.53	$585.88
31643	Diag bronchoscope/catheter	Y		A2	$446.00	10.1732	$421.17	$439.79
31645	Bronchoscopy, clear airways	Y		A2	$333.00	10.1732	$421.17	$355.04
31646	Bronchoscopy, reclear airway	Y		A2	$333.00	10.1732	$421.17	$355.04
31656	Bronchoscopy, inj for x-ray	Y		A2	$333.00	10.1732	$421.17	$355.04
31715	Injection for bronchus x-ray	N		N1				
31717	Bronchial brush biopsy	Y		A2	$236.42	4.2060	$174.13	$220.85
31720	Clearance of airways	N	CH	A2	$47.32	0.3904	$16.16	$39.53
31730	Intro, windpipe wire/tube	Y		A2	$236.42	4.2060	$174.13	$220.85
31750	Repair of windpipe	Y		A2	$717.00	40.5598	$1,679.18	$957.55
31755	Repair of windpipe	Y		A2	$446.00	40.5598	$1,679.18	$754.30
31820	Closure of windpipe lesion	Y		A2	$333.00	16.6341	$688.65	$421.91
31825	Repair of windpipe defect	Y		A2	$446.00	24.3535	$1,008.23	$586.56
31830	Revise windpipe scar	Y		A2	$446.00	24.3535	$1,008.23	$586.56
32000	Drainage of chest	Y		A2	$222.78	5.3095	$219.81	$222.04
32002	Treatment of collapsed lung	Y		G2		5.3095	$219.81	$219.81
32019	Insert pleural catheter	Y		G2		31.7598	$1,314.86	$1,314.86
32400	Needle biopsy chest lining	Y		A2	$333.00	9.5741	$396.37	$348.84
32405	Biopsy, lung or mediastinum	Y		A2	$333.00	9.5741	$396.37	$348.84
32420	Puncture/clear lung	Y		A2	$222.78	5.3095	$219.81	$222.04
32960	Therapeutic pneumothorax	Y		G2		5.3095	$219.81	$219.81
33010	Drainage of heart sac	Y		A2	$222.78	5.3095	$219.81	$222.04
33011	Repeat drainage of heart sac	Y		A2	$222.78	5.3095	$219.81	$222.04
33206	Insertion of heart pacemaker	Y		J8		171.4188	$7,096.74	$7,096.74
33207	Insertion of heart pacemaker	Y		J8		171.4188	$7,096.74	$7,096.74
33208	Insertion of heart pacemaker	Y		J8		202.2251	$8,372.12	$8,372.12
33210	Insertion of heart electrode	Y	CH	J8		98.1097	$4,061.74	$4,061.74
33211	Insertion of heart electrode	Y	CH	J8		98.1097	$4,061.74	$4,061.74
33212	Insertion of pulse generator	Y		H8	$510.00	140.4331	$5,813.93	$5,438.26
33213	Insertion of pulse generator	Y		H8	$510.00	150.5751	$6,233.81	$5,815.00
33214	Upgrade of pacemaker system	Y		J8		202.2251	$8,372.12	$8,372.12
33215	Reposition pacing-defib lead	Y		G2		24.7274	$1,023.71	$1,023.71
33216	Insert lead pace-defib, one	Y	CH	J8		98.1097	$4,061.74	$4,061.74
33217	Insert lead pace-defib, dual	Y	CH	J8		98.1097	$4,061.74	$4,061.74
33218	Repair lead pace-defib, one	Y		G2		24.7274	$1,023.71	$1,023.71
33220	Repair lead pace-defib, dual	Y		G2		24.7274	$1,023.71	$1,023.71
33222	Revise pocket, pacemaker	Y		A2	$446.00	15.4399	$639.21	$494.30
33223	Revise pocket, pacing-defib	Y		A2	$446.00	15.4399	$639.21	$494.30
33224	Insert pacing lead & connect	Y		J8		360.3278	$14,917.57	$14,917.57
33225	Lventric pacing lead add-on	Y		J8		360.3278	$14,917.57	$14,917.57
33226	Reposition l ventric lead	Y		G2		24.7274	$1,023.71	$1,023.71
33233	Removal of pacemaker system	Y		A2	$446.00	24.7274	$1,023.71	$590.43
33234	Removal of pacemaker system	Y		G2		24.7274	$1,023.71	$1,023.71
33235	Removal pacemaker electrode	Y		G2		24.7274	$1,023.71	$1,023.71
33240	Insert pulse generator	Y	CH	J8		523.1751	$21,659.45	$21,659.45
33241	Remove pulse generator	Y		G2		24.7274	$1,023.71	$1,023.71
33249	Eltrd/insert pace-defib	Y	CH	J8		596.7345	$24,704.81	$24,704.81
33282	Implant pat-active ht record	N		J8		99.4780	$4,118.39	$4,118.39
33284	Remove pat-active ht record	Y		G2		6.1077	$252.86	$252.86
33508	Endoscopic vein harvest	N		N1				
35188	Repair blood vessel lesion	Y		A2	$630.00	39.8001	$1,647.72	$884.43
35207	Repair blood vessel lesion	Y		A2	$630.00	39.8001	$1,647.72	$884.43
35473	Repair arterial blockage	Y		G2		46.0685	$1,907.24	$1,907.24
35474	Repair arterial blockage	Y		G2		46.0685	$1,907.24	$1,907.24
35476	Repair venous blockage	Y		G2		46.0685	$1,907.24	$1,907.24
35492	Atherectomy, percutaneous	Y		G2		88.7717	$3,675.15	$3,675.15
35572	Harvest femoropopliteal vein	N		N1				
35761	Exploration of artery/vein	Y		G2		30.5379	$1,264.27	$1,264.27

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS Code	Short Descriptor	Subject to multiple procedure discounting	Comment indicator	Payment indicator	CY 2007 ASC payment rate	Proposed fully implemented payment weight	Proposed CY 2008 fully implemented payment	Proposed CY 2008 first transition year payment
35875	Removal of clot in graft	Y		A2	$1,339.00	39.8001	$1,647.72	$1,416.18
35876	Removal of clot in graft	Y		A2	$1,339.00	39.8001	$1,647.72	$1,416.18
36000	Place needle in vein	N		N1				
36002	Pseudoaneurysm injection trt	N		G2		2.4859	$102.92	$102.92
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				
36145	Artery to vein shunt	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	$510.00	29.3210	$1,213.89	$685.97
36261	Revision of infusion pump	Y		A2	$446.00	29.3210	$1,213.89	$637.97
36262	Removal of infusion pump	Y		A2	$333.00	24.5273	$1,015.43	$503.61
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	Y		G2		0.2091	$8.66	$8.66
36425	Vein access cutdown > 1 yr	Y		R2		0.2091	$8.66	$8.66
36430	Blood transfusion service	N		P3		0.7998	$33.11	$33.11
36440	Bl push transfuse, 2 yr or <	N		R2		3.4924	$144.59	$144.59
36450	Bl exchange/transfuse, nb	N		R2		3.4924	$144.59	$144.59
36468	Injection(s), spider veins	Y		R2		0.8046	$33.31	$33.31
36469	Injection(s), spider veins	Y	CH	R2		0.8046	$33.31	$33.31
36470	Injection therapy of vein	Y		P2		0.8046	$33.31	$33.31
36471	Injection therapy of veins	Y		P2		0.8046	$33.31	$33.31
36475	Endovenous rf, 1st vein	Y		A2	$1,339.00	43.6609	$1,807.56	$1,456.14
36476	Endovenous rf, vein add-on	Y		A2	$1,339.00	26.4396	$1,094.60	$1,277.90
36478	Endovenous laser, 1st vein	Y		A2	$1,339.00	26.4396	$1,094.60	$1,277.90
36479	Endovenous laser vein addon	Y		A2	$1,339.00	26.4396	$1,094.60	$1,277.90
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		12.1982	$505.01	$505.01
36512	Apheresis rbc	N		G2		12.1982	$505.01	$505.01
36513	Apheresis platelets	N		G2		12.1982	$505.01	$505.01
36514	Apheresis plasma	N		G2		12.1982	$505.01	$505.01
36515	Apheresis, adsorp/reinfuse	N		G2		31.9648	$1,323.34	$1,323.34
36516	Apheresis, selective	N		G2		31.9648	$1,323.34	$1,323.34
36522	Photopheresis	N		G2		31.9648	$1,323.34	$1,323.34
36540	Collect blood venous device	N		N1				
36550	Declot vascular device	Y		P3		0.2886	$11.95	$11.95
36555	Insert non-tunnel cv cath	Y		A2	$333.00	11.0043	$455.58	$363.65
36556	Insert non-tunnel cv cath	Y		A2	$333.00	11.0043	$455.58	$363.65
36557	Insert tunneled cv cath	Y		A2	$446.00	24.5273	$1,015.43	$588.36
36558	Insert tunneled cv cath	Y		A2	$446.00	24.5273	$1,015.43	$588.36
36560	Insert tunneled cv cath	Y		A2	$510.00	29.3210	$1,213.89	$685.97
36561	Insert tunneled cv cath	Y		A2	$510.00	29.3210	$1,213.89	$685.97
36563	Insert tunneled cv cath	Y		A2	$510.00	29.3210	$1,213.89	$685.97
36565	Insert tunneled cv cath	Y		A2	$510.00	29.3210	$1,213.89	$685.97
36566	Insert tunneled cv cath	Y		H8	$510.00	116.7686	$4,834.22	$4,203.51
36568	Insert picc cath	Y		A2	$333.00	11.0043	$455.58	$363.65
36569	Insert picc cath	Y		A2	$333.00	11.0043	$455.58	$363.65
36570	Insert picvad cath	Y		A2	$510.00	24.5273	$1,015.43	$636.36
36571	Insert picvad cath	Y		A2	$510.00	24.5273	$1,015.43	$636.36
36575	Repair tunneled cv cath	Y		A2	$446.00	6.1077	$252.86	$397.72
36576	Repair tunneled cv cath	Y		A2	$446.00	11.0043	$455.58	$448.40
36578	Replace tunneled cv cath	Y		A2	$446.00	24.5273	$1,015.43	$588.36
36580	Replace cvad cath	Y		A2	$333.00	11.0043	$455.58	$363.65
36581	Replace tunneled cv cath	Y		A2	$446.00	24.5273	$1,015.43	$588.36

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS Code	Short Descriptor	Subject to multiple procedure discounting	Comment indicator	Payment indicator	CY 2007 ASC payment rate	Proposed fully implemented payment weight	Proposed CY 2008 fully implemented payment	Proposed CY 2008 first transition year payment
36582	Replace tunneled cv cath	Y		A2	$510.00	29.3210	$1,213.89	$685.97
36583	Replace tunneled cv cath	Y		A2	$510.00	29.3210	$1,213.89	$685.97
36584	Replace picc cath	Y		A2	$333.00	11.0043	$455.58	$363.65
36585	Replace picvad cath	Y		A2	$510.00	24.5273	$1,015.43	$636.36
36589	Removal tunneled cv cath	Y		A2	$333.00	6.1077	$252.86	$312.97
36590	Removal tunneled cv cath	Y		A2	$333.00	11.0043	$455.58	$363.65
36595	Mech remov tunneled cv cath	Y		G2		24.5273	$1,015.43	$1,015.43
36596	Mech remov tunneled cv cath	Y		G2		11.0043	$455.58	$455.58
36597	Reposition venous catheter	Y		G2		11.0043	$455.58	$455.58
36598	Inj w/fluor, eval cv device	Y	CH	P3		1.9872	$82.27	$82.27
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	$333.00	29.3210	$1,213.89	$553.22
36680	Insert needle, bone cavity	Y		G2		1.1915	$49.33	$49.33
36800	Insertion of cannula	Y		A2	$510.00	30.5379	$1,264.27	$698.57
36810	Insertion of cannula	Y		A2	$510.00	30.5379	$1,264.27	$698.57
36815	Insertion of cannula	Y		A2	$510.00	30.5379	$1,264.27	$698.57
36818	Av fuse, uppr arm, cephalic	Y		A2	$510.00	39.8001	$1,647.72	$794.43
36819	Av fuse, uppr arm, basilic	Y		A2	$510.00	39.8001	$1,647.72	$794.43
36820	Av fusion/forearm vein	Y		A2	$510.00	39.8001	$1,647.72	$794.43
36821	Av fusion direct any site	Y		A2	$510.00	39.8001	$1,647.72	$794.43
36825	Artery-vein autograft	Y		A2	$630.00	39.8001	$1,647.72	$884.43
36830	Artery-vein nonautograft	Y		A2	$630.00	39.8001	$1,647.72	$884.43
36831	Open thrombect av fistula	Y		A2	$1,339.00	39.8001	$1,647.72	$1,416.18
36832	Av fistula revision, open	Y		A2	$630.00	39.8001	$1,647.72	$884.43
36833	Av fistula revision	Y		A2	$630.00	39.8001	$1,647.72	$884.43
36834	Repair A-V aneurysm	Y		A2	$510.00	39.8001	$1,647.72	$794.43
36835	Artery to vein shunt	Y		A2	$630.00	30.5379	$1,264.27	$788.57
36860	External cannula declotting	Y		A2	$127.40	2.5179	$104.24	$121.61
36861	Cannula declotting	Y		A2	$510.00	30.5379	$1,264.27	$698.57
36870	Percut thrombect av fistula	Y		A2	$1,339.00	41.0875	$1,701.02	$1,429.51
37184	Prim art mech thrombectomy	Y		G2		39.8001	$1,647.72	$1,647.72
37185	Prim art m-thrombect add-on	Y		G2		39.8001	$1,647.72	$1,647.72
37186	Sec art m-thrombect add-on	Y		G2		39.8001	$1,647.72	$1,647.72
37187	Venous mech thrombectomy	Y		G2		39.8001	$1,647.72	$1,647.72
37188	Venous m-thrombectomy add-on	Y		G2		39.8001	$1,647.72	$1,647.72
37200	Transcatheter biopsy	Y		G2		29.3210	$1,213.89	$1,213.89
37203	Transcatheter retrieval	Y		G2		29.3210	$1,213.89	$1,213.89
37250	Iv us first vessel add-on	N	CH	N1				
37251	Iv us each add vessel add-on	N	CH	N1				
37500	Endoscopy ligate perf veins	Y		A2	$510.00	43.6609	$1,807.56	$834.39
37607	Ligation of a-v fistula	Y		A2	$510.00	26.4396	$1,094.60	$656.15
37609	Temporal artery procedure	Y		A2	$446.00	16.5832	$686.54	$506.14
37650	Revision of major vein	Y		A2	$446.00	26.4396	$1,094.60	$608.15
37700	Revise leg vein	Y		A2	$446.00	26.4396	$1,094.60	$608.15
37718	Ligate/strip short leg vein	Y		A2	$510.00	26.4396	$1,094.60	$656.15
37722	Ligate/strip long leg vein	Y		A2	$510.00	43.6609	$1,807.56	$834.39
37735	Removal of leg veins/lesion	Y		A2	$510.00	43.6609	$1,807.56	$834.39
37760	Ligation, leg veins, open	Y		A2	$510.00	26.4396	$1,094.60	$656.15
37765	Phleb veins—extrem—to 20	Y		R2		26.4396	$1,094.60	$1,094.60
37766	Phleb veins—extrem 20+	Y		R2		26.4396	$1,094.60	$1,094.60
37780	Revision of leg vein	Y		A2	$510.00	26.4396	$1,094.60	$656.15
37785	Ligate/divide/excise vein	Y		A2	$510.00	26.4396	$1,094.60	$656.15
37790	Penile venous occlusion	Y		A2	$510.00	35.1574	$1,455.52	$746.38
38200	Injection for spleen x-ray	N		N1				
38204	Bl donor search management	N		N1				
38205	Harvest allogenic stem cells	N		G2		12.1982	$505.01	$505.01
38206	Harvest auto stem cells	N		G2		12.1982	$505.01	$505.01
38220	Bone marrow aspiration	Y	CH	P3		2.6302	$108.89	$108.89
38221	Bone marrow biopsy	Y	CH	P3		2.7621	$114.35	$114.35
38230	Bone marrow collection	N		G2		31.9648	$1,323.34	$1,323.34
38241	Bone marrow/stem transplant	N		G2		31.9648	$1,323.34	$1,323.34
38242	Lymphocyte infuse transplant	N		R2		12.1982	$505.01	$505.01
38300	Drainage, lymph node lesion	Y		A2	$333.00	12.5792	$520.78	$379.95
38305	Drainage, lymph node lesion	Y		A2	$446.00	19.0457	$788.49	$531.62
38308	Incision of lymph channels	Y		A2	$446.00	23.5105	$973.33	$577.83
38500	Biopsy/removal, lymph nodes	Y		A2	$446.00	23.5105	$973.33	$577.83
38505	Needle biopsy, lymph nodes	Y		A2	$240.00	7.3012	$302.27	$255.57
38510	Biopsy/removal, lymph nodes	Y		A2	$446.00	23.5105	$973.33	$577.83
38520	Biopsy/removal, lymph nodes	Y		A2	$446.00	23.5105	$973.33	$577.83
38525	Biopsy/removal, lymph nodes	Y		A2	$446.00	23.5105	$973.33	$577.83
38530	Biopsy/removal, lymph nodes	Y		A2	$446.00	23.5105	$973.33	$577.83
38542	Explore deep node(s), neck	Y		A2	$446.00	45.1729	$1,870.16	$802.04
38550	Removal, neck/armpit lesion	Y		A2	$510.00	23.5105	$973.33	$625.83
38555	Removal, neck/armpit lesion	Y		A2	$630.00	23.5105	$973.33	$715.83

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS Code	Short Descriptor	Subject to multiple procedure discounting	Comment indicator	Payment indicator	CY 2007 ASC payment rate	Proposed fully implemented payment weight	Proposed CY 2008 fully implemented payment	Proposed CY 2008 first transition year payment
38570	Laparoscopy, lymph node biop	Y		A2	$1,339.00	46.1201	$1,909.37	$1,481.59
38571	Laparoscopy, lymphadenectomy	Y		A2	$1,339.00	71.0022	$2,939.49	$1,739.12
38572	Laparoscopy, lymphadenectomy	Y		A2	$1,339.00	46.1201	$1,909.37	$1,481.59
38700	Removal of lymph nodes, neck	Y		G2		23.5105	$973.33	$973.33
38740	Remove armpit lymph nodes	Y		A2	$446.00	45.1729	$1,870.16	$802.04
38745	Remove armpit lymph nodes	Y		A2	$630.00	45.1729	$1,870.16	$940.04
38760	Remove groin lymph nodes	Y		A2	$446.00	23.5105	$973.33	$577.83
38790	Inject for lymphatic x-ray	N		N1				
38792	Identify sentinel node	N		N1				
38794	Access thoracic lymph duct	N		N1				
40490	Biopsy of lip	Y		P3		1.5336	$63.49	$63.49
40500	Partial excision of lip	Y		A2	$446.00	16.6341	$688.65	$506.66
40510	Partial excision of lip	Y		A2	$446.00	24.3535	$1,008.23	$586.56
40520	Partial excision of lip	Y		A2	$446.00	16.6341	$688.65	$506.66
40525	Reconstruct lip with flap	Y		A2	$446.00	24.3535	$1,008.23	$586.56
40527	Reconstruct lip with flap	Y		A2	$446.00	24.3535	$1,008.23	$586.56
40530	Partial removal of lip	Y		A2	$446.00	24.3535	$1,008.23	$586.56
40650	Repair lip	Y		A2	$464.15	7.6539	$316.87	$427.33
40652	Repair lip	Y		A2	$464.15	7.6539	$316.87	$427.33
40654	Repair lip	Y		A2	$464.15	7.6539	$316.87	$427.33
40700	Repair cleft lip/nasal	Y		A2	$995.00	40.5598	$1,679.18	$1,166.05
40701	Repair cleft lip/nasal	Y		A2	$995.00	40.5598	$1,679.18	$1,166.05
40702	Repair cleft lip/nasal	Y		R2		40.5598	$1,679.18	$1,679.18
40720	Repair cleft lip/nasal	Y		A2	$995.00	40.5598	$1,679.18	$1,166.05
40761	Repair cleft lip/nasal	Y		A2	$510.00	40.5598	$1,679.18	$802.30
40800	Drainage of mouth lesion	Y		P2		1.4630	$60.57	$60.57
40801	Drainage of mouth lesion	Y		A2	$446.00	7.6539	$316.87	$413.72
40804	Removal, foreign body, mouth	N		P2		0.6416	$26.56	$26.56
40805	Removal, foreign body, mouth	Y		P3		3.9495	$163.51	$163.51
40806	Incision of lip fold	Y		P3		1.7481	$72.37	$72.37
40808	Biopsy of mouth lesion	Y		P3		2.5643	$106.16	$106.16
40810	Excision of mouth lesion	Y		P3		2.6879	$111.28	$111.28
40812	Excise/repair mouth lesion	Y		P3		3.4053	$140.98	$140.98
40814	Excise/repair mouth lesion	Y		A2	$446.00	16.6341	$688.65	$506.66
40816	Excision of mouth lesion	Y		A2	$446.00	24.3535	$1,008.23	$586.56
40818	Excise oral mucosa for graft	Y		A2	$150.72	2.5765	$106.67	$139.71
40819	Excise lip or cheek fold	Y		A2	$333.00	7.6539	$316.87	$328.97
40820	Treatment of mouth lesion	Y		P3		3.7763	$156.34	$156.34
40830	Repair mouth laceration	Y		G2		2.5765	$106.67	$106.67
40831	Repair mouth laceration	Y		A2	$333.00	7.6539	$316.87	$328.97
40840	Reconstruction of mouth	Y		A2	$446.00	24.3535	$1,008.23	$586.56
40842	Reconstruction of mouth	Y		A2	$510.00	24.3535	$1,008.23	$634.56
40843	Reconstruction of mouth	Y		A2	$510.00	24.3535	$1,008.23	$634.56
40844	Reconstruction of mouth	Y		A2	$717.00	40.5598	$1,679.18	$957.55
40845	Reconstruction of mouth	Y		A2	$717.00	40.5598	$1,679.18	$957.55
41000	Drainage of mouth lesion	Y		P3		1.9954	$82.61	$82.61
41005	Drainage of mouth lesion	Y		A2	$150.72	2.5765	$106.67	$139.71
41006	Drainage of mouth lesion	Y		A2	$333.00	24.3535	$1,008.23	$501.81
41007	Drainage of mouth lesion	Y		A2	$333.00	16.6341	$688.65	$421.91
41008	Drainage of mouth lesion	Y		A2	$333.00	16.6341	$688.65	$421.91
41009	Drainage of mouth lesion	Y		A2	$150.72	2.5765	$106.67	$139.71
41010	Incision of tongue fold	Y		A2	$333.00	7.6539	$316.87	$328.97
41015	Drainage of mouth lesion	Y		A2	$150.72	2.5765	$106.67	$139.71
41016	Drainage of mouth lesion	Y		A2	$333.00	7.6539	$316.87	$328.97
41017	Drainage of mouth lesion	Y		A2	$333.00	7.6539	$316.87	$328.97
41018	Drainage of mouth lesion	Y		A2	$333.00	7.6539	$316.87	$328.97
41100	Biopsy of tongue	Y		P3		2.0860	$86.36	$86.36
41105	Biopsy of tongue	Y		P3		2.0365	$84.31	$84.31
41108	Biopsy of floor of mouth	Y		P3		1.8717	$77.49	$77.49
41110	Excision of tongue lesion	Y		P3		2.7043	$111.96	$111.96
41112	Excision of tongue lesion	Y		A2	$446.00	16.6341	$688.65	$506.66
41113	Excision of tongue lesion	Y		A2	$446.00	16.6341	$688.65	$506.66
41114	Excision of tongue lesion	Y		A2	$446.00	24.3535	$1,008.23	$586.56
41115	Excision of tongue fold	Y		P3		3.0920	$128.01	$128.01
41116	Excision of mouth lesion	Y		A2	$333.00	16.6341	$688.65	$421.91
41120	Partial removal of tongue	Y		A2	$717.00	24.3535	$1,008.23	$789.81
41250	Repair tongue laceration	Y		A2	$150.72	2.5765	$106.67	$139.71
41251	Repair tongue laceration	Y		A2	$150.72	2.5765	$106.67	$139.71
41252	Repair tongue laceration	Y		A2	$446.00	7.6539	$316.87	$413.72
41500	Fixation of tongue	Y		A2	$333.00	24.3535	$1,008.23	$501.81
41510	Tongue to lip surgery	Y		A2	$333.00	16.6341	$688.65	$421.91
41520	Reconstruction, tongue fold	Y		A2	$446.00	7.6539	$316.87	$413.72
41800	Drainage of gum lesion	Y		A2	$88.46	1.4630	$60.57	$81.49
41805	Removal foreign body, gum	Y		P3		3.0176	$124.93	$124.93
41806	Removal foreign body, jawbone	Y		P3		3.8836	$160.78	$160.78
41820	Excision, gum, each quadrant	Y		R2		7.6539	$316.87	$316.87

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS Code	Short Descriptor	Subject to multiple procedure discounting	Comment indicator	Payment indicator	CY 2007 ASC payment rate	Proposed fully implemented payment weight	Proposed CY 2008 fully implemented payment	Proposed CY 2008 first transition year payment
41821	Excision of gum flap	Y		G2		7.6539	$316.87	$316.87
41822	Excision of gum lesion	Y		P3		3.5618	$147.46	$147.46
41823	Excision of gum lesion	Y		P3		4.9471	$204.81	$204.81
41825	Excision of gum lesion	Y		P3		2.7703	$114.69	$114.69
41826	Excision of gum lesion	Y		P3		3.1002	$128.35	$128.35
41827	Excision of gum lesion	Y		A2	$446.00	24.3535	$1,008.23	$586.56
41828	Excision of gum lesion	Y		P3		3.2568	$134.83	$134.83
41830	Removal of gum tissue	Y		P3		4.5184	$187.06	$187.06
41850	Treatment of gum lesion	Y		R2		16.6341	$688.65	$688.65
41870	Gum graft	Y		G2		24.3535	$1,008.23	$1,008.23
41872	Repair gum	Y		P3		4.5348	$187.74	$187.74
41874	Repair tooth socket	Y		P3		4.3452	$179.89	$179.89
42000	Drainage mouth roof lesion	Y		A2	$150.72	2.5765	$106.67	$139.71
42100	Biopsy roof of mouth	Y		P3		1.7809	$73.73	$73.73
42104	Excision lesion, mouth roof	Y		P3		2.4983	$103.43	$103.43
42106	Excision lesion, mouth roof	Y		P3		3.1580	$130.74	$130.74
42107	Excision lesion, mouth roof	Y		A2	$446.00	24.3535	$1,008.23	$586.56
42120	Remove palate/lesion	Y		A2	$630.00	40.5598	$1,679.18	$892.30
42140	Excision of uvula	Y		A2	$446.00	7.6539	$316.87	$413.72
42145	Repair palate, pharynx/uvula	Y		A2	$717.00	24.3535	$1,008.23	$789.81
42160	Treatment mouth roof lesion	Y		P3		3.2899	$136.20	$136.20
42180	Repair palate	Y		A2	$150.72	2.5765	$106.67	$139.71
42182	Repair palate	Y		A2	$446.00	40.5598	$1,679.18	$754.30
42200	Reconstruct cleft palate	Y		A2	$717.00	40.5598	$1,679.18	$957.55
42205	Reconstruct cleft palate	Y		A2	$717.00	40.5598	$1,679.18	$957.55
42210	Reconstruct cleft palate	Y		A2	$717.00	40.5598	$1,679.18	$957.55
42215	Reconstruct cleft palate	Y		A2	$995.00	40.5598	$1,679.18	$1,166.05
42220	Reconstruct cleft palate	Y		A2	$717.00	40.5598	$1,679.18	$957.55
42226	Lengthening of palate	Y		A2	$717.00	40.5598	$1,679.18	$957.55
42235	Repair palate	Y		A2	$717.00	16.6341	$688.65	$709.91
42260	Repair nose to lip fistula	Y		A2	$630.00	24.3535	$1,008.23	$724.56
42280	Preparation, palate mold	Y		P3		1.7314	$71.68	$71.68
42281	Insertion, palate prosthesis	Y		G2		16.6341	$688.65	$688.65
42300	Drainage of salivary gland	Y		A2	$333.00	16.6341	$688.65	$421.91
42305	Drainage of salivary gland	Y		A2	$446.00	16.6341	$688.65	$506.66
42310	Drainage of salivary gland	Y		A2	$150.72	2.5765	$106.67	$139.71
42320	Drainage of salivary gland	Y		A2	$150.72	2.5765	$106.67	$139.71
42330	Removal of salivary stone	Y		P3		2.6715	$110.60	$110.60
42335	Removal of salivary stone	Y		P3		4.3534	$180.23	$180.23
42340	Removal of salivary stone	Y		A2	$446.00	16.6341	$688.65	$506.66
42400	Biopsy of salivary gland	Y		P3		1.4841	$61.44	$61.44
42405	Biopsy of salivary gland	Y		A2	$446.00	16.6341	$688.65	$506.66
42408	Excision of salivary cyst	Y		A2	$510.00	16.6341	$688.65	$554.66
42409	Drainage of salivary cyst	Y		A2	$510.00	16.6341	$688.65	$554.66
42410	Excise parotid gland/lesion	Y		A2	$510.00	40.5598	$1,679.18	$802.30
42415	Excise parotid gland/lesion	Y		A2	$995.00	40.5598	$1,679.18	$1,166.05
42420	Excise parotid gland/lesion	Y		A2	$995.00	40.5598	$1,679.18	$1,166.05
42425	Excise parotid gland/lesion	Y		A2	$995.00	40.5598	$1,679.18	$1,166.05
42440	Excise submaxillary gland	Y		A2	$510.00	40.5598	$1,679.18	$802.30
42450	Excise sublingual gland	Y		A2	$446.00	24.3535	$1,008.23	$586.56
42500	Repair salivary duct	Y		A2	$510.00	24.3535	$1,008.23	$634.56
42505	Repair salivary duct	Y		A2	$630.00	40.5598	$1,679.18	$892.30
42507	Parotid duct diversion	Y		A2	$510.00	40.5598	$1,679.18	$802.30
42508	Parotid duct diversion	Y		A2	$630.00	40.5598	$1,679.18	$892.30
42509	Parotid duct diversion	Y		A2	$630.00	40.5598	$1,679.18	$892.30
42510	Parotid duct diversion	Y		A2	$630.00	40.5598	$1,679.18	$892.30
42550	Injection for salivary x-ray	N		N1				
42600	Closure of salivary fistula	Y		A2	$333.00	16.6341	$688.65	$421.91
42650	Dilation of salivary duct	Y		P3		0.9729	$40.28	$40.28
42660	Dilation of salivary duct	Y		P3		1.1543	$47.79	$47.79
42665	Ligation of salivary duct	Y		A2	$995.00	24.3535	$1,008.23	$998.31
42700	Drainage of tonsil abscess	Y		A2	$150.72	2.5765	$106.67	$139.71
42720	Drainage of throat abscess	Y		A2	$333.00	16.6341	$688.65	$421.91
42725	Drainage of throat abscess	Y		A2	$446.00	40.5598	$1,679.18	$754.30
42800	Biopsy of throat	Y		P3		1.8882	$78.17	$78.17
42802	Biopsy of throat	Y		A2	$333.00	16.6341	$688.65	$421.91
42804	Biopsy of upper nose/throat	Y		A2	$333.00	16.6341	$688.65	$421.91
42806	Biopsy of upper nose/throat	Y		A2	$446.00	24.3535	$1,008.23	$586.56
42808	Excise pharynx lesion	Y		A2	$446.00	16.6341	$688.65	$506.66
42809	Remove pharynx foreign body	N		G2		0.6416	$26.56	$26.56
42810	Excision of neck cyst	Y		A2	$510.00	24.3535	$1,008.23	$634.56
42815	Excision of neck cyst	Y		A2	$717.00	40.5598	$1,679.18	$957.55
42820	Remove tonsils and adenoids	Y		A2	$510.00	22.9075	$948.37	$619.59
42821	Remove tonsils and adenoids	Y		A2	$717.00	22.9075	$948.37	$774.84
42825	Removal of tonsils	Y		A2	$630.00	22.9075	$948.37	$709.59
42826	Removal of tonsils	Y		A2	$630.00	22.9075	$948.37	$709.59

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS Code	Short Descriptor	Subject to multiple procedure discounting	Comment indicator	Payment indicator	CY 2007 ASC payment rate	Proposed fully implemented payment weight	Proposed CY 2008 fully implemented payment	Proposed CY 2008 first transition year payment
42830	Removal of adenoids	Y		A2	$630.00	22.9075	$948.37	$709.59
42831	Removal of adenoids	Y		A2	$630.00	22.9075	$948.37	$709.59
42835	Removal of adenoids	Y		A2	$630.00	22.9075	$948.37	$709.59
42836	Removal of adenoids	Y		A2	$630.00	22.9075	$948.37	$709.59
42860	Excision of tonsil tags	Y		A2	$510.00	22.9075	$948.37	$619.59
42870	Excision of lingual tonsil	Y		A2	$510.00	22.9075	$948.37	$619.59
42890	Partial removal of pharynx	Y		A2	$995.00	40.5598	$1,679.18	$1,166.05
42892	Revision of pharyngeal walls	Y		A2	$995.00	40.5598	$1,679.18	$1,166.05
42900	Repair throat wound	Y		A2	$333.00	7.6539	$316.87	$328.97
42950	Reconstruction of throat	Y		A2	$446.00	24.3535	$1,008.23	$586.56
42955	Surgical opening of throat	Y		A2	$446.00	24.3535	$1,008.23	$586.56
42960	Control throat bleeding	Y		A2	$72.48	1.1708	$48.47	$66.48
42962	Control throat bleeding	Y		A2	$446.00	40.5598	$1,679.18	$754.30
42970	Control nose/throat bleeding	Y		R2		1.1708	$48.47	$48.47
42972	Control nose/throat bleeding	Y		A2	$510.00	16.6341	$688.65	$554.66
43030	Throat muscle surgery	Y		G2		16.6341	$688.65	$688.65
43200	Esophagus endoscopy	Y		A2	$333.00	8.6730	$359.06	$339.52
43201	Esoph scope w/submucous inj	Y		A2	$333.00	8.6730	$359.06	$339.52
43202	Esophagus endoscopy, biopsy	Y		A2	$333.00	8.6730	$359.06	$339.52
43204	Esoph scope w/sclerosis inj	Y		A2	$333.00	8.6730	$359.06	$339.52
43205	Esophagus endoscopy/ligation	Y		A2	$333.00	8.6730	$359.06	$339.52
43215	Esophagus endoscopy	Y		A2	$333.00	8.6730	$359.06	$339.52
43216	Esophagus endoscopy/lesion	Y		A2	$333.00	8.6730	$359.06	$339.52
43217	Esophagus endoscopy	Y		A2	$333.00	8.6730	$359.06	$339.52
43219	Esophagus endoscopy	Y		A2	$333.00	25.2289	$1,044.48	$510.87
43220	Esoph endoscopy, dilation	Y		A2	$333.00	8.6730	$359.06	$339.52
43226	Esoph endoscopy, dilation	Y		A2	$333.00	8.6730	$359.06	$339.52
43227	Esoph endoscopy, repair	Y		A2	$446.00	8.6730	$359.06	$424.27
43228	Esoph endoscopy, ablation	Y		A2	$446.00	24.6480	$1,020.43	$589.61
43231	Esoph endoscopy w/us exam	Y		A2	$446.00	8.6730	$359.06	$424.27
43232	Esoph endoscopy w/us fn bx	Y		A2	$446.00	8.6730	$359.06	$424.27
43234	Upper GI endoscopy, exam	Y		A2	$333.00	8.6730	$359.06	$339.52
43235	Uppr gi endoscopy, diagnosis	Y		A2	$333.00	8.6730	$359.06	$339.52
43236	Uppr gi scope w/submuc inj	Y		A2	$446.00	8.6730	$359.06	$424.27
43237	Endoscopic us exam, esoph	Y		A2	$446.00	8.6730	$359.06	$424.27
43238	Uppr gi endoscopy w/us fn bx	Y		A2	$446.00	8.6730	$359.06	$424.27
43239	Upper GI endoscopy, biopsy	Y		A2	$446.00	8.6730	$359.06	$424.27
43240	Esoph endoscope w/drain cyst	Y		A2	$446.00	8.6730	$359.06	$424.27
43241	Upper GI endoscopy with tube	Y		A2	$446.00	8.6730	$359.06	$424.27
43242	Uppr gi endoscopy w/us fn bx	Y		A2	$446.00	8.6730	$359.06	$424.27
43243	Upper gi endoscopy & inject	Y		A2	$446.00	8.6730	$359.06	$424.27
43244	Upper GI endoscopy/ligation	Y		A2	$446.00	8.6730	$359.06	$424.27
43245	Uppr gi scope dilate strictr	Y		A2	$446.00	8.6730	$359.06	$424.27
43246	Place gastrostomy tube	Y		A2	$446.00	8.6730	$359.06	$424.27
43247	Operative upper GI endoscopy	Y		A2	$446.00	8.6730	$359.06	$424.27
43248	Uppr gi endoscopy/guide wire	Y		A2	$446.00	8.6730	$359.06	$424.27
43249	Esoph endoscopy, dilation	Y		A2	$446.00	8.6730	$359.06	$424.27
43250	Upper GI endoscopy/tumor	Y		A2	$446.00	8.6730	$359.06	$424.27
43251	Operative upper GI endoscopy	Y		A2	$446.00	8.6730	$359.06	$424.27
43255	Operative upper GI endoscopy	Y		A2	$446.00	8.6730	$359.06	$424.27
43256	Uppr gi endoscopy w/stent	Y		A2	$510.00	25.2289	$1,044.48	$643.62
43257	Uppr gi scope w/thrml txmnt	Y		A2	$510.00	24.6480	$1,020.43	$637.61
43258	Operative upper GI endoscopy	Y		A2	$510.00	8.6730	$359.06	$472.27
43259	Endoscopic ultrasound exam	Y		A2	$510.00	8.6730	$359.06	$472.27
43260	Endo cholangiopancreatograph	Y		A2	$446.00	21.2820	$881.07	$554.77
43261	Endo cholangiopancreatograph	Y		A2	$446.00	21.2820	$881.07	$554.77
43262	Endo cholangiopancreatograph	Y		A2	$446.00	21.2820	$881.07	$554.77
43263	Endo cholangiopancreatograph	Y		A2	$446.00	21.2820	$881.07	$554.77
43264	Endo cholangiopancreatograph	Y		A2	$446.00	21.2820	$881.07	$554.77
43265	Endo cholangiopancreatograph	Y		A2	$446.00	21.2820	$881.07	$554.77
43267	Endo cholangiopancreatograph	Y		A2	$446.00	21.2820	$881.07	$554.77
43268	Endo cholangiopancreatograph	Y		A2	$446.00	25.2289	$1,044.48	$595.62
43269	Endo cholangiopancreatograph	Y		A2	$446.00	25.2289	$1,044.48	$595.62
43271	Endo cholangiopancreatograph	Y		A2	$446.00	21.2820	$881.07	$554.77
43272	Endo cholangiopancreatograph	Y		A2	$446.00	21.2820	$881.07	$554.77
43450	Dilate esophagus	Y		A2	$333.00	6.0867	$251.99	$312.75
43453	Dilate esophagus	Y		A2	$333.00	6.0867	$251.99	$312.75
43456	Dilate esophagus	Y		A2	$335.41	6.0867	$251.99	$314.56
43458	Dilate esophagus	Y		A2	$335.41	8.6730	$359.06	$341.32
43600	Biopsy of stomach	Y		A2	$333.00	8.6730	$359.06	$339.52
43653	Laparoscopy, gastrostomy	Y		A2	$1,339.00	46.1201	$1,909.37	$1,481.59
43750	Place gastrostomy tube	Y		A2	$446.00	8.6730	$359.06	$424.27
43760	Change gastrostomy tube	Y		A2	$144.98	3.2914	$136.26	$142.80
43761	Reposition gastrostomy tube	Y		A2	$333.00	8.6730	$359.06	$339.52
43870	Repair stomach opening	Y		A2	$333.00	8.6730	$359.06	$339.52
43886	Revise gastric port, open	Y		G2		20.9338	$866.66	$866.66

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS Code	Short Descriptor	Subject to multiple procedure discounting	Comment indicator	Payment indicator	CY 2007 ASC payment rate	Proposed fully implemented payment weight	Proposed CY 2008 fully implemented payment	Proposed CY 2008 first transition year payment
43887	Remove gastric port, open	Y		G2		4.6816	$193.82	$193.82
43888	Change gastric port, open	Y		G2		20.9338	$866.66	$866.66
44100	Biopsy of bowel	Y		A2	$333.00	8.6730	$359.06	$339.52
44312	Revision of ileostomy	Y		A2	$333.00	20.9338	$866.66	$466.42
44340	Revision of colostomy	Y		A2	$510.00	20.9338	$866.66	$599.17
44360	Small bowel endoscopy	Y		A2	$446.00	9.6264	$398.53	$434.13
44361	Small bowel endoscopy/biopsy	Y		A2	$446.00	9.6264	$398.53	$434.13
44363	Small bowel endoscopy	Y		A2	$446.00	9.6264	$398.53	$434.13
44364	Small bowel endoscopy	Y		A2	$446.00	9.6264	$398.53	$434.13
44365	Small bowel endoscopy	Y		A2	$446.00	9.6264	$398.53	$434.13
44366	Small bowel endoscopy	Y		A2	$446.00	9.6264	$398.53	$434.13
44369	Small bowel endoscopy	Y		A2	$446.00	9.6264	$398.53	$434.13
44370	Small bowel endoscopy/stent	Y		A2	$1,339.00	25.2289	$1,044.48	$1,265.37
44372	Small bowel endoscopy	Y		A2	$446.00	9.6264	$398.53	$434.13
44373	Small bowel endoscopy	Y		A2	$446.00	9.6264	$398.53	$434.13
44376	Small bowel endoscopy	Y		A2	$446.00	9.6264	$398.53	$434.13
44377	Small bowel endoscopy/biopsy	Y		A2	$446.00	9.6264	$398.53	$434.13
44378	Small bowel endoscopy	Y		A2	$446.00	9.6264	$398.53	$434.13
44379	Sbowel endoscope w/stent	Y		A2	$1,339.00	25.2289	$1,044.48	$1,265.37
44380	Small bowel endoscopy	Y		A2	$333.00	9.6264	$398.53	$349.38
44382	Small bowel endoscopy	Y		A2	$333.00	9.6264	$398.53	$349.38
44383	Ileoscopy w/stent	Y		A2	$1,339.00	25.2289	$1,044.48	$1,265.37
44385	Endoscopy of bowel pouch	Y		A2	$333.00	9.0360	$374.09	$343.27
44386	Endoscopy, bowel pouch/biop	Y		A2	$333.00	9.0360	$374.09	$343.27
44388	Colonoscopy	Y		A2	$333.00	9.0360	$374.09	$343.27
44389	Colonoscopy with biopsy	Y		A2	$333.00	9.0360	$374.09	$343.27
44390	Colonoscopy for foreign body	Y		A2	$333.00	9.0360	$374.09	$343.27
44391	Colonoscopy for bleeding	Y		A2	$333.00	9.0360	$374.09	$343.27
44392	Colonoscopy & polypectomy	Y		A2	$333.00	9.0360	$374.09	$343.27
44393	Colonoscopy, lesion removal	Y		A2	$333.00	9.0360	$374.09	$343.27
44394	Colonoscopy w/snare	Y		A2	$333.00	9.0360	$374.09	$343.27
44397	Colonoscopy w/stent	Y		A2	$333.00	25.2289	$1,044.48	$510.87
44701	Intraop colon lavage add-on	N		N1				
45000	Drainage of pelvic abscess	Y		A2	$312.07	11.6524	$482.41	$354.66
45005	Drainage of rectal abscess	Y		A2	$446.00	11.6524	$482.41	$455.10
45020	Drainage of rectal abscess	Y		A2	$446.00	11.6524	$482.41	$455.10
45100	Biopsy of rectum	Y		A2	$333.00	23.2282	$961.65	$490.16
45108	Removal of anorectal lesion	Y		A2	$446.00	23.2282	$961.65	$574.91
45150	Excision of rectal stricture	Y		A2	$446.00	23.2282	$961.65	$574.91
45160	Excision of rectal lesion	Y		A2	$446.00	23.2282	$961.65	$574.91
45170	Excision of rectal lesion	Y		A2	$446.00	23.2282	$961.65	$574.91
45190	Destruction, rectal tumor	Y		A2	$1,339.00	23.2282	$961.65	$1,244.66
45300	Proctosigmoidoscopy dx	Y		P3		1.4345	$59.39	$59.39
45303	Proctosigmoidoscopy dilate	Y		P2		8.8611	$366.85	$366.85
45305	Proctosigmoidoscopy w/bx	Y		A2	$333.00	8.8611	$366.85	$341.46
45307	Proctosigmoidoscopy fb	Y		A2	$333.00	21.8923	$906.34	$476.34
45308	Proctosigmoidoscopy removal	Y		A2	$333.00	8.8611	$366.85	$341.46
45309	Proctosigmoidoscopy removal	Y		A2	$333.00	8.8611	$366.85	$341.46
45315	Proctosigmoidoscopy removal	Y		A2	$333.00	8.8611	$366.85	$341.46
45317	Proctosigmoidoscopy bleed	Y		A2	$333.00	8.8611	$366.85	$341.46
45320	Proctosigmoidoscopy ablate	Y		A2	$333.00	21.8923	$906.34	$476.34
45321	Proctosigmoidoscopy volvul	Y		A2	$333.00	21.8923	$906.34	$476.34
45327	Proctosigmoidoscopy w/stent	Y		A2	$333.00	25.2289	$1,044.48	$510.87
45330	Diagnostic sigmoidoscopy	Y		P3		1.9705	$81.58	$81.58
45331	Sigmoidoscopy and biopsy	Y		A2	$299.24	5.1441	$212.97	$277.67
45332	Sigmoidoscopy w/fb removal	Y		A2	$299.24	5.1441	$212.97	$277.67
45333	Sigmoidoscopy & polypectomy	Y		A2	$333.00	8.8611	$366.85	$341.46
45334	Sigmoidoscopy for bleeding	Y		A2	$333.00	8.8611	$366.85	$341.46
45335	Sigmoidoscopy w/submuc inj	Y		A2	$299.24	5.1441	$212.97	$277.67
45337	Sigmoidoscopy & decompress	Y		A2	$299.24	5.1441	$212.97	$277.67
45338	Sigmoidoscopy w/tumr remove	Y		A2	$333.00	8.8611	$366.85	$341.46
45339	Sigmoidoscopy w/ablate tumr	Y		A2	$333.00	8.8611	$366.85	$341.46
45340	Sig w/balloon dilation	Y		A2	$333.00	8.8611	$366.85	$341.46
45341	Sigmoidoscopy w/ultrasound	Y		A2	$333.00	8.8611	$366.85	$341.46
45342	Sigmoidoscopy w/us guide bx	Y		A2	$333.00	8.8611	$366.85	$341.46
45345	Sigmoidoscopy w/stent	Y		A2	$333.00	25.2289	$1,044.48	$510.87
45355	Surgical colonoscopy	Y		A2	$333.00	9.0360	$374.09	$343.27
45378	Diagnostic colonoscopy	Y		A2	$446.00	9.0360	$374.09	$428.02
45379	Colonoscopy w/fb removal	Y		A2	$446.00	9.0360	$374.09	$428.02
45380	Colonoscopy and biopsy	Y		A2	$446.00	9.0360	$374.09	$428.02
45381	Colonoscopy, submucous inj	Y		A2	$446.00	9.0360	$374.09	$428.02
45382	Colonoscopy/control bleeding	Y		A2	$446.00	9.0360	$374.09	$428.02
45383	Lesion removal colonoscopy	Y		A2	$446.00	9.0360	$374.09	$428.02
45384	Lesion remove colonoscopy	Y		A2	$446.00	9.0360	$374.09	$428.02
45385	Lesion removal colonoscopy	Y		A2	$446.00	9.0360	$374.09	$428.02
45386	Colonoscopy dilate stricture	Y		A2	$446.00	9.0360	$374.09	$428.02

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS Code	Short Descriptor	Subject to multiple procedure discounting	Comment indicator	Payment indicator	CY 2007 ASC payment rate	Proposed fully implemented payment weight	Proposed CY 2008 fully implemented payment	Proposed CY 2008 first transition year payment
45387	Colonoscopy w/stent	Y		A2	$333.00	25.2289	$1,044.48	$510.87
45391	Colonoscopy w/endoscope us	Y		A2	$446.00	9.0360	$374.09	$428.02
45392	Colonoscopy w/endoscopic fnb	Y		A2	$446.00	9.0360	$374.09	$428.02
45500	Repair of rectum	Y		A2	$446.00	23.2282	$961.65	$574.91
45505	Repair of rectum	Y		A2	$446.00	30.5544	$1,264.95	$650.74
45520	Treatment of rectal prolapse	Y		P2		0.8046	$33.31	$33.31
45560	Repair of rectocele	Y		A2	$446.00	30.5544	$1,264.95	$650.74
45900	Reduction of rectal prolapse	Y		A2	$312.07	4.5189	$187.08	$280.82
45905	Dilation of anal sphincter	Y		A2	$333.00	23.2282	$961.65	$490.16
45910	Dilation of rectal narrowing	Y		A2	$333.00	23.2282	$961.65	$490.16
45915	Remove rectal obstruction	Y		A2	$312.07	11.6524	$482.41	$354.66
45990	Surg dx exam, anorectal	Y		A2	$312.07	23.2282	$961.65	$474.47
46020	Placement of seton	Y		A2	$510.00	23.2282	$961.65	$622.91
46030	Removal of rectal marker	Y		A2	$312.07	4.5189	$187.08	$280.82
46040	Incision of rectal abscess	Y		A2	$510.00	23.2282	$961.65	$622.91
46045	Incision of rectal abscess	Y		A2	$446.00	23.2282	$961.65	$574.91
46050	Incision of anal abscess	Y		A2	$312.07	11.6524	$482.41	$354.66
46060	Incision of rectal abscess	Y		A2	$446.00	23.2282	$961.65	$574.91
46070	Incision of anal septum	Y		G2		11.6524	$482.41	$482.41
46080	Incision of anal sphincter	Y		A2	$510.00	23.2282	$961.65	$622.91
46083	Incise external hemorrhoid	Y		P3		2.0036	$82.95	$82.95
46200	Removal of anal fissure	Y		A2	$446.00	23.2282	$961.65	$574.91
46210	Removal of anal crypt	Y		A2	$446.00	23.2282	$961.65	$574.91
46211	Removal of anal crypts	Y		A2	$446.00	23.2282	$961.65	$574.91
46220	Removal of anal tag	Y		A2	$333.00	23.2282	$961.65	$490.16
46221	Ligation of hemorrhoid(s)	Y		P3		2.6138	$108.21	$108.21
46230	Removal of anal tags	Y		A2	$333.00	23.2282	$961.65	$490.16
46250	Hemorrhoidectomy	Y		A2	$510.00	23.2282	$961.65	$622.91
46255	Hemorrhoidectomy	Y		A2	$510.00	23.2282	$961.65	$622.91
46257	Remove hemorrhoids & fissure	Y		A2	$510.00	23.2282	$961.65	$622.91
46258	Remove hemorrhoids & fistula	Y		A2	$510.00	23.2282	$961.65	$622.91
46260	Hemorrhoidectomy	Y		A2	$510.00	23.2282	$961.65	$622.91
46261	Remove hemorrhoids & fissure	Y		A2	$630.00	23.2282	$961.65	$712.91
46262	Remove hemorrhoids & fistula	Y		A2	$630.00	23.2282	$961.65	$712.91
46270	Removal of anal fistula	Y		A2	$510.00	23.2282	$961.65	$622.91
46275	Removal of anal fistula	Y		A2	$510.00	23.2282	$961.65	$622.91
46280	Removal of anal fistula	Y		A2	$630.00	23.2282	$961.65	$712.91
46285	Removal of anal fistula	Y		A2	$333.00	23.2282	$961.65	$490.16
46288	Repair anal fistula	Y		A2	$630.00	23.2282	$961.65	$712.91
46320	Removal of hemorrhoid clot	Y		P3		1.8635	$77.15	$77.15
46500	Injection into hemorrhoid(s)	Y		P3		2.3498	$97.28	$97.28
46505	Chemodenervation anal musc	Y	CH	P3		2.5973	$107.53	$107.53
46600	Diagnostic anoscopy	N		P2		0.6416	$26.56	$26.56
46604	Anoscopy and dilation	Y		P2		8.8611	$366.85	$366.85
46606	Anoscopy and biopsy	Y		P3		3.1498	$130.40	$130.40
46608	Anoscopy, remove for body	Y		A2	$333.00	8.8611	$366.85	$341.46
46610	Anoscopy, remove lesion	Y		A2	$333.00	21.8923	$906.34	$476.34
46611	Anoscopy	Y		A2	$333.00	8.8611	$366.85	$341.46
46612	Anoscopy, remove lesions	Y		A2	$333.00	21.8923	$906.34	$476.34
46614	Anoscopy, control bleeding	Y		P3		1.8386	$76.12	$76.12
46615	Anoscopy	Y		A2	$446.00	21.8923	$906.34	$561.09
46700	Repair of anal stricture	Y		A2	$510.00	23.2282	$961.65	$622.91
46706	Repr of anal fistula w/glue	Y		A2	$333.00	30.5544	$1,264.95	$565.99
46750	Repair of anal sphincter	Y		A2	$510.00	30.5544	$1,264.95	$698.74
46753	Reconstruction of anus	Y		A2	$510.00	23.2282	$961.65	$622.91
46754	Removal of suture from anus	Y		A2	$446.00	23.2282	$961.65	$574.91
46760	Repair of anal sphincter	Y		A2	$446.00	30.5544	$1,264.95	$650.74
46761	Repair of anal sphincter	Y		A2	$510.00	30.5544	$1,264.95	$698.74
46762	Implant artificial sphincter	Y		A2	$995.00	30.5544	$1,264.95	$1,062.49
46900	Destruction, anal lesion(s)	Y		P3		2.5560	$105.82	$105.82
46910	Destruction, anal lesion(s)	Y		P3		2.7870	$115.38	$115.38
46916	Cryosurgery, anal lesion(s)	Y		P2		1.5119	$62.59	$62.59
46917	Laser surgery, anal lesions	Y		A2	$333.00	20.0977	$832.04	$457.76
46922	Excision of anal lesion(s)	Y		A2	$333.00	20.0977	$832.04	$457.76
46924	Destruction, anal lesion(s)	Y		A2	$333.00	20.0977	$832.04	$457.76
46934	Destruction of hemorrhoids	Y		P3		4.3534	$180.23	$180.23
46935	Destruction of hemorrhoids	Y		P3		2.9930	$123.91	$123.91
46936	Destruction of hemorrhoids	Y		P3		4.5597	$188.77	$188.77
46937	Cryotherapy of rectal lesion	Y		A2	$446.00	23.2282	$961.65	$574.91
46938	Cryotherapy of rectal lesion	Y		A2	$446.00	30.5544	$1,264.95	$650.74
46940	Treatment of anal fissure	Y		P3		1.9872	$82.27	$82.27
46942	Treatment of anal fissure	Y		P3		1.9046	$78.85	$78.85
46945	Ligation of hemorrhoids	Y		P3		3.3145	$137.22	$137.22
46946	Ligation of hemorrhoids	Y		A2	$333.00	11.6524	$482.41	$370.35
46947	Hemorrhoidopexy by stapling	Y		A2	$995.00	30.5544	$1,264.95	$1,062.49
47000	Needle biopsy of liver	Y		A2	$333.00	9.5741	$396.37	$348.84

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS Code	Short Descriptor	Subject to multiple procedure discounting	Comment indicator	Payment indicator	CY 2007 ASC payment rate	Proposed fully implemented payment weight	Proposed CY 2008 fully implemented payment	Proposed CY 2008 first transition year payment
47001	Needle biopsy, liver add-on	N		N1				
47382	Percut ablate liver rf	Y		G2		44.1192	$1,826.53	$1,826.53
47500	Injection for liver x-rays	N		N1				
47505	Injection for liver x-rays	N		N1				
47510	Insert catheter, bile duct	Y		A2	$446.00	28.7304	$1,189.44	$631.86
47511	Insert bile duct drain	Y		A2	$1,245.85	28.7304	$1,189.44	$1,231.75
47525	Change bile duct catheter	Y		A2	$333.00	14.8912	$616.50	$403.88
47530	Revise/reinsert bile tube	Y		A2	$333.00	14.8912	$616.50	$403.88
47552	Biliary endoscopy thru skin	Y		A2	$446.00	28.7304	$1,189.44	$631.86
47553	Biliary endoscopy thru skin	Y		A2	$510.00	28.7304	$1,189.44	$679.86
47554	Biliary endoscopy thru skin	Y		A2	$510.00	28.7304	$1,189.44	$679.86
47555	Biliary endoscopy thru skin	Y		A2	$510.00	28.7304	$1,189.44	$679.86
47556	Biliary endoscopy thru skin	Y		A2	$1,245.85	28.7304	$1,189.44	$1,231.75
47560	Laparoscopy w/cholangio	Y		A2	$510.00	34.8153	$1,441.35	$742.84
47561	Laparo w/cholangio/biopsy	Y		A2	$510.00	34.8153	$1,441.35	$742.84
47562	Laparoscopic cholecystectomy	Y		G2		46.1201	$1,909.37	$1,909.37
47563	Laparo cholecystectomy/graph	Y		G2		46.1201	$1,909.37	$1,909.37
47564	Laparo cholecystectomy/explr	Y		G2		46.1201	$1,909.37	$1,909.37
47630	Remove bile duct stone	Y		A2	$510.00	28.7304	$1,189.44	$679.86
48102	Needle biopsy, pancreas	Y		A2	$333.00	9.5741	$396.37	$348.84
49080	Puncture, peritoneal cavity	Y		A2	$222.78	5.3095	$219.81	$222.04
49081	Removal of abdominal fluid	Y		A2	$222.78	5.3095	$219.81	$222.04
49180	Biopsy, abdominal mass	Y		A2	$333.00	9.5741	$396.37	$348.84
49250	Excision of umbilicus	Y		A2	$630.00	25.4636	$1,054.19	$736.05
49320	Diag laparo separate proc	Y		A2	$510.00	34.8153	$1,441.35	$742.84
49321	Laparoscopy, biopsy	Y		A2	$630.00	34.8153	$1,441.35	$832.84
49322	Laparoscopy, aspiration	Y		A2	$630.00	34.8153	$1,441.35	$832.84
49400	Air injection into abdomen	N		N1				
49402	Remove foreign body, adbomen	Y		A2	$446.00	25.4636	$1,054.19	$598.05
49419	Insrt abdom cath for chemotx	Y		A2	$333.00	30.5379	$1,264.27	$565.82
49420	Insert abdom drain, temp	Y		A2	$333.00	31.7598	$1,314.86	$578.47
49421	Insert abdom drain, perm	Y		A2	$333.00	31.7598	$1,314.86	$578.47
49422	Remove perm cannula/catheter	Y		A2	$333.00	24.7274	$1,023.71	$505.68
49423	Exchange drainage catheter	Y		G2		14.8912	$616.50	$616.50
49424	Assess cyst, contrast inject	N		N1				
49426	Revise abdomen-venous shunt	Y		A2	$446.00	25.4636	$1,054.19	$598.05
49427	Injection, abdominal shunt	N		N1				
49429	Removal of shunt	Y		G2		24.7274	$1,023.71	$1,023.71
49495	Rpr ing hernia baby, reduc	Y		A2	$630.00	31.1722	$1,290.53	$795.13
49496	Rpr ing hernia baby, blocked	Y		A2	$630.00	31.1722	$1,290.53	$795.13
49500	Rpr ing hernia, init, reduce	Y		A2	$630.00	31.1722	$1,290.53	$795.13
49501	Rpr ing hernia, init blocked	Y		A2	$1,339.00	31.1722	$1,290.53	$1,326.88
49505	Prp i/hern init reduc >5 yr	Y		A2	$630.00	31.1722	$1,290.53	$795.13
49507	Prp i/hern init block >5 yr	Y		A2	$1,339.00	31.1722	$1,290.53	$1,326.88
49520	Rerepair ing hernia, reduce	Y		A2	$995.00	31.1722	$1,290.53	$1,068.88
49521	Rerepair ing hernia, blocked	Y		A2	$1,339.00	31.1722	$1,290.53	$1,326.88
49525	Repair ing hernia, sliding	Y		A2	$630.00	31.1722	$1,290.53	$795.13
49540	Repair lumbar hernia	Y		A2	$446.00	31.1722	$1,290.53	$657.13
49550	Rpr rem hernia, init, reduce	Y		A2	$717.00	31.1722	$1,290.53	$860.38
49553	Rpr fem hernia, init blocked	Y		A2	$1,339.00	31.1722	$1,290.53	$1,326.88
49555	Rerepair fem hernia, reduce	Y		A2	$717.00	31.1722	$1,290.53	$860.38
49557	Rerepair fem hernia, blocked	Y		A2	$1,339.00	31.1722	$1,290.53	$1,326.88
49560	Rpr ventral hern init, reduc	Y		A2	$630.00	31.1722	$1,290.53	$795.13
49561	Rpr ventral hern init, block	Y		A2	$1,339.00	31.1722	$1,290.53	$1,326.88
49565	Rerepair ventrl hern, reduce	Y		A2	$630.00	31.1722	$1,290.53	$795.13
49566	Rerepair ventrl hern, block	Y		A2	$1,339.00	31.1722	$1,290.53	$1,326.88
49568	Hernia repair w/mesh	Y		A2	$995.00	31.1722	$1,290.53	$1,068.88
49570	Rpr epigastric hern, reduce	Y		A2	$630.00	31.1722	$1,290.53	$795.13
49572	Rpr epigastric hern, blocked	Y		A2	$1,339.00	31.1722	$1,290.53	$1,326.88
49580	Rpr umbil hern, reduc < 5 yr	Y		A2	$630.00	31.1722	$1,290.53	$795.13
49582	Rpr umbil hern, block < 5 yr	Y		A2	$1,339.00	31.1722	$1,290.53	$1,326.88
49585	Rpr umbil hern, reduc > 5 yr	Y		A2	$630.00	31.1722	$1,290.53	$795.13
49587	Rpr umbil hern, block > 5 yr	Y		A2	$1,339.00	31.1722	$1,290.53	$1,326.88
49590	Repair spigelian hernia	Y		A2	$510.00	31.1722	$1,290.53	$705.13
49600	Repair umbilical lesion	Y		A2	$630.00	31.1722	$1,290.53	$795.13
49650	Laparo hernia repair initial	Y		A2	$630.00	46.1201	$1,909.37	$949.84
49651	Laparo hernia repair recur	Y		A2	$995.00	46.1201	$1,909.37	$1,223.59
50200	Biopsy of kidney	Y		A2	$333.00	9.5741	$396.37	$348.84
50382	Change ureter stent, percut	Y		G2		25.2775	$1,046.49	$1,046.49
50384	Remove ureter stent, percut	Y		G2		18.1376	$750.90	$750.90
50387	Change ext/int ureter stent	Y		G2		14.8912	$616.50	$616.50
50389	Remove renal tube w/fluoro	Y		G2		6.1077	$252.86	$252.86
50390	Drainage of kidney lesion	Y		A2	$333.00	9.5741	$396.37	$348.84
50391	Instll rx agnt into rnal tub	Y		P2		1.0850	$44.92	$44.92
50392	Insert kidney drain	Y		A2	$333.00	18.1376	$750.90	$437.48
50393	Insert ureteral tube	Y		A2	$333.00	25.2775	$1,046.49	$511.37

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS Code	Short Descriptor	Subject to multiple procedure discounting	Comment indicator	Payment indicator	CY 2007 ASC payment rate	Proposed fully implemented payment weight	Proposed CY 2008 fully implemented payment	Proposed CY 2008 first transition year payment
50394	Injection for kidney x-ray	N		N1				
50395	Create passage to kidney	Y		A2	$333.00	18.1376	$750.90	$437.48
50396	Measure kidney pressure	Y		A2	$131.50	2.1659	$89.67	$121.04
50398	Change kidney tube	Y		A2	$333.00	14.8912	$616.50	$403.88
50551	Kidney endoscopy	Y		A2	$333.00	6.1077	$252.86	$312.97
50553	Kidney endoscopy	Y		A2	$333.00	25.2775	$1,046.49	$511.37
50555	Kidney endoscopy & biopsy	Y		A2	$333.00	6.1077	$252.86	$312.97
50557	Kidney endoscopy & treatment	Y		A2	$333.00	25.2775	$1,046.49	$511.37
50561	Kidney endoscopy & treatment	Y		A2	$333.00	25.2775	$1,046.49	$511.37
50562	Renal scope w/tumor resect	Y		G2		6.1077	$252.86	$252.86
50570	Kidney endoscopy	Y		G2		6.1077	$252.86	$252.86
50572	Kidney endoscopy	Y		G2		6.1077	$252.86	$252.86
50574	Kidney endoscopy & biopsy	Y		G2		6.1077	$252.86	$252.86
50575	Kidney endoscopy	Y		G2		36.9175	$1,528.38	$1,528.38
50576	Kidney endoscopy & treatment	Y		G2		18.1376	$750.90	$750.90
50580	Kidney endoscopy & treatment	Y	CH	G2		18.1376	$750.90	$750.90
50590	Fragmenting of kidney stone	Y		G2		43.0352	$1,781.66	$1,781.66
50592	Perc rf ablate renal tumor	Y		G2		44.1192	$1,826.53	$1,826.53
50684	Injection for ureter x-ray	N		N1				
50686	Measure ureter pressure	Y		P2		1.0850	$44.92	$44.92
50688	Change of ureter tube/stent	Y		A2	$333.00	14.8912	$616.50	$403.88
50690	Injection for ureter x-ray	N		N1				
50947	Laparo new ureter/bladder	Y		A2	$1,339.00	46.1201	$1,909.37	$1,481.59
50948	Laparo new ureter/bladder	Y		A2	$1,339.00	46.1201	$1,909.37	$1,481.59
50951	Endoscopy of ureter	Y		A2	$333.00	6.1077	$252.86	$312.97
50953	Endoscopy of ureter	Y		A2	$333.00	6.1077	$252.86	$312.97
50955	Ureter endoscopy & biopsy	Y		A2	$333.00	25.2775	$1,046.49	$511.37
50957	Ureter endoscopy & treatment	Y		A2	$333.00	25.2775	$1,046.49	$511.37
50961	Ureter endoscopy & treatment	Y		A2	$333.00	25.2775	$1,046.49	$511.37
50970	Ureter endoscopy	Y		A2	$333.00	6.1077	$252.86	$312.97
50972	Ureter endoscopy & catheter	Y		A2	$333.00	6.1077	$252.86	$312.97
50974	Ureter endoscopy & biopsy	Y		A2	$333.00	18.1376	$750.90	$437.48
50976	Ureter endoscopy & treatment	Y		A2	$333.00	18.1376	$750.90	$437.48
50980	Ureter endoscopy & treatment	Y		A2	$333.00	25.2775	$1,046.49	$511.37
51000	Drainage of bladder	Y		P3		1.1790	$48.81	$48.81
51005	Drainage of bladder	Y		P2		1.0850	$44.92	$44.92
51010	Drainage of bladder	Y		A2	$333.00	19.6126	$811.96	$452.74
51020	Incise & treat bladder	Y		A2	$630.00	25.2775	$1,046.49	$734.12
51030	Incise & treat bladder	Y		A2	$630.00	25.2775	$1,046.49	$734.12
51040	Incise & drain bladder	Y		A2	$630.00	25.2775	$1,046.49	$734.12
51045	Incise bladder/drain ureter	Y		A2	$399.24	6.1077	$252.86	$362.65
51050	Removal of bladder stone	Y		A2	$630.00	25.2775	$1,046.49	$734.12
51065	Remove ureter calculus	Y		A2	$630.00	25.2775	$1,046.49	$734.12
51080	Drainage of bladder abscess	Y		A2	$333.00	19.0457	$788.49	$446.87
51500	Removal of bladder cyst	Y		A2	$630.00	31.1722	$1,290.53	$795.13
51520	Removal of bladder lesion	Y		A2	$630.00	25.2775	$1,046.49	$734.12
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		1.2780	$52.91	$52.91
51701	Insert bladder catheter	N		P2		0.6416	$26.56	$26.56
51702	Insert temp bladder cath	N		P2		0.6416	$26.56	$26.56
51703	Insert bladder cath, complex	Y		P2		1.0850	$44.92	$44.92
51705	Change of bladder tube	Y		P3		1.7727	$73.39	$73.39
51710	Change of bladder tube	Y		A2	$333.00	14.8912	$616.50	$403.88
51715	Endoscopic injection/implant	Y		A2	$510.00	30.1994	$1,250.26	$695.07
51720	Treatment of bladder lesion	Y		P3		1.3935	$57.69	$57.69
51725	Simple cystometrogram	Y		P2		3.0601	$126.69	$126.69
51726	Complex cystometrogram	Y		A2	$209.48	3.0601	$126.69	$188.78
51736	Urine flow measurement	Y		P3		0.4452	$18.43	$18.43
51741	Electro-uroflowmetry, first	Y		P3		0.5111	$21.16	$21.16
51772	Urethra pressure profile	Y		A2	$131.50	2.1659	$89.67	$121.04
51784	Anal/urinary muscle study	Y		P2		1.0850	$44.92	$44.92
51785	Anal/urinary muscle study	Y		A2	$66.92	1.0850	$44.92	$61.42
51792	Urinary reflex study	Y		P2		1.0850	$44.92	$44.92
51795	Urine voiding pressure study	Y		P2		2.1659	$89.67	$89.67
51797	Intraabdominal pressure test	Y		P2		2.1659	$89.67	$89.67
51798	Us urine capacity measure	N		P3		0.3792	$15.70	$15.70
51880	Repair of bladder opening	Y		A2	$333.00	25.2775	$1,046.49	$511.37
51992	Laparo sling operation	Y		A2	$717.00	46.1201	$1,909.37	$1,015.09
52000	Cystoscopy	Y		A2	$333.00	6.1077	$252.86	$312.97
52001	Cystoscopy, removal of clots	Y		A2	$399.24	18.1376	$750.90	$487.16
52005	Cystoscopy & ureter catheter	Y		A2	$446.00	18.1376	$750.90	$522.23
52007	Cystoscopy and biopsy	Y		A2	$446.00	25.2775	$1,046.49	$596.12
52010	Cystoscopy & duct catheter	Y		A2	$399.24	6.1077	$252.86	$362.65
52204	Cystoscopy w/biopsy(s)	Y		A2	$446.00	18.1376	$750.90	$522.23

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS Code	Short Descriptor	Subject to multiple procedure discounting	Comment indicator	Payment indicator	CY 2007 ASC payment rate	Proposed fully implemented payment weight	Proposed CY 2008 fully implemented payment	Proposed CY 2008 first transition year payment
52214	Cystoscopy and treatment	Y		A2	$446.00	25.2775	$1,046.49	$596.12
52224	Cystoscopy and treatment	Y		A2	$446.00	25.2775	$1,046.49	$596.12
52234	Cystoscopy and treatment	Y		A2	$446.00	25.2775	$1,046.49	$596.12
52235	Cystoscopy and treatment	Y		A2	$510.00	25.2775	$1,046.49	$644.12
52240	Cystoscopy and treatment	Y		A2	$510.00	25.2775	$1,046.49	$644.12
52250	Cystoscopy and radiotracer	Y		A2	$630.00	25.2775	$1,046.49	$734.12
52260	Cystoscopy and treatment	Y		A2	$446.00	18.1376	$750.90	$522.23
52265	Cystoscopy and treatment	Y		P2		6.1077	$252.86	$252.86
52270	Cystoscopy & revise urethra	Y		A2	$446.00	18.1376	$750.90	$522.23
52275	Cystoscopy & revise urethra	Y		A2	$446.00	25.2775	$1,046.49	$596.12
52276	Cystoscopy and treatment	Y		A2	$510.00	25.2775	$1,046.49	$644.12
52277	Cystoscopy and treatment	Y		A2	$446.00	25.2775	$1,046.49	$596.12
52281	Cystoscopy and treatment	Y		A2	$446.00	18.1376	$750.90	$522.23
52282	Cystoscopy, implant stent	Y		A2	$1,339.00	36.9175	$1,528.38	$1,386.35
52283	Cystoscopy and treatment	Y		A2	$446.00	25.2775	$1,046.49	$596.12
52285	Cystoscopy and treatment	Y		A2	$446.00	18.1376	$750.90	$522.23
52290	Cystoscopy and treatment	Y		A2	$446.00	18.1376	$750.90	$522.23
52300	Cystoscopy and treatment	Y		A2	$446.00	25.2775	$1,046.49	$596.12
52301	Cystoscopy and treatment	Y		A2	$510.00	25.2775	$1,046.49	$644.12
52305	Cystoscopy and treatment	Y		A2	$446.00	25.2775	$1,046.49	$596.12
52310	Cystoscopy and treatment	Y		A2	$399.24	18.1376	$750.90	$487.16
52315	Cystoscopy and treatment	Y		A2	$446.00	25.2775	$1,046.49	$596.12
52317	Remove bladder stone	Y		A2	$333.00	25.2775	$1,046.49	$511.37
52318	Remove bladder stone	Y		A2	$446.00	25.2775	$1,046.49	$596.12
52320	Cystoscopy and treatment	Y		A2	$717.00	25.2775	$1,046.49	$799.37
52325	Cystoscopy, stone removal	Y		A2	$630.00	25.2775	$1,046.49	$734.12
52327	Cystoscopy, inject material	Y		A2	$446.00	25.2775	$1,046.49	$596.12
52330	Cystoscopy and treatment	Y		A2	$446.00	25.2775	$1,046.49	$596.12
52332	Cystoscopy and treatment	Y		A2	$446.00	25.2775	$1,046.49	$596.12
52334	Create passage to kidney	Y		A2	$510.00	25.2775	$1,046.49	$644.12
52341	Cysto w/ureter stricture tx	Y		A2	$510.00	25.2775	$1,046.49	$644.12
52342	Cysto w/up stricture tx	Y		A2	$510.00	25.2775	$1,046.49	$644.12
52343	Cysto w/renal stricture tx	Y		A2	$510.00	25.2775	$1,046.49	$644.12
52344	Cysto/uretero, stricture tx	Y		A2	$510.00	25.2775	$1,046.49	$644.12
52345	Cysto/uretero w/up stricture	Y		A2	$510.00	25.2775	$1,046.49	$644.12
52346	Cystouretero w/renal strict	Y		A2	$510.00	25.2775	$1,046.49	$644.12
52351	Cystouretero & or pyeloscope	Y		A2	$510.00	25.2775	$1,046.49	$644.12
52352	Cystouretero w/stone remove	Y		A2	$630.00	25.2775	$1,046.49	$734.12
52353	Cystouretero w/lithotripsy	Y		A2	$630.00	36.9175	$1,528.38	$854.60
52354	Cystouretero w/biopsy	Y		A2	$630.00	25.2775	$1,046.49	$734.12
52355	Cystouretero w/excise tumor	Y		A2	$630.00	25.2775	$1,046.49	$734.12
52400	Cystouretero w/congen repr	Y		A2	$510.00	25.2775	$1,046.49	$644.12
52402	Cystourethro cut ejacul duct	Y		A2	$510.00	25.2775	$1,046.49	$644.12
52450	Incision of prostate	Y		A2	$510.00	25.2775	$1,046.49	$644.12
52500	Revision of bladder neck	Y		A2	$510.00	25.2775	$1,046.49	$644.12
52510	Dilation prostatic urethra	Y		A2	$510.00	25.2775	$1,046.49	$644.12
52601	Prostatectomy (TURP)	Y		A2	$630.00	36.9175	$1,528.38	$854.60
52606	Control postop bleeding	Y		A2	$333.00	25.2775	$1,046.49	$511.37
52612	Prostatectomy, first stage	Y		A2	$446.00	36.9175	$1,528.38	$716.60
52614	Prostatectomy, second stage	Y		A2	$333.00	36.9175	$1,528.38	$631.85
52620	Remove residual prostate	Y		A2	$333.00	36.9175	$1,528.38	$631.85
52630	Remove prostate regrowth	Y		A2	$446.00	36.9175	$1,528.38	$716.60
52640	Relieve bladder contracture	Y		A2	$446.00	25.2775	$1,046.49	$596.12
52647	Laser surgery of prostate	Y		A2	$1,339.00	45.9021	$1,900.35	$1,479.34
52648	Laser surgery of prostate	Y		A2	$1,339.00	45.9021	$1,900.35	$1,479.34
52700	Drainage of prostate abscess	Y		A2	$446.00	25.2775	$1,046.49	$596.12
53000	Incision of urethra	Y		A2	$333.00	19.6570	$813.80	$453.20
53010	Incision of urethra	Y		A2	$333.00	19.6570	$813.80	$453.20
53020	Incision of urethra	Y		A2	$333.00	19.6570	$813.80	$453.20
53025	Incision of urethra	Y		R2		19.6570	$813.80	$813.80
53040	Drainage of urethra abscess	Y		A2	$446.00	19.6570	$813.80	$537.95
53060	Drainage of urethra abscess	Y		P3		1.7068	$70.66	$70.66
53080	Drainage of urinary leakage	Y		A2	$510.00	19.6570	$813.80	$585.95
53085	Drainage of urinary leakage	Y		G2		19.6570	$813.80	$813.80
53200	Biopsy of urethra	Y		A2	$333.00	19.6570	$813.80	$453.20
53210	Removal of urethra	Y		A2	$717.00	30.1994	$1,250.26	$850.32
53215	Removal of urethra	Y		A2	$717.00	19.6570	$813.80	$741.20
53220	Treatment of urethra lesion	Y		A2	$446.00	30.1994	$1,250.26	$647.07
53230	Removal of urethra lesion	Y		A2	$446.00	30.1994	$1,250.26	$647.07
53235	Removal of urethra lesion	Y		A2	$510.00	19.6570	$813.80	$585.95
53240	Surgery for urethra pouch	Y		A2	$446.00	30.1994	$1,250.26	$647.07
53250	Removal of urethra gland	Y		A2	$446.00	19.6570	$813.80	$537.95
53260	Treatment of urethra lesion	Y		A2	$446.00	19.6570	$813.80	$537.95
53265	Treatment of urethra lesion	Y		A2	$446.00	19.6570	$813.80	$537.95
53270	Removal of urethra gland	Y		A2	$446.00	19.6570	$813.80	$537.95
53275	Repair of urethra defect	Y		A2	$446.00	19.6570	$813.80	$537.95

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS Code	Short Descriptor	Subject to multiple procedure discounting	Comment indicator	Payment indicator	CY 2007 ASC payment rate	Proposed fully implemented payment weight	Proposed CY 2008 fully implemented payment	Proposed CY 2008 first transition year payment
53400	Revise urethra, stage 1	Y		A2	$510.00	30.1994	$1,250.26	$695.07
53405	Revise urethra, stage 2	Y		A2	$446.00	30.1994	$1,250.26	$647.07
53410	Reconstruction of urethra	Y		A2	$446.00	30.1994	$1,250.26	$647.07
53420	Reconstruct urethra, stage 1	Y		A2	$510.00	30.1994	$1,250.26	$695.07
53425	Reconstruct urethra, stage 2	Y		A2	$446.00	30.1994	$1,250.26	$647.07
53430	Reconstruction of urethra	Y		A2	$446.00	30.1994	$1,250.26	$647.07
53431	Reconstruct urethra/bladder	Y		A2	$446.00	30.1994	$1,250.26	$647.07
53440	Male sling procedure	N	CH	H8	$446.00	109.0807	$4,515.94	$3,569.83
53442	Remove/revise male sling	Y		A2	$333.00	30.1994	$1,250.26	$562.32
53444	Insert tandem cuff	N	CH	H8	$446.00	109.0807	$4,515.94	$3,569.83
53445	Insert uro/ves nck sphincter	N		H8	$333.00	191.7932	$7,940.24	$6,492.40
53446	Remove uro sphincter	Y		A2	$333.00	30.1994	$1,250.26	$562.32
53447	Remove/replace ur sphincter	N		H8	$333.00	191.7932	$7,940.24	$6,492.40
53449	Repair uro sphincter	Y		A2	$333.00	30.1994	$1,250.26	$562.32
53450	Revision of urethra	Y		A2	$333.00	30.1994	$1,250.26	$562.32
53460	Revision of urethra	Y		A2	$333.00	19.6570	$813.80	$453.20
53502	Repair of urethra injury	Y		A2	$446.00	19.6570	$813.80	$537.95
53505	Repair of urethra injury	Y		A2	$446.00	30.1994	$1,250.26	$647.07
53510	Repair of urethra injury	Y		A2	$446.00	19.6570	$813.80	$537.95
53515	Repair of urethra injury	Y		A2	$446.00	30.1994	$1,250.26	$647.07
53520	Repair of urethra defect	Y		A2	$446.00	30.1994	$1,250.26	$647.07
53600	Dilate urethra stricture	Y		P3		0.9483	$39.26	$39.26
53601	Dilate urethra stricture	Y	CH	P2		1.0850	$44.92	$44.92
53605	Dilate urethra stricture	Y		A2	$446.00	18.1376	$750.90	$522.23
53620	Dilate urethra stricture	Y		P3		1.5254	$63.15	$63.15
53621	Dilate urethra stricture	Y		P3		1.5995	$66.22	$66.22
53660	Dilation of urethra	Y		P3		1.0802	$44.72	$44.72
53661	Dilation of urethra	Y		P3		1.0720	$44.38	$44.38
53665	Dilation of urethra	Y		A2	$333.00	19.6570	$813.80	$453.20
53850	Prostatic microwave thermotx	Y		P2		36.9175	$1,528.38	$1,528.38
53852	Prostatic rf thermotx	Y		P2		36.9175	$1,528.38	$1,528.38
53853	Prostatic water thermother	Y		P2		25.2775	$1,046.49	$1,046.49
54000	Slitting of prepuce	Y		A2	$446.00	19.6570	$813.80	$537.95
54001	Slitting of prepuce	Y		A2	$446.00	19.6570	$813.80	$537.95
54015	Drain penis lesion	Y		A2	$630.00	19.0457	$788.49	$669.62
54050	Destruction, penis lesion(s)	Y		P2		1.5119	$62.59	$62.59
54055	Destruction, penis lesion(s)	Y		P3		1.4676	$60.76	$60.76
54056	Cryosurgery, penis lesion(s)	Y		P2		0.8046	$33.31	$33.31
54057	Laser surg, penis lesion(s)	Y		A2	$333.00	20.0977	$832.04	$457.76
54060	Excision of penis lesion(s)	Y		A2	$333.00	20.0977	$832.04	$457.76
54065	Destruction, penis lesion(s)	Y		A2	$333.00	20.0977	$832.04	$457.76
54100	Biopsy of penis	Y		A2	$333.00	16.5832	$686.54	$421.39
54105	Biopsy of penis	Y		A2	$333.00	21.4534	$888.17	$471.79
54110	Treatment of penis lesion	Y		A2	$446.00	35.1574	$1,455.52	$698.38
54111	Treat penis lesion, graft	Y		A2	$446.00	35.1574	$1,455.52	$698.38
54112	Treat penis lesion, graft	Y		A2	$446.00	35.1574	$1,455.52	$698.38
54115	Treatment of penis lesion	Y		A2	$333.00	19.0457	$788.49	$446.87
54120	Partial removal of penis	Y		A2	$446.00	35.1574	$1,455.52	$698.38
54150	Circumcision w/regionl block	Y		A2	$333.00	22.7802	$943.10	$485.53
54160	Circumcision, neonate	Y		A2	$446.00	22.7802	$943.10	$570.28
54161	Circum 28 days or older	Y		A2	$446.00	22.7802	$943.10	$570.28
54162	Lysis penil circumic lesion	Y		A2	$446.00	22.7802	$943.10	$570.28
54163	Repair of circumcision	Y		A2	$446.00	22.7802	$943.10	$570.28
54164	Frenulotomy of penis	Y		A2	$446.00	22.7802	$943.10	$570.28
54200	Treatment of penis lesion	Y		P3		1.5667	$64.86	$64.86
54205	Treatment of penis lesion	Y		A2	$630.00	35.1574	$1,455.52	$836.38
54220	Treatment of penis lesion	Y		A2	$131.50	2.1659	$89.67	$121.04
54230	Prepare penis study	N		N1				
54231	Dynamic cavernosometry	Y		P3		1.3686	$56.66	$56.66
54235	Penile injection	Y		P3		0.9729	$40.28	$40.28
54240	Penis study	Y		P3		0.6679	$27.65	$27.65
54250	Penis study	Y		P3		0.2309	$9.56	$9.56
54300	Revision of penis	Y		A2	$510.00	35.1574	$1,455.52	$746.38
54304	Revision of penis	Y		A2	$510.00	35.1574	$1,455.52	$746.38
54308	Reconstruction of urethra	Y		A2	$510.00	35.1574	$1,455.52	$746.38
54312	Reconstruction of urethra	Y		A2	$510.00	35.1574	$1,455.52	$746.38
54316	Reconstruction of urethra	Y		A2	$510.00	35.1574	$1,455.52	$746.38
54318	Reconstruction of urethra	Y		A2	$510.00	35.1574	$1,455.52	$746.38
54322	Reconstruction of urethra	Y		A2	$510.00	35.1574	$1,455.52	$746.38
54324	Reconstruction of urethra	Y		A2	$510.00	35.1574	$1,455.52	$746.38
54326	Reconstruction of urethra	Y		A2	$510.00	35.1574	$1,455.52	$746.38
54328	Revise penis/urethra	Y		A2	$510.00	35.1574	$1,455.52	$746.38
54340	Secondary urethral surgery	Y		A2	$510.00	35.1574	$1,455.52	$746.38
54344	Secondary urethral surgery	Y		A2	$510.00	35.1574	$1,455.52	$746.38
54348	Secondary urethral surgery	Y		A2	$510.00	35.1574	$1,455.52	$746.38
54352	Reconstruct urethra/penis	Y		A2	$510.00	35.1574	$1,455.52	$746.38

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS Code	Short Descriptor	Subject to multiple procedure discounting	Comment indicator	Payment indicator	CY 2007 ASC payment rate	Proposed fully implemented payment weight	Proposed CY 2008 fully implemented payment	Proposed CY 2008 first transition year payment
54360	Penis plastic surgery	Y		A2	$510.00	35.1574	$1,455.52	$746.38
54380	Repair penis	Y		A2	$510.00	35.1574	$1,455.52	$746.38
54385	Repair penis	Y		A2	$510.00	35.1574	$1,455.52	$746.38
54400	Insert semi-rigid prosthesis	N	CH	H8	$510.00	109.0807	$4,515.94	$3,617.83
54401	Insert self-contd prosthesis	N		H8	$510.00	191.7932	$7,940.24	$6,625.15
54405	Insert multi-comp penis pros	N		H8	$510.00	191.7932	$7,940.24	$6,625.15
54406	Remove muti-comp penis pros	Y		A2	$510.00	35.1574	$1,455.52	$746.38
54408	Repair multi-comp penis pros	Y		A2	$510.00	35.1574	$1,455.52	$746.38
54410	Remove/replace penis prosth	N		H8	$510.00	191.7932	$7,940.24	$6,625.15
54415	Remove self-contd penis pros	Y		A2	$510.00	35.1574	$1,455.52	$746.38
54416	Remv/repl penis contain pros	N		H8	$510.00	191.7932	$7,940.24	$6,625.15
54420	Revision of penis	Y		A2	$630.00	35.1574	$1,455.52	$836.38
54435	Revision of penis	Y		A2	$630.00	35.1574	$1,455.52	$836.38
54440	Repair of penis	Y		A2	$630.00	35.1574	$1,455.52	$836.38
54450	Preputial stretching	Y		A2	$209.48	3.0601	$126.69	$188.78
54500	Biopsy of testis	Y		A2	$333.00	13.9599	$577.94	$394.24
54505	Biopsy of testis	Y		A2	$333.00	22.7802	$943.10	$485.53
54512	Excise lesion testis	Y		A2	$446.00	22.7802	$943.10	$570.28
54520	Removal of testis	Y		A2	$510.00	22.7802	$943.10	$618.28
54522	Orchiectomy, partial	Y		A2	$510.00	22.7802	$943.10	$618.28
54530	Removal of testis	Y		A2	$630.00	31.1722	$1,290.53	$795.13
54550	Exploration for testis	Y		A2	$630.00	31.1722	$1,290.53	$795.13
54560	Exploration for testis	Y		G2		22.7802	$943.10	$943.10
54600	Reduce testis torsion	Y		A2	$630.00	22.7802	$943.10	$708.28
54620	Suspension of testis	Y		A2	$510.00	22.7802	$943.10	$618.28
54640	Suspension of testis	Y		A2	$630.00	31.1722	$1,290.53	$795.13
54660	Revision of testis	Y		A2	$446.00	22.7802	$943.10	$570.28
54670	Repair testis injury	Y		A2	$510.00	22.7802	$943.10	$618.28
54680	Relocation of testis(es)	Y		A2	$510.00	22.7802	$943.10	$618.28
54690	Laparoscopy, orchiectomy	Y		A2	$1,339.00	46.1201	$1,909.37	$1,481.59
54692	Laparoscopy, orchiopexy	Y		G2		71.0022	$2,939.49	$2,939.49
54700	Drainage of scrotum	Y		A2	$446.00	22.7802	$943.10	$570.28
54800	Biopsy of epididymis	Y		A2	$127.16	4.5062	$186.56	$142.01
54830	Remove epididymis lesion	Y		A2	$510.00	22.7802	$943.10	$618.28
54840	Remove epididymis lesion	Y		A2	$630.00	22.7802	$943.10	$708.28
54860	Removal of epididymis	Y		A2	$510.00	22.7802	$943.10	$618.28
54861	Removal of epididymis	Y		A2	$630.00	22.7802	$943.10	$708.28
54865	Explore epididymis	Y		A2	$333.00	22.7802	$943.10	$485.53
54900	Fusion of spermatic ducts	Y		A2	$630.00	22.7802	$943.10	$708.28
54901	Fusion of spermatic ducts	Y		A2	$630.00	22.7802	$943.10	$708.28
55000	Drainage of hydrocele	Y		P3		1.6159	$66.90	$66.90
55040	Removal of hydrocele	Y		A2	$510.00	31.1722	$1,290.53	$705.13
55041	Removal of hydroceles	Y		A2	$717.00	31.1722	$1,290.53	$860.38
55060	Repair of hydrocele	Y		A2	$630.00	22.7802	$943.10	$708.28
55100	Drainage of scrotum abscess	Y		A2	$333.00	12.5792	$520.78	$379.95
55110	Explore scrotum	Y		A2	$446.00	22.7802	$943.10	$570.28
55120	Removal of scrotum lesion	Y		A2	$446.00	22.7802	$943.10	$570.28
55150	Removal of scrotum	Y		A2	$333.00	22.7802	$943.10	$485.53
55175	Revision of scrotum	Y		A2	$333.00	22.7802	$943.10	$485.53
55180	Revision of scrotum	Y		A2	$446.00	22.7802	$943.10	$570.28
55200	Incision of sperm duct	Y		A2	$446.00	22.7802	$943.10	$570.28
55250	Removal of sperm duct(s)	Y		A2	$446.00	22.7802	$943.10	$570.28
55300	Prepare, sperm duct x-ray	N		N1				
55400	Repair of sperm duct	Y		A2	$333.00	22.7802	$943.10	$485.53
55450	Ligation of sperm duct	Y		P3		5.2027	$215.39	$215.39
55500	Removal of hydrocele	Y		A2	$510.00	22.7802	$943.10	$618.28
55520	Removal of sperm cord lesion	Y		A2	$630.00	22.7802	$943.10	$708.28
55530	Revise spermatic cord veins	Y		A2	$630.00	22.7802	$943.10	$708.28
55535	Revise spermatic cord veins	Y		A2	$630.00	31.1722	$1,290.53	$795.13
55540	Revise hernia & sperm veins	Y		A2	$717.00	31.1722	$1,290.53	$860.38
55550	Laparo ligate spermatic vein	Y		A2	$1,339.00	46.1201	$1,909.37	$1,481.59
55600	Incise sperm duct pouch	Y		R2		22.7802	$943.10	$943.10
55680	Remove sperm pouch lesion	Y		A2	$333.00	22.7802	$943.10	$485.53
55700	Biopsy of prostate	Y		A2	$345.83	11.3168	$468.52	$376.50
55705	Biopsy of prostate	Y		A2	$345.83	11.3168	$468.52	$376.50
55720	Drainage of prostate abscess	Y		A2	$333.00	25.2775	$1,046.49	$511.37
55725	Drainage of prostate abscess	Y		A2	$446.00	25.2775	$1,046.49	$596.12
55860	Surgical exposure, prostate	Y		G2		19.6126	$811.96	$811.96
55870	Electroejaculation	Y		P3		1.6572	$68.61	$68.61
55873	Cryoablate prostate	Y	CH	H8	$1,339.00	163.2548	$6,758.75	$6,201.03
55875	Transperi needle place, pros	N	CH	A2	$1,339.00	36.9175	$1,528.38	$1,386.35
55876*	Place rt device/marker, pros	Y		P3		1.6903	$69.98	$69.98
56405	I & D of vulva/perineum	Y		P3		1.0307	$42.67	$42.67
56420	Drainage of gland abscess	Y		P2		1.4138	$58.53	$58.53
56440	Surgery for vulva lesion	Y		A2	$446.00	19.2052	$795.10	$533.28
56441	Lysis of labial lesion(s)	Y		A2	$333.00	19.2052	$795.10	$448.53

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS Code	Short Descriptor	Subject to multiple procedure discounting	Comment indicator	Payment indicator	CY 2007 ASC payment rate	Proposed fully implemented payment weight	Proposed CY 2008 fully implemented payment	Proposed CY 2008 first transition year payment
56442	Hymenotomy	Y		A2	$333.00	19.2052	$795.10	$448.53
56501	Destroy, vulva lesions, sim	Y		P3		1.4017	$58.03	$58.03
56515	Destroy vulva lesion/s compl	Y		A2	$510.00	20.0977	$832.04	$590.51
56605	Biopsy of vulva/perineum	Y		P3		0.8162	$33.79	$33.79
56606	Biopsy of vulva/perineum	Y		P3		0.3546	$14.68	$14.68
56620	Partial removal of vulva	Y		A2	$717.00	19.2052	$795.10	$736.53
56625	Complete removal of vulva	Y		A2	$995.00	19.2052	$795.10	$945.03
56700	Partial removal of hymen	Y		A2	$333.00	19.2052	$795.10	$448.53
56740	Remove vagina gland lesion	Y		A2	$510.00	19.2052	$795.10	$581.28
56800	Repair of vagina	Y		A2	$510.00	19.2052	$795.10	$581.28
56805	Repair clitoris	Y		G2		19.2052	$795.10	$795.10
56810	Repair of perineum	Y		A2	$717.00	19.2052	$795.10	$736.53
56820	Exam of vulva w/scope	Y		P3		1.0307	$42.67	$42.67
56821	Exam/biopsy of vulva w/scope	Y		P3		1.3522	$55.98	$55.98
57000	Exploration of vagina	Y		A2	$333.00	19.2052	$795.10	$448.53
57010	Drainage of pelvic abscess	Y		A2	$446.00	19.2052	$795.10	$533.28
57020	Drainage of pelvic fluid	Y		A2	$409.33	7.4497	$308.42	$384.10
57022	I & d vaginal hematoma, pp	Y		G2		12.5792	$520.78	$520.78
57023	I & d vag hematoma, non-ob	Y		A2	$333.00	19.0457	$788.49	$446.87
57061	Destroy vag lesions, simple	Y		P3		1.3027	$53.93	$53.93
57065	Destroy vag lesions, complex	Y		A2	$333.00	19.2052	$795.10	$448.53
57100	Biopsy of vagina	Y		P3		0.8329	$34.48	$34.48
57105	Biopsy of vagina	Y		A2	$446.00	19.2052	$795.10	$533.28
57130	Remove vagina lesion	Y		A2	$446.00	19.2052	$795.10	$533.28
57135	Remove vagina lesion	Y		A2	$446.00	19.2052	$795.10	$533.28
57150	Treat vagina infection	Y		P3		0.6925	$28.67	$28.67
57155	Insert uteri tandems/ovoids	Y		A2	$409.33	7.4497	$308.42	$384.10
57160	Insert pessary/other device	Y		P3		0.8493	$35.16	$35.16
57170	Fitting of diaphragm/cap	Y		P2		0.1414	$5.85	$5.85
57180	Treat vaginal bleeding	Y		A2	$178.05	1.4138	$58.53	$148.17
57200	Repair of vagina	Y		A2	$333.00	19.2052	$795.10	$448.53
57210	Repair vagina/perineum	Y		A2	$446.00	19.2052	$795.10	$533.28
57220	Revision of urethra	Y		A2	$510.00	43.2255	$1,789.54	$829.89
57230	Repair of urethral lesion	Y		A2	$510.00	32.9713	$1,365.01	$723.75
57240	Repair bladder & vagina	Y		A2	$717.00	32.9713	$1,365.01	$879.00
57250	Repair rectum & vagina	Y		A2	$717.00	32.9713	$1,365.01	$879.00
57260	Repair of vagina	Y		A2	$717.00	32.9713	$1,365.01	$879.00
57265	Extensive repair of vagina	Y		A2	$995.00	43.2255	$1,789.54	$1,193.64
57267	Insert mesh/pelvic flr addon	Y		A2	$995.00	32.9713	$1,365.01	$1,087.50
57268	Repair of bowel bulge	Y		A2	$510.00	32.9713	$1,365.01	$723.75
57287	Revise/remove sling repair	Y		G2		32.9713	$1,365.01	$1,365.01
57288	Repair bladder defect	Y		A2	$717.00	43.2255	$1,789.54	$985.14
57289	Repair bladder & vagina	Y		A2	$717.00	32.9713	$1,365.01	$879.00
57291	Construction of vagina	Y		A2	$717.00	32.9713	$1,365.01	$879.00
57300	Repair rectum-vagina fistula	Y		A2	$510.00	32.9713	$1,365.01	$723.75
57320	Repair bladder-vagina lesion	Y		G2		32.9713	$1,365.01	$1,365.01
57400	Dilation of vagina	Y		A2	$446.00	19.2052	$795.10	$533.28
57410	Pelvic examination	Y		A2	$446.00	19.2052	$795.10	$533.28
57415	Remove vaginal foreign body	Y		A2	$446.00	19.2052	$795.10	$533.28
57420	Exam of vagina w/scope	Y		P3		1.0635	$44.03	$44.03
57421	Exam/biopsy of vag w/scope	Y		P3		1.4181	$58.71	$58.71
57452	Exam of cervix w/scope	Y		P3		1.0143	$41.99	$41.99
57454	Bx/curett of cervix w/scope	Y		P3		1.2534	$51.89	$51.89
57455	Biopsy of cervix w/scope	Y		P3		1.3275	$54.96	$54.96
57456	Endocerv curettage w/scope	Y		P3		1.2780	$52.91	$52.91
57460	Bx of cervix w/scope, leep	Y		P3		4.1638	$172.38	$172.38
57461	Conz of cervix w/scope, leep	Y		P3		4.3865	$181.60	$181.60
57500	Biopsy of cervix	Y		P3		1.8717	$77.49	$77.49
57505	Endocervical curettage	Y		P3		1.1461	$47.45	$47.45
57510	Cauterization of cervix	Y		P3		1.1872	$49.15	$49.15
57511	Cryocautery of cervix	Y	CH	P3		1.4099	$58.37	$58.37
57513	Laser surgery of cervix	Y		A2	$446.00	19.2052	$795.10	$533.28
57520	Conization of cervix	Y		A2	$446.00	19.2052	$795.10	$533.28
57522	Conization of cervix	Y		A2	$446.00	19.2052	$795.10	$533.28
57530	Removal of cervix	Y		A2	$510.00	32.9713	$1,365.01	$723.75
57550	Removal of residual cervix	Y		A2	$510.00	32.9713	$1,365.01	$723.75
57556	Remove cervix, repair bowel	Y		A2	$717.00	43.2255	$1,789.54	$985.14
57558	D&c of cervical stump	Y		A2	$510.00	19.2052	$795.10	$581.28
57700	Revision of cervix	Y		A2	$333.00	19.2052	$795.10	$448.53
57720	Revision of cervix	Y		A2	$510.00	19.2052	$795.10	$581.28
57800	Dilation of cervical canal	Y		P3		0.6101	$25.26	$25.26
58100	Biopsy of uterus lining	Y		P3		1.0143	$41.99	$41.99
58110	Bx done w/colposcopy add-on	N	CH	N1				
58120	Dilation and curettage	Y		A2	$446.00	19.2052	$795.10	$533.28
58145	Myomectomy vag method	Y		A2	$717.00	32.9713	$1,365.01	$879.00
58301	Remove intrauterine device	Y		P3		0.9729	$40.28	$40.28

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS Code	Short Descriptor	Subject to multiple procedure discounting	Comment indicator	Payment indicator	CY 2007 ASC payment rate	Proposed fully implemented payment weight	Proposed CY 2008 fully implemented payment	Proposed CY 2008 first transition year payment
58321	Artificial insemination	Y		P3		0.8575	$35.50	$35.50
58322	Artificial insemination	Y		P3		0.9234	$38.23	$38.23
58323	Sperm washing	Y		P3		0.2886	$11.95	$11.95
58340	Catheter for hysterography	N		N1				
58345	Reopen fallopian tube	Y		R2		19.2052	$795.10	$795.10
58346	Insert heyman uteri capsule	Y		A2	$446.00	19.2052	$795.10	$533.28
58350	Reopen fallopian tube	Y		A2	$510.00	32.9713	$1,365.01	$723.75
58353	Endometr ablate, thermal	Y		A2	$995.00	32.9713	$1,365.01	$1,087.50
58356	Endometrial cryoablation	Y		P3		43.0481	$1,782.19	$1,782.19
58545	Laparoscopic myomectomy	Y		A2	$1,339.00	34.8153	$1,441.35	$1,364.59
58546	Laparo-myomectomy, complex	Y		A2	$1,339.00	46.1201	$1,909.37	$1,481.59
58550	Laparo-asst vag hysterectomy	Y		A2	$1,339.00	71.0022	$2,939.49	$1,739.12
58552	Laparo-vag hyst incl t/o	Y		G2		46.1201	$1,909.37	$1,909.37
58555	Hysteroscopy, dx, sep proc	Y		A2	$333.00	22.1171	$915.65	$478.66
58558	Hysteroscopy, biopsy	Y		A2	$510.00	22.1171	$915.65	$611.41
58559	Hysteroscopy, lysis	Y		A2	$446.00	22.1171	$915.65	$563.41
58560	Hysteroscopy, resect septum	Y		A2	$510.00	34.8162	$1,441.39	$742.85
58561	Hysteroscopy, remove myoma	Y		A2	$510.00	34.8162	$1,441.39	$742.85
58562	Hysteroscopy, remove fb	Y		A2	$510.00	22.1171	$915.65	$611.41
58563	Hysteroscopy, ablation	Y		A2	$1,339.00	34.8162	$1,441.39	$1,364.60
58565	Hysteroscopy, sterilization	Y		A2	$1,339.00	43.2255	$1,789.54	$1,451.64
58600	Division of fallopian tube	Y		G2		32.9713	$1,365.01	$1,365.01
58615	Occlude fallopian tube(s)	Y		G2		19.2052	$795.10	$795.10
58660	Laparoscopy, lysis	Y		A2	$717.00	46.1201	$1,909.37	$1,015.09
58661	Laparoscopy, remove adnexa	Y		A2	$717.00	46.1201	$1,909.37	$1,015.09
58662	Laparoscopy, excise lesions	Y		A2	$717.00	46.1201	$1,909.37	$1,015.09
58670	Laparoscopy, tubal cautery	Y		A2	$510.00	46.1201	$1,909.37	$859.84
58671	Laparoscopy, tubal block	Y		A2	$510.00	46.1201	$1,909.37	$859.84
58672	Laparoscopy, fimbrioplasty	Y		A2	$717.00	46.1201	$1,909.37	$1,015.09
58673	Laparoscopy, salpingostomy	Y		A2	$717.00	46.1201	$1,909.37	$1,015.09
58800	Drainage of ovarian cyst(s)	Y		A2	$510.00	19.2052	$795.10	$581.28
58805	Drainage of ovarian cyst(s)	Y	CH	G2		32.9713	$1,365.01	$1,365.01
58820	Drain ovary abscess, open	Y		A2	$510.00	32.9713	$1,365.01	$723.75
58900	Biopsy of ovary(s)	Y		A2	$510.00	19.2052	$795.10	$581.28
58970	Retrieval of oocyte	Y		A2	$245.92	3.0466	$126.13	$215.97
58974	Transfer of embryo	Y		A2	$245.92	3.0466	$126.13	$215.97
58976	Transfer of embryo	Y		A2	$245.92	3.0466	$126.13	$215.97
59000	Amniocentesis, diagnostic	Y	CH	P3		1.5667	$64.86	$64.86
59001	Amniocentesis, therapeutic	Y		R2		7.4497	$308.42	$308.42
59012	Fetal cord puncture,prenatal	Y		G2		3.0466	$126.13	$126.13
59015	Chorion biopsy	Y		P3		1.2285	$50.86	$50.86
59020	Fetal contract stress test	Y		P3		0.5771	$23.89	$23.89
59025	Fetal non-stress test	Y		P3		0.2886	$11.95	$11.95
59070	Transabdom amnioinfus w/us	Y		G2		3.0466	$126.13	$126.13
59072	Umbilical cord occlud w/us	Y		G2		3.0466	$126.13	$126.13
59076	Fetal shunt placement, w/us	Y		G2		3.0466	$126.13	$126.13
59100	Remove uterus lesion	Y		R2		32.9713	$1,365.01	$1,365.01
59150	Treat ectopic pregnancy	Y		G2		46.1201	$1,909.37	$1,909.37
59151	Treat ectopic pregnancy	Y		G2		46.1201	$1,909.37	$1,909.37
59160	D& c after delivery	Y		A2	$510.00	19.2052	$795.10	$581.28
59200	Insert cervical dilator	Y		P3		0.8821	$36.52	$36.52
59300	Episiotomy or vaginal repair	Y		P3		1.7973	$74.41	$74.41
59320	Revision of cervix	Y		A2	$333.00	19.2052	$795.10	$448.53
59412	Antepartum manipulation	Y		G2		19.2052	$795.10	$795.10
59414	Deliver placenta	Y		G2		19.2052	$795.10	$795.10
59812	Treatment of miscarriage	Y		A2	$717.00	19.2052	$795.10	$736.53
59820	Care of miscarriage	Y		A2	$717.00	19.2052	$795.10	$736.53
59821	Treatment of miscarriage	Y		A2	$717.00	19.2052	$795.10	$736.53
59840	Abortion	Y		A2	$717.00	19.2052	$795.10	$736.53
59841	Abortion	Y		A2	$717.00	19.2052	$795.10	$736.53
59866	Abortion (mpr)	Y		G2		3.0466	$126.13	$126.13
59870	Evacuate mole of uterus	Y		A2	$717.00	19.2052	$795.10	$736.53
59871	Remove cerclage suture	Y		A2	$717.00	19.2052	$795.10	$736.53
60000	Drain thyroid/tongue cyst	Y		A2	$333.00	7.6539	$316.87	$328.97
60001	Aspirate/inject thyriod cyst	Y		P3		1.3686	$56.66	$56.66
60100	Biopsy of thyroid	Y		P3		1.1048	$45.74	$45.74
60200	Remove thyroid lesion	Y		A2	$446.00	45.1729	$1,870.16	$802.04
60280	Remove thyroid duct lesion	Y		A2	$630.00	45.1729	$1,870.16	$940.04
60281	Remove thyroid duct lesion	Y		A2	$630.00	45.1729	$1,870.16	$940.04
61000	Remove cranial cavity fluid	Y		R2		8.6797	$359.34	$359.34
61001	Remove cranial cavity fluid	Y		R2		8.6797	$359.34	$359.34
61020	Remove brain cavity fluid	Y		A2	$183.83	8.6797	$359.34	$227.71
61026	Injection into brain canal	Y		A2	$183.83	8.6797	$359.34	$227.71
61050	Remove brain canal fluid	Y		A2	$183.83	8.6797	$359.34	$227.71
61055	Injection into brain canal	Y		A2	$183.83	8.6797	$359.34	$227.71
61070	Brain canal shunt procedure	Y		A2	$183.83	3.2914	$136.26	$171.94

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS Code	Short Descriptor	Subject to multiple procedure discounting	Comment indicator	Payment indicator	CY 2007 ASC payment rate	Proposed fully implemented payment weight	Proposed CY 2008 fully implemented payment	Proposed CY 2008 first transition year payment
61215	Insert brain-fluid device	Y		A2	$510.00	37.1117	$1,536.42	$766.61
61330	Decompress eye socket	Y		G2		40.5598	$1,679.18	$1,679.18
61334	Explore orbit/remove object	Y		G2		40.5598	$1,679.18	$1,679.18
61790	Treat trigeminal nerve	Y		A2	$510.00	18.5069	$766.19	$574.05
61791	Treat trigeminal tract	Y		A2	$351.92	15.5687	$644.54	$425.08
61795	Brain surgery using computer	N	CH	N1	$302.04			
61880	Revise/remove neuroelectrode	Y		G2		24.1752	$1,000.85	$1,000.85
61885	Insrt/redo neurostim 1 array	N		H8	$446.00	284.8210	$11,791.59	$11,031.64
61886	Implant neurostim arrays	Y		H8	$510.00	384.8428	$15,932.49	$15,191.32
61888	Revise/remove neuroreceiver	Y		A2	$333.00	35.7248	$1,479.01	$619.50
62194	Replace/irrigate catheter	Y		A2	$333.00	8.6797	$359.34	$339.59
62225	Replace/irrigate catheter	Y		A2	$333.00	14.8912	$616.50	$403.88
62230	Replace/revise brain shunt	Y		A2	$446.00	37.1117	$1,536.42	$718.61
62252	Csf shunt reprogram	N		P3		1.0720	$44.38	$44.38
62263	Epidural lysis mult sessions	Y		A2	$333.00	15.5687	$644.54	$410.89
62264	Epidural lysis on single day	Y		A2	$333.00	15.5687	$644.54	$410.89
62268	Drain spinal cord cyst	Y		A2	$183.83	8.6797	$359.34	$227.71
62269	Needle biopsy, spinal cord	Y		A2	$333.00	9.5741	$396.37	$348.84
62270	Spinal fluid tap, diagnostic	Y		A2	$139.00	4.1589	$172.18	$147.30
62272	Drain cerebro spinal fluid	Y		A2	$139.00	4.1589	$172.18	$147.30
62273	Inject epidural patch	Y		A2	$333.00	4.1589	$172.18	$292.80
62280	Treat spinal cord lesion	Y		A2	$333.00	7.1370	$295.47	$323.62
62281	Treat spinal cord lesion	Y		A2	$333.00	7.1370	$295.47	$323.62
62282	Treat spinal canal lesion	Y		A2	$333.00	7.1370	$295.47	$323.62
62284	Injection for myelogram	N		N1				
62287	Percutaneous diskectomy	Y		A2	$1,339.00	32.0518	$1,326.94	$1,335.99
62290	Inject for spine disk x-ray	N		N1				
62291	Inject for spine disk x-ray	N		N1				
62292	Injection into disk lesion	Y	CH	R2		8.6797	$359.34	$359.34
62294	Injection into spinal artery	Y		A2	$183.83	8.6797	$359.34	$227.71
62310	Inject spine c/t	Y		A2	$333.00	7.1370	$295.47	$323.62
62311	Inject spine l/s (cd)	Y		A2	$333.00	7.1370	$295.47	$323.62
62318	Inject spine w/cath, c/t	Y		A2	$333.00	7.1370	$295.47	$323.62
62319	Inject spine w/cath l/s (cd)	Y		A2	$333.00	7.1370	$295.47	$323.62
62350	Implant spinal canal cath	Y		A2	$446.00	37.1117	$1,536.42	$718.61
62355	Remove spinal canal catheter	Y		A2	$446.00	15.5687	$644.54	$495.64
62360	Insert spine infusion device	Y		A2	$446.00	37.1117	$1,536.42	$718.61
62361	Implant spine infusion pump	Y		H8	$446.00	255.4150	$10,574.18	$9,781.61
62362	Implant spine infusion pump	Y		H8	$446.00	255.4150	$10,574.18	$9,781.61
62365	Remove spine infusion device	Y		A2	$446.00	32.0518	$1,326.94	$666.24
62367	Analyze spine infusion pump	N		P3		0.4205	$17.41	$17.41
62368	Analyze spine infusion pump	N		P3		0.5278	$21.85	$21.85
63600	Remove spinal cord lesion	Y		A2	$446.00	18.5069	$766.19	$526.05
63610	Stimulation of spinal cord	Y		A2	$333.00	18.5069	$766.19	$441.30
63615	Remove lesion of spinal cord	Y		R2		18.5069	$766.19	$766.19
63650	Implant neuroelectrodes	N		H8	$446.00	82.9543	$3,434.31	$2,896.42
63655	Implant neuroelectrodes	N		J8		107.3027	$4,442.33	$4,442.33
63660	Revise/remove neuroelectrode	Y		A2	$333.00	24.1752	$1,000.85	$499.96
63685	Insrt/redo spine n generator	Y		H8	$446.00	280.0420	$11,593.74	$10,925.15
63688	Revise/remove neuroreceiver	Y		A2	$333.00	35.7248	$1,479.01	$619.50
63744	Revision of spinal shunt	Y		A2	$510.00	37.1117	$1,536.42	$766.61
63746	Removal of spinal shunt	Y		A2	$446.00	6.1077	$252.86	$397.72
64400	Nblock inj, trigeminal	Y		P3		1.3604	$56.32	$56.32
64402	Nblock inj, facial	Y		P3		1.2449	$51.54	$51.54
64405	Nblock inj, occipital	Y		P3		1.0802	$44.72	$44.72
64408	Nblock inj, vagus	Y		P3		1.2449	$51.54	$51.54
64410	Nblock inj, phrenic	Y		A2	$333.00	7.1370	$295.47	$323.62
64412	Nblock inj, spinal accessor	Y		P3		1.9541	$80.90	$80.90
64413	Nblock inj, cervical plexus	Y		P3		1.2944	$53.59	$53.59
64415	Nblock inj, brachial plexus	Y		A2	$139.00	4.1589	$172.18	$147.30
64416	Nblock cont infuse, b plex	Y		G2		7.1370	$295.47	$295.47
64417	Nblock inj, axillary	Y		A2	$139.00	4.1589	$172.18	$147.30
64418	Nblock inj, suprascapular	Y		P3		1.8551	$76.80	$76.80
64420	Nblock inj, intercost, sng	Y		A2	$139.00	4.1589	$172.18	$147.30
64421	Nblock inj, intercost, mlt	Y		A2	$333.00	4.1589	$172.18	$292.80
64425	Nblock inj, ilio-ing/hypogi	Y		P3		1.2203	$50.52	$50.52
64430	Nblock inj, pudendal	Y		A2	$139.00	7.1370	$295.47	$178.12
64435	Nblock inj, paracervical	Y		P3		1.8551	$76.80	$76.80
64445	Nblock inj, sciatic, sng	Y		P3		1.7727	$73.39	$73.39
64446	Nblk inj, sciatic, cont inf	Y		G2		15.5687	$644.54	$644.54
64447	Nblock inj fem, single	Y	CH	R2		4.1589	$172.18	$172.18
64450	Nblock, other peripheral	Y		P3		1.0307	$42.67	$42.67
64470	Inj paravertebral c/t	Y		A2	$333.00	7.1370	$295.47	$323.62
64472	Inj paravertebral c/t add-on	Y		A2	$333.00	4.1589	$172.18	$292.80
64475	Inj paravertebral l/s	Y		A2	$333.00	7.1370	$295.47	$323.62
64476	Inj paravertebral l/s add-on	Y		A2	$333.00	4.1589	$172.18	$292.80

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS Code	Short Descriptor	Subject to multiple procedure discounting	Comment indicator	Payment indicator	CY 2007 ASC payment rate	Proposed fully implemented payment weight	Proposed CY 2008 fully implemented payment	Proposed CY 2008 first transition year payment
64479	Inj foramen epidural c/t	Y		A2	$333.00	7.1370	$295.47	$323.62
64480	Inj foramen epidural add-on	Y		A2	$333.00	4.1589	$172.18	$292.80
64483	Inj foramen epidural l/s	Y		A2	$333.00	7.1370	$295.47	$323.62
64484	Inj foramen epidural add-on	Y		A2	$333.00	7.1370	$295.47	$323.62
64505	Nblock, spenopalatine gangl	Y		P3		0.9729	$40.28	$40.28
64508	Nblock, carotid sinus s/p	Y		P3		2.1768	$90.12	$90.12
64510	Nblock, stellate ganglion	Y		A2	$333.00	7.1370	$295.47	$323.62
64517	Nblock inj, hypogas plxs	Y		A2	$139.00	7.1370	$295.47	$178.12
64520	Nblock, lumbar/thoracic	Y		A2	$333.00	7.1370	$295.47	$323.62
64530	Nblock inj, celiac pelus	Y		A2	$333.00	7.1370	$295.47	$323.62
64553	Implant neuroelectrodes	N		H8	$333.00	317.8027	$13,157.03	$12,089.52
64555	Implant neuroelectrodes	N		J8		82.9543	$3,434.31	$3,434.31
64560	Implant neuroelectrodes	N		J8		82.9543	$3,434.31	$3,434.31
64561	Implant neuroelectrodes	N		H8	$510.00	82.9543	$3,434.31	$2,944.42
64565	Implant neuroelectrodes	N		J8		82.9543	$3,434.31	$3,434.31
64573	Implant neuroelectrodes	N		H8	$333.00	317.8027	$13,157.03	$12,089.52
64575	Implant neuroelectrodes	N		H8	$333.00	107.3027	$4,442.33	$3,664.85
64577	Implant neuroelectrodes	N		H8	$333.00	107.3027	$4,442.33	$3,664.85
64580	Implant neuroelectrodes	N		H8	$333.00	107.3027	$4,442.33	$3,664.85
64581	Implant neuroelectrodes	N		H8	$510.00	107.3027	$4,442.33	$3,797.60
64585	Revise/remove neuroelectrode	Y		A2	$333.00	24.1752	$1,000.85	$499.96
64590	Insrt/redo pn/gastr stimul	Y		H8	$446.00	280.0420	$11,593.74	$10,925.15
64595	Revise/rmv pn/gastr stimul	Y		A2	$333.00	35.7248	$1,479.01	$619.50
64600	Injection treatment of nerve	Y		A2	$333.00	15.5687	$644.54	$410.89
64605	Injection treatment of nerve	Y		A2	$333.00	15.5687	$644.54	$410.89
64610	Injection treatment of nerve	Y		A2	$333.00	15.5687	$644.54	$410.89
64612	Destroy nerve, face muscle	Y		P3		1.6821	$69.64	$69.64
64613	Destroy nerve, neck muscle	Y		P3		1.7727	$73.39	$73.39
64614	Destroy nerve, extrem musc	Y		P3		1.9954	$82.61	$82.61
64620	Injection treatment of nerve	Y		A2	$333.00	7.1370	$295.47	$323.62
64622	Destr paravertebrl nerve l/s	Y		A2	$333.00	7.1370	$295.47	$323.62
64623	Destr paravertebral n add-on	Y		A2	$333.00	7.1370	$295.47	$323.62
64626	Destr paravertebrl nerve c/t	Y		A2	$333.00	7.1370	$295.47	$323.62
64627	Destr paravertebral n add-on	Y		A2	$333.00	2.3254	$96.27	$273.82
64630	Injection treatment of nerve	Y		A2	$351.92	7.1370	$295.47	$337.81
64640	Injection treatment of nerve	Y		P3		2.7126	$112.30	$112.30
64650	Chemodenerv eccrine glands	Y	CH	P3		0.6597	$27.31	$27.31
64653	Chemodenerv eccrine glands	Y	CH	P3		0.7007	$29.01	$29.01
64680	Injection treatment of nerve	Y		A2	$390.95	7.1370	$295.47	$367.08
64681	Injection treatment of nerve	Y		A2	$446.00	15.5687	$644.54	$495.64
64702	Revise finger/toe nerve	Y		A2	$333.00	18.5069	$766.19	$441.30
64704	Revise hand/foot nerve	Y		A2	$333.00	18.5069	$766.19	$441.30
64708	Revise arm/leg nerve	Y		A2	$446.00	18.5069	$766.19	$526.05
64712	Revision of sciatic nerve	Y		A2	$446.00	18.5069	$766.19	$526.05
64713	Revision of arm nerve(s)	Y		A2	$446.00	18.5069	$766.19	$526.05
64714	Revise low back nerve(s)	Y		A2	$446.00	18.5069	$766.19	$526.05
64716	Revision of cranial nerve	Y		A2	$510.00	18.5069	$766.19	$574.05
64718	Revise ulnar nerve at elbow	Y		A2	$446.00	18.5069	$766.19	$526.05
64719	Revise ulnar nerve at wrist	Y		A2	$446.00	18.5069	$766.19	$526.05
64721	Carpal tunnel surgery	Y		A2	$446.00	18.5069	$766.19	$526.05
64722	Relieve pressure on nerve(s)	Y		A2	$333.00	18.5069	$766.19	$441.30
64726	Release foot/toe nerve	Y		A2	$333.00	18.5069	$766.19	$441.30
64727	Internal nerve revision	Y		A2	$333.00	18.5069	$766.19	$441.30
64732	Incision of brow nerve	Y		A2	$446.00	18.5069	$766.19	$526.05
64734	Incision of cheek nerve	Y		A2	$446.00	18.5069	$766.19	$526.05
64736	Incision of chin nerve	Y		A2	$446.00	18.5069	$766.19	$526.05
64738	Incision of jaw nerve	Y		A2	$446.00	18.5069	$766.19	$526.05
64740	Incision of tongue nerve	Y		A2	$446.00	18.5069	$766.19	$526.05
64742	Incision of facial nerve	Y		A2	$446.00	18.5069	$766.19	$526.05
64744	Incise nerve, back of head	Y		A2	$446.00	18.5069	$766.19	$526.05
64746	Incise diaphragm nerve	Y		A2	$446.00	18.5069	$766.19	$526.05
64761	Incision of pelvis nerve	Y		G2		18.5069	$766.19	$766.19
64763	Incise hip/thigh nerve	Y		G2		18.5069	$766.19	$766.19
64766	Incise hip/thigh nerve	Y		G2		32.0518	$1,326.94	$1,326.94
64771	Sever cranial nerve	Y		A2	$446.00	18.5069	$766.19	$526.05
64772	Incision of spinal nerve	Y		A2	$446.00	18.5069	$766.19	$526.05
64774	Remove skin nerve lesion	Y		A2	$446.00	18.5069	$766.19	$526.05
64776	Remove digit nerve lesion	Y		A2	$510.00	18.5069	$766.19	$574.05
64778	Digit nerve surgery add-on	Y		A2	$446.00	18.5069	$766.19	$526.05
64782	Remove limb nerve lesion	Y		A2	$510.00	18.5069	$766.19	$574.05
64783	Limb nerve surgery add-on	Y		A2	$446.00	18.5069	$766.19	$526.05
64784	Remove nerve lesion	Y		A2	$510.00	18.5069	$766.19	$574.05
64786	Remove sciatic nerve lesion	Y		A2	$510.00	32.0518	$1,326.94	$714.24
64787	Implant nerve end	Y		A2	$446.00	18.5069	$766.19	$526.05
64788	Remove skin nerve lesion	Y		A2	$510.00	18.5069	$766.19	$574.05
64790	Removal of nerve lesion	Y		A2	$510.00	18.5069	$766.19	$574.05

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS Code	Short Descriptor	Subject to multiple procedure discounting	Comment indicator	Payment indicator	CY 2007 ASC payment rate	Proposed fully implemented payment weight	Proposed CY 2008 fully implemented payment	Proposed CY 2008 first transition year payment
64792	Removal of nerve lesion	Y		A2	$510.00	32.0518	$1,326.94	$714.24
64795	Biopsy of nerve	Y		A2	$446.00	18.5069	$766.19	$526.05
64802	Remove sympathetic nerves	Y		A2	$446.00	18.5069	$766.19	$526.05
64820	Remove sympathetic nerves	Y		G2		18.5069	$766.19	$766.19
64821	Remove sympathetic nerves	Y		A2	$630.00	26.7322	$1,106.71	$749.18
64822	Remove sympathetic nerves	Y		G2		26.7322	$1,106.71	$1,106.71
64823	Remove sympathetic nerves	Y		G2		26.7322	$1,106.71	$1,106.71
64831	Repair of digit nerve	Y		A2	$630.00	32.0518	$1,326.94	$804.24
64832	Repair nerve add-on	Y		A2	$333.00	32.0518	$1,326.94	$581.49
64834	Repair of hand or foot nerve	Y		A2	$446.00	32.0518	$1,326.94	$666.24
64835	Repair of hand or foot nerve	Y		A2	$510.00	32.0518	$1,326.94	$714.24
64836	Repair of hand or foot nerve	Y		A2	$510.00	32.0518	$1,326.94	$714.24
64837	Repair nerve add-on	Y		A2	$333.00	32.0518	$1,326.94	$581.49
64840	Repair of leg nerve	Y		A2	$446.00	32.0518	$1,326.94	$666.24
64856	Repair/transpose nerve	Y		A2	$446.00	32.0518	$1,326.94	$666.24
64857	Repair arm/leg nerve	Y		A2	$446.00	32.0518	$1,326.94	$666.24
64858	Repair sciatic nerve	Y		A2	$446.00	32.0518	$1,326.94	$666.24
64859	Nerve surgery	Y		A2	$333.00	32.0518	$1,326.94	$581.49
64861	Repair of arm nerves	Y		A2	$510.00	32.0518	$1,326.94	$714.24
64862	Repair of low back nerves	Y		A2	$510.00	32.0518	$1,326.94	$714.24
64864	Repair of facial nerve	Y		A2	$510.00	32.0518	$1,326.94	$714.24
64865	Repair of facial nerve	Y		A2	$630.00	32.0518	$1,326.94	$804.24
64870	Fusion of facial/other nerve	Y		A2	$630.00	32.0518	$1,326.94	$804.24
64872	Subsequent repair of nerve	Y		A2	$446.00	32.0518	$1,326.94	$666.24
64874	Repair & revise nerve add-on	Y		A2	$510.00	32.0518	$1,326.94	$714.24
64876	Repair nerve/shorten bone	Y		A2	$510.00	32.0518	$1,326.94	$714.24
64885	Nerve graft, head or neck	Y		A2	$446.00	32.0518	$1,326.94	$666.24
64886	Nerve graft, head or neck	Y		A2	$446.00	32.0518	$1,326.94	$666.24
64890	Nerve graft, hand or foot	Y		A2	$446.00	32.0518	$1,326.94	$666.24
64891	Nerve graft, hand or foot	Y		A2	$446.00	32.0518	$1,326.94	$666.24
64892	Nerve graft, arm or leg	Y		A2	$446.00	32.0518	$1,326.94	$666.24
64893	Nerve graft, arm or leg	Y		A2	$446.00	32.0518	$1,326.94	$666.24
64895	Nerve graft, hand or foot	Y		A2	$510.00	32.0518	$1,326.94	$714.24
64896	Nerve graft, hand or foot	Y		A2	$510.00	32.0518	$1,326.94	$714.24
64897	Nerve graft, arm or leg	Y		A2	$510.00	32.0518	$1,326.94	$714.24
64898	Nerve graft, arm or leg	Y		A2	$510.00	32.0518	$1,326.94	$714.24
64901	Nerve graft add-on	Y		A2	$446.00	32.0518	$1,326.94	$666.24
64902	Nerve graft add-on	Y		A2	$446.00	32.0518	$1,326.94	$666.24
64905	Nerve pedicle transfer	Y		A2	$446.00	32.0518	$1,326.94	$666.24
64907	Nerve pedicle transfer	Y		A2	$333.00	32.0518	$1,326.94	$581.49
65091	Revise eye	Y		A2	$510.00	37.3504	$1,546.31	$769.08
65093	Revise eye with implant	Y		A2	$510.00	37.3504	$1,546.31	$769.08
65101	Removal of eye	Y		A2	$510.00	37.3504	$1,546.31	$769.08
65103	Remove eye/insert implant	Y		A2	$510.00	37.3504	$1,546.31	$769.08
65105	Remove eye/attach implant	Y		A2	$630.00	37.3504	$1,546.31	$859.08
65110	Removal of eye	Y		A2	$717.00	37.3504	$1,546.31	$924.33
65112	Remove eye/revise socket	Y		A2	$995.00	37.3504	$1,546.31	$1,132.83
65114	Remove eye/revise socket	Y		A2	$995.00	37.3504	$1,546.31	$1,132.83
65125	Revise ocular implant	Y		G2		19.2280	$796.04	$796.04
65130	Insert ocular implant	Y		A2	$510.00	24.8916	$1,030.51	$640.13
65135	Insert ocular implant	Y		A2	$446.00	24.8916	$1,030.51	$592.13
65140	Attach ocular implant	Y		A2	$510.00	37.3504	$1,546.31	$769.08
65150	Revise ocular implant	Y		A2	$446.00	24.8916	$1,030.51	$592.13
65155	Reinsert ocular implant	Y		A2	$510.00	37.3504	$1,546.31	$769.08
65175	Removal of ocular implant	Y		A2	$333.00	19.2280	$796.04	$448.76
65205	Remove foreign body from eye	N		P3		0.5029	$20.82	$20.82
65210	Remove foreign body from eye	N		P3		0.6266	$25.94	$25.94
65220	Remove foreign body from eye	N		G2		1.1576	$47.92	$47.92
65222	Remove foreign body from eye	N		P3		0.6925	$28.67	$28.67
65235	Remove foreign body from eye	Y		A2	$446.00	16.5252	$684.14	$505.54
65260	Remove foreign body from eye	Y		A2	$510.00	18.8779	$781.55	$577.89
65265	Remove foreign body from eye	Y		A2	$630.00	29.0019	$1,200.68	$772.67
65270	Repair of eye wound	Y		A2	$446.00	19.2280	$796.04	$533.51
65272	Repair of eye wound	Y		A2	$446.00	24.0821	$997.00	$583.75
65275	Repair of eye wound	Y		A2	$630.00	24.0821	$997.00	$721.75
65280	Repair of eye wound	Y		A2	$630.00	18.8779	$781.55	$667.89
65285	Repair of eye wound	Y		A2	$630.00	38.1121	$1,577.84	$866.96
65286	Repair of eye wound	Y		P2		5.1145	$211.74	$211.74
65290	Repair of eye socket wound	Y		A2	$510.00	24.3920	$1,009.83	$634.96
65400	Removal of eye lesion	Y		A2	$333.00	16.5252	$684.14	$420.79
65410	Biopsy of cornea	Y		A2	$446.00	16.5252	$684.14	$505.54
65420	Removal of eye lesion	Y		A2	$446.00	16.5252	$684.14	$505.54
65426	Removal of eye lesion	Y		A2	$717.00	24.0821	$997.00	$787.00
65430	Corneal smear	N		P3		0.9894	$40.96	$40.96
65435	Curette/treat cornea	Y		P3		0.7669	$31.75	$31.75
65436	Curette/treat cornea	Y		G2		16.5252	$684.14	$684.14

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS Code	Short Descriptor	Subject to multiple procedure discounting	Comment indicator	Payment indicator	CY 2007 ASC payment rate	Proposed fully implemented payment weight	Proposed CY 2008 fully implemented payment	Proposed CY 2008 first transition year payment
65450	Treatment of corneal lesion	N		G2		2.3117	$95.70	$95.70
65600	Revision of cornea	Y		P3		3.9164	$162.14	$162.14
65710	Corneal transplant	Y		A2	$995.00	38.2919	$1,585.28	$1,142.57
65730	Corneal transplant	Y		A2	$995.00	38.2919	$1,585.28	$1,142.57
65750	Corneal transplant	Y		A2	$995.00	38.2919	$1,585.28	$1,142.57
65755	Corneal transplant	Y		A2	$995.00	38.2919	$1,585.28	$1,142.57
65770	Revise cornea with implant	Y		A2	$995.00	83.0605	$3,438.70	$1,605.93
65772	Correction of astigmatism	Y		A2	$630.00	16.5252	$684.14	$643.54
65775	Correction of astigmatism	Y		A2	$630.00	16.5252	$684.14	$643.54
65780	Ocular reconst, transplant	Y		A2	$717.00	38.2919	$1,585.28	$934.07
65781	Ocular reconst, transplant	Y		A2	$717.00	38.2919	$1,585.28	$934.07
65782	Ocular reconst, transplant	Y		A2	$717.00	38.2919	$1,585.28	$934.07
65800	Drainage of eye	Y		A2	$333.00	16.5252	$684.14	$420.79
65805	Drainage of eye	Y		A2	$333.00	16.5252	$684.14	$420.79
65810	Drainage of eye	Y		A2	$510.00	24.0821	$997.00	$631.75
65815	Drainage of eye	Y		A2	$446.00	24.0821	$997.00	$583.75
65820	Relieve inner eye pressure	Y		A2	$333.00	5.1145	$211.74	$302.69
65850	Incision of eye	Y		A2	$630.00	24.0821	$997.00	$721.75
65855	Laser surgery of eye	Y		P3		3.2403	$134.15	$134.15
65860	Incise inner eye adhesions	Y		P3		3.0343	$125.62	$125.62
65865	Incise inner eye adhesions	Y		A2	$333.00	16.5252	$684.14	$420.79
65870	Incise inner eye adhesions	Y		A2	$630.00	24.0821	$997.00	$721.75
65875	Incise inner eye adhesions	Y		A2	$630.00	24.0821	$997.00	$721.75
65880	Incise inner eye adhesions	Y		A2	$630.00	16.5252	$684.14	$643.54
65900	Remove eye lesion	Y		A2	$717.00	16.5252	$684.14	$708.79
65920	Remove implant of eye	Y		A2	$995.00	24.0821	$997.00	$995.50
65930	Remove blood clot from eye	Y		A2	$717.00	24.0821	$997.00	$787.00
66020	Injection treatment of eye	Y		A2	$333.00	16.5252	$684.14	$420.79
66030	Injection treatment of eye	Y		A2	$333.00	5.1145	$211.74	$302.69
66130	Remove eye lesion	Y		A2	$995.00	24.0821	$997.00	$995.50
66150	Glaucoma surgery	Y		A2	$630.00	24.0821	$997.00	$721.75
66155	Glaucoma surgery	Y		A2	$630.00	24.0821	$997.00	$721.75
66160	Glaucoma surgery	Y		A2	$446.00	24.0821	$997.00	$583.75
66165	Glaucoma surgery	Y		A2	$630.00	24.0821	$997.00	$721.75
66170	Glaucoma surgery	Y		A2	$630.00	24.0821	$997.00	$721.75
66172	Incision of eye	Y		A2	$630.00	24.0821	$997.00	$721.75
66180	Implant eye shunt	Y		A2	$717.00	40.8481	$1,691.11	$960.53
66185	Revise eye shunt	Y		A2	$446.00	40.8481	$1,691.11	$757.28
66220	Repair eye lesion	Y		A2	$510.00	38.1121	$1,577.84	$776.96
66225	Repair/graft eye lesion	Y		A2	$630.00	40.8481	$1,691.11	$895.28
66250	Follow-up surgery of eye	Y		A2	$446.00	16.5252	$684.14	$505.54
66500	Incision of iris	Y		A2	$333.00	5.1145	$211.74	$302.69
66505	Incision of iris	Y		A2	$333.00	5.1145	$211.74	$302.69
66600	Remove iris and lesion	Y		A2	$510.00	24.0821	$997.00	$631.75
66605	Removal of iris	Y		A2	$510.00	24.0821	$997.00	$631.75
66625	Removal of iris	Y		A2	$372.94	5.1145	$211.74	$332.64
66630	Removal of iris	Y		A2	$510.00	24.0821	$997.00	$631.75
66635	Removal of iris	Y		A2	$510.00	24.0821	$997.00	$631.75
66680	Repair iris & ciliary body	Y		A2	$510.00	24.0821	$997.00	$631.75
66682	Repair iris & ciliary body	Y		A2	$446.00	24.0821	$997.00	$583.75
66700	Destruction, ciliary body	Y		A2	$446.00	16.5252	$684.14	$505.54
66710	Ciliary transsleral therapy	Y		A2	$446.00	16.5252	$684.14	$505.54
66711	Ciliary endoscopic ablation	Y		A2	$446.00	16.5252	$684.14	$505.54
66720	Destruction, ciliary body	Y		A2	$446.00	16.5252	$684.14	$505.54
66740	Destruction, ciliary body	Y		A2	$446.00	24.0821	$997.00	$583.75
66761	Revision of iris	Y		P3		4.4029	$182.28	$182.28
66762	Revision of iris	Y		P3		4.4606	$184.67	$184.67
66770	Removal of inner eye lesion	Y		P3		4.8234	$199.69	$199.69
66820	Incision, secondary cataract	Y		G2		5.1145	$211.74	$211.74
66821	After cataract laser surgery	Y		A2	$312.50	5.2389	$216.89	$288.60
66825	Reposition intraocular lens	Y		A2	$630.00	24.0821	$997.00	$721.75
66830	Removal of lens lesion	Y		A2	$372.94	5.1145	$211.74	$332.64
66840	Removal of lens material	Y		A2	$630.00	14.9022	$616.95	$626.74
66850	Removal of lens material	Y		A2	$995.00	29.7487	$1,231.60	$1,054.15
66852	Removal of lens material	Y		A2	$630.00	29.7487	$1,231.60	$780.40
66920	Extraction of lens	Y		A2	$630.00	29.7487	$1,231.60	$780.40
66930	Extraction of lens	Y		A2	$717.00	29.7487	$1,231.60	$845.65
66940	Extraction of lens	Y		A2	$717.00	14.9022	$616.95	$691.99
66982	Cataract surgery, complex	Y		A2	$973.00	24.2197	$1,002.70	$980.43
66983	Cataract surg w/iol, 1 stage	Y		A2	$973.00	24.2197	$1,002.70	$980.43
66984	Cataract surg w/iol, 1 stage	Y		A2	$973.00	24.2197	$1,002.70	$980.43
66985	Insert lens prosthesis	Y		A2	$826.00	24.2197	$1,002.70	$870.18
66986	Exchange lens prosthesis	Y		A2	$826.00	24.2197	$1,002.70	$870.18
66990	Ophthalmic endoscope add-on	N		N1				
67005	Partial removal of eye fluid	Y		A2	$630.00	29.0019	$1,200.68	$772.67
67010	Partial removal of eye fluid	Y		A2	$630.00	29.0019	$1,200.68	$772.67

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS Code	Short Descriptor	Subject to multiple procedure discounting	Comment indicator	Payment indicator	CY 2007 ASC payment rate	Proposed fully implemented payment weight	Proposed CY 2008 fully implemented payment	Proposed CY 2008 first transition year payment
67015	Release of eye fluid	Y		A2	$333.00	29.0019	$1,200.68	$549.92
67025	Replace eye fluid	Y		A2	$333.00	29.0019	$1,200.68	$549.92
67027	Implant eye drug system	Y		A2	$630.00	38.1121	$1,577.84	$866.96
67028	Injection eye drug	N		P3		2.0200	$83.63	$83.63
67030	Incise inner eye strands	Y		A2	$333.00	18.8779	$781.55	$445.14
67031	Laser surgery, eye strands	Y		A2	$312.50	5.2389	$216.89	$288.60
67036	Removal of inner eye fluid	Y		A2	$630.00	38.1121	$1,577.84	$866.96
67038	Strip retinal membrane	Y		A2	$717.00	38.1121	$1,577.84	$932.21
67039	Laser treatment of retina	Y		A2	$995.00	38.1121	$1,577.84	$1,140.71
67040	Laser treatment of retina	Y		A2	$995.00	38.1121	$1,577.84	$1,140.71
67101	Repair detached retina	Y		P3		7.3135	$302.78	$302.78
67105	Repair detached retina	Y		P2		5.2389	$216.89	$216.89
67107	Repair detached retina	Y		A2	$717.00	38.1121	$1,577.84	$932.21
67108	Repair detached retina	Y		A2	$995.00	38.1121	$1,577.84	$1,140.71
67110	Repair detached retina	Y		P3		7.9565	$329.40	$329.40
67112	Rerepair detached retina	Y		A2	$995.00	38.1121	$1,577.84	$1,140.71
67115	Release encircling material	Y		A2	$446.00	18.8779	$781.55	$529.89
67120	Remove eye implant material	Y		A2	$446.00	18.8779	$781.55	$529.89
67121	Remove eye implant material	Y		A2	$446.00	29.0019	$1,200.68	$634.67
67141	Treatment of retina	Y		A2	$241.77	4.0100	$166.01	$222.83
67145	Treatment of retina	Y		P3		4.6007	$190.47	$190.47
67208	Treatment of retinal lesion	Y		P3		4.8976	$202.76	$202.76
67210	Treatment of retinal lesion	Y		P3		5.2027	$215.39	$215.39
67218	Treatment of retinal lesion	Y		A2	$717.00	18.8779	$781.55	$733.14
67220	Treatment of choroid lesion	Y		P2		4.0100	$166.01	$166.01
67221	Ocular photodynamic ther	Y		P3		3.0094	$124.59	$124.59
67225	Eye photodynamic ther add-on	Y		P3		0.1978	$8.19	$8.19
67227	Treatment of retinal lesion	Y		A2	$333.00	29.0019	$1,200.68	$549.92
67228	Treatment of retinal lesion	Y		P2		5.2389	$216.89	$216.89
67250	Reinforce eye wall	Y		A2	$510.00	19.2280	$796.04	$581.51
67255	Reinforce/graft eye wall	Y		A2	$510.00	29.0019	$1,200.68	$682.67
67311	Revise eye muscle	Y		A2	$510.00	24.3920	$1,009.83	$634.96
67312	Revise two eye muscles	Y		A2	$630.00	24.3920	$1,009.83	$724.96
67314	Revise eye muscle	Y		A2	$630.00	24.3920	$1,009.83	$724.96
67316	Revise two eye muscles	Y		A2	$630.00	24.3920	$1,009.83	$724.96
67318	Revise eye muscle(s)	Y		A2	$630.00	24.3920	$1,009.83	$724.96
67320	Revise eye muscle(s) add-on	Y		A2	$630.00	24.3920	$1,009.83	$724.96
67331	Eye surgery follow-up add-on	Y		A2	$630.00	24.3920	$1,009.83	$724.96
67332	Rerevise eye muscles add-on	Y		A2	$630.00	24.3920	$1,009.83	$724.96
67334	Revise eye muscle w/suture	Y		A2	$630.00	24.3920	$1,009.83	$724.96
67335	Eye suture during surgery	Y		A2	$630.00	24.3920	$1,009.83	$724.96
67340	Revise eye muscle add-on	Y		A2	$630.00	24.3920	$1,009.83	$724.96
67343	Release eye tissue	Y		A2	$995.00	24.3920	$1,009.83	$998.71
67345	Destroy nerve of eye muscle	Y		P3		1.9787	$81.92	$81.92
67346	Biopsy, eye muscle	Y		A2	$333.00	14.2784	$591.13	$397.53
67400	Explore/biopsy eye socket	Y		A2	$510.00	24.8916	$1,030.51	$640.13
67405	Explore/drain eye socket	Y		A2	$630.00	24.8916	$1,030.51	$730.13
67412	Explore/treat eye socket	Y		A2	$717.00	24.8916	$1,030.51	$795.38
67413	Explore/treat eye socket	Y		A2	$717.00	24.8916	$1,030.51	$795.38
67414	Explr/decompress eye socket	Y		G2		37.3504	$1,546.31	$1,546.31
67415	Aspiration, orbital contents	Y		A2	$333.00	19.2280	$796.04	$448.76
67420	Explore/treat eye socket	Y		A2	$717.00	37.3504	$1,546.31	$924.33
67430	Explore/treat eye socket	Y		A2	$717.00	37.3504	$1,546.31	$924.33
67440	Explore/drain eye socket	Y		A2	$717.00	37.3504	$1,546.31	$924.33
67445	Explr/decompress eye socket	Y		A2	$717.00	37.3504	$1,546.31	$924.33
67450	Explore/biopsy eye socket	Y		A2	$717.00	37.3504	$1,546.31	$924.33
67500	Inject/treat eye socket	N		G2		2.3117	$95.70	$95.70
67505	Inject/treat eye socket	Y		G2		2.8636	$118.55	$118.55
67515	Inject/treat eye socket	Y		P3		0.5688	$23.55	$23.55
67550	Insert eye socket implant	Y		A2	$630.00	37.3504	$1,546.31	$859.08
67560	Revise eye socket implant	Y		A2	$446.00	24.8916	$1,030.51	$592.13
67570	Decompress optic nerve	Y		A2	$630.00	37.3504	$1,546.31	$859.08
67700	Drainage of eyelid abscess	Y		P2		2.8636	$118.55	$118.55
67710	Incision of eyelid	Y		P3		3.7432	$154.97	$154.97
67715	Incision of eyelid fold	Y		A2	$333.00	19.2280	$796.04	$448.76
67800	Remove eyelid lesion	Y		P3		1.2534	$51.89	$51.89
67801	Remove eyelid lesions	Y		P3		1.5089	$62.47	$62.47
67805	Remove eyelid lesions	Y		P3		1.9541	$80.90	$80.90
67808	Remove eyelid lesion(s)	Y		A2	$446.00	19.2280	$796.04	$533.51
67810	Biopsy of eyelid	Y		P2		2.8636	$118.55	$118.55
67820	Revise eyelashes	N		P3		0.4370	$18.09	$18.09
67825	Revise eyelashes	Y		P3		1.2944	$53.59	$53.59
67830	Revise eyelashes	Y		A2	$446.00	7.1099	$294.35	$408.09
67835	Revise eyelashes	Y		A2	$446.00	19.2280	$796.04	$533.51
67840	Remove eyelid lesion	Y		P3		3.8751	$160.43	$160.43
67850	Treat eyelid lesion	Y		P3		2.7457	$113.67	$113.67

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS Code	Short Descriptor	Subject to multiple procedure discounting	Comment indicator	Payment indicator	CY 2007 ASC payment rate	Proposed fully implemented payment weight	Proposed CY 2008 fully implemented payment	Proposed CY 2008 first transition year payment
67875	Closure of eyelid by suture	Y		G2		7.1099	$294.35	$294.35
67880	Revision of eyelid	Y		A2	$510.00	16.5252	$684.14	$553.54
67882	Revision of eyelid	Y		A2	$510.00	19.2280	$796.04	$581.51
67900	Repair brow defect	Y		A2	$630.00	19.2280	$796.04	$671.51
67901	Repair eyelid defect	Y		A2	$717.00	19.2280	$796.04	$736.76
67902	Repair eyelid defect	Y		A2	$717.00	19.2280	$796.04	$736.76
67903	Repair eyelid defect	Y		A2	$630.00	19.2280	$796.04	$671.51
67904	Repair eyelid defect	Y		A2	$630.00	19.2280	$796.04	$671.51
67906	Repair eyelid defect	Y		A2	$717.00	19.2280	$796.04	$736.76
67908	Repair eyelid defect	Y		A2	$630.00	19.2280	$796.04	$671.51
67909	Revise eyelid defect	Y		A2	$630.00	19.2280	$796.04	$671.51
67911	Revise eyelid defect	Y		A2	$510.00	19.2280	$796.04	$581.51
67912	Correction eyelid w/implant	Y		A2	$510.00	19.2280	$796.04	$581.51
67914	Repair eyelid defect	Y		A2	$510.00	19.2280	$796.04	$581.51
67915	Repair eyelid defect	Y		P3		4.2792	$177.16	$177.16
67916	Repair eyelid defect	Y		A2	$630.00	19.2280	$796.04	$671.51
67917	Repair eyelid defect	Y		A2	$630.00	19.2280	$796.04	$671.51
67921	Repair eyelid defect	Y		A2	$510.00	19.2280	$796.04	$581.51
67922	Repair eyelid defect	Y		P3		4.1969	$173.75	$173.75
67923	Repair eyelid defect	Y		A2	$630.00	19.2280	$796.04	$671.51
67924	Repair eyelid defect	Y		A2	$630.00	19.2280	$796.04	$671.51
67930	Repair eyelid wound	Y		P3		4.1720	$172.72	$172.72
67935	Repair eyelid wound	Y		A2	$446.00	19.2280	$796.04	$533.51
67938	Remove eyelid foreign body	N		P2		1.1576	$47.92	$47.92
67950	Revision of eyelid	Y		A2	$446.00	19.2280	$796.04	$533.51
67961	Revision of eyelid	Y		A2	$510.00	19.2280	$796.04	$581.51
67966	Revision of eyelid	Y		A2	$510.00	19.2280	$796.04	$581.51
67971	Reconstruction of eyelid	Y		A2	$510.00	24.8916	$1,030.51	$640.13
67973	Reconstruction of eyelid	Y		A2	$510.00	24.8916	$1,030.51	$640.13
67974	Reconstruction of eyelid	Y		A2	$510.00	24.8916	$1,030.51	$640.13
67975	Reconstruction of eyelid	Y		A2	$510.00	19.2280	$796.04	$581.51
68020	Incise/drain eyelid lining	Y		P3		1.0966	$45.40	$45.40
68040	Treatment of eyelid lesions	N		P3		0.5442	$22.53	$22.53
68100	Biopsy of eyelid lining	Y		P3		2.3169	$95.92	$95.92
68110	Remove eyelid lining lesion	Y		P3		2.9684	$122.89	$122.89
68115	Remove eyelid lining lesion	Y		A2	$446.00	19.2280	$796.04	$533.51
68130	Remove eyelid lining lesion	Y		A2	$446.00	16.5252	$684.14	$505.54
68135	Remove eyelid lining lesion	Y		P3		1.4099	$58.37	$58.37
68200	Treat eyelid by injection	N		P3		0.4123	$17.07	$17.07
68320	Revise/graft eyelid lining	Y		A2	$630.00	19.2280	$796.04	$671.51
68325	Revise/graft eyelid lining	Y		A2	$630.00	24.8916	$1,030.51	$730.13
68326	Revise/graft eyelid lining	Y		A2	$630.00	24.8916	$1,030.51	$730.13
68328	Revise/graft eyelid lining	Y		A2	$630.00	24.8916	$1,030.51	$730.13
68330	Revise eyelid lining	Y		A2	$630.00	24.0821	$997.00	$721.75
68335	Revise/graft eyelid lining	Y		A2	$630.00	24.8916	$1,030.51	$730.13
68340	Separate eyelid adhesions	Y		A2	$630.00	19.2280	$796.04	$671.51
68360	Revise eyelid lining	Y		A2	$446.00	24.0821	$997.00	$583.75
68362	Revise eyelid lining	Y		A2	$446.00	24.0821	$997.00	$583.75
68371	Harvest eye tissue, alograft	Y		A2	$446.00	16.5252	$684.14	$505.54
68400	Incise/drain tear gland	Y		P2		2.8636	$118.55	$118.55
68420	Incise/drain tear sac	Y		P3		4.4606	$184.67	$184.67
68440	Incise tear duct opening	Y		P3		1.3771	$57.01	$57.01
68500	Removal of tear gland	Y		A2	$510.00	24.8916	$1,030.51	$640.13
68505	Partial removal, tear gland	Y		A2	$510.00	24.8916	$1,030.51	$640.13
68510	Biopsy of tear gland	Y		A2	$333.00	19.2280	$796.04	$448.76
68520	Removal of tear sac	Y		A2	$510.00	24.8916	$1,030.51	$640.13
68525	Biopsy of tear sac	Y		A2	$333.00	19.2280	$796.04	$448.76
68530	Clearance of tear duct	Y		P3		5.6973	$235.87	$235.87
68540	Remove tear gland lesion	Y		A2	$510.00	24.8916	$1,030.51	$640.13
68550	Remove tear gland lesion	Y		A2	$510.00	24.8916	$1,030.51	$640.13
68700	Repair tear ducts	Y		A2	$446.00	24.8916	$1,030.51	$592.13
68705	Revise tear duct opening	Y		P2		2.8636	$118.55	$118.55
68720	Create tear sac drain	Y		A2	$630.00	24.8916	$1,030.51	$730.13
68745	Create tear duct drain	Y		A2	$630.00	24.8916	$1,030.51	$730.13
68750	Create tear duct drain	Y		A2	$630.00	24.8916	$1,030.51	$730.13
68760	Close tear duct opening	N		P2		2.3117	$95.70	$95.70
68761	Close tear duct opening	N		P3		1.6986	$70.32	$70.32
68770	Close tear system fistula	Y		A2	$630.00	19.2280	$796.04	$671.51
68801	Dilate tear duct opening	N		P2		1.1576	$47.92	$47.92
68810	Probe nasolacrimal duct	N		A2	$131.86	2.3117	$95.70	$122.82
68811	Probe nasolacrimal duct	Y		A2	$446.00	19.2280	$796.04	$533.51
68815	Probe nasolacrimal duct	Y		A2	$446.00	19.2280	$796.04	$533.51
68840	Explore/irrigate tear ducts	N		P2		1.1576	$47.92	$47.92
68850	Injection for tear sac x-ray	N		N1				
69000	Drain external ear lesion	Y		P2		1.4630	$60.57	$60.57
69005	Drain external ear lesion	Y		P3		2.4075	$99.67	$99.67

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS Code	Short Descriptor	Subject to multiple procedure discounting	Comment indicator	Payment indicator	CY 2007 ASC payment rate	Proposed fully implemented payment weight	Proposed CY 2008 fully implemented payment	Proposed CY 2008 first transition year payment
69020	Drain outer ear canal lesion	Y		P2		1.4630	$60.57	$60.57
69100	Biopsy of external ear	Y		P3		1.4676	$60.76	$60.76
69105	Biopsy of external ear canal	Y		P3		2.0283	$83.97	$83.97
69110	Remove external ear, partial	Y		A2	$333.00	16.5832	$686.54	$421.39
69120	Removal of external ear	Y		A2	$446.00	24.3535	$1,008.23	$586.56
69140	Remove ear canal lesion(s)	Y		A2	$446.00	24.3535	$1,008.23	$586.56
69145	Remove ear canal lesion(s)	Y		A2	$446.00	16.5832	$686.54	$506.14
69150	Extensive ear canal surgery	Y		A2	$464.15	7.6539	$316.87	$427.33
69200	Clear outer ear canal	N		P2		0.6416	$26.56	$26.56
69205	Clear outer ear canal	Y		A2	$333.00	21.4534	$888.17	$471.79
69210	Remove impacted ear wax	N		P3		0.4947	$20.48	$20.48
69220	Clean out mastoid cavity	Y		P2		0.8046	$33.31	$33.31
69222	Clean out mastoid cavity	Y		P3		3.1826	$131.76	$131.76
69300	Revise external ear	Y		A2	$510.00	24.3535	$1,008.23	$634.56
69310	Rebuild outer ear canal	Y		A2	$510.00	40.5598	$1,679.18	$802.30
69320	Rebuild outer ear canal	Y		A2	$995.00	40.5598	$1,679.18	$1,166.05
69400	Inflate middle ear canal	Y		P3		2.0200	$83.63	$83.63
69401	Inflate middle ear canal	Y		P3		1.1295	$46.76	$46.76
69405	Catheterize middle ear canal	Y		P3		2.9188	$120.84	$120.84
69420	Incision of eardrum	Y		P2		2.5765	$106.67	$106.67
69421	Incision of eardrum	Y		A2	$510.00	16.6341	$688.65	$554.66
69424	Remove ventilating tube	Y		P3		1.8386	$76.12	$76.12
69433	Create eardrum opening	Y		P3		2.6056	$107.87	$107.87
69436	Create eardrum opening	Y		A2	$510.00	16.6341	$688.65	$554.66
69440	Exploration of middle ear	Y		A2	$510.00	24.3535	$1,008.23	$634.56
69450	Eardrum revision	Y		A2	$333.00	40.5598	$1,679.18	$669.55
69501	Mastoidectomy	Y		A2	$995.00	40.5598	$1,679.18	$1,166.05
69502	Mastoidectomy	Y		A2	$995.00	24.3535	$1,008.23	$998.31
69505	Remove mastoid structures	Y		A2	$995.00	40.5598	$1,679.18	$1,166.05
69511	Extensive mastoid surgery	Y		A2	$995.00	40.5598	$1,679.18	$1,166.05
69530	Extensive mastoid surgery	Y		A2	$995.00	40.5598	$1,679.18	$1,166.05
69540	Remove ear lesion	Y		P3		3.1085	$128.69	$128.69
69550	Remove ear lesion	Y		A2	$717.00	40.5598	$1,679.18	$957.55
69552	Remove ear lesion	Y		A2	$995.00	40.5598	$1,679.18	$1,166.05
69601	Mastoid surgery revision	Y		A2	$995.00	40.5598	$1,679.18	$1,166.05
69602	Mastoid surgery revision	Y		A2	$995.00	40.5598	$1,679.18	$1,166.05
69603	Mastoid surgery revision	Y		A2	$995.00	40.5598	$1,679.18	$1,166.05
69604	Mastoid surgery revision	Y		A2	$995.00	40.5598	$1,679.18	$1,166.05
69605	Mastoid surgery revision	Y		A2	$995.00	40.5598	$1,679.18	$1,166.05
69610	Repair of eardrum	Y		P3		4.2546	$176.14	$176.14
69620	Repair of eardrum	Y		A2	$446.00	24.3535	$1,008.23	$586.56
69631	Repair eardrum structures	Y		A2	$717.00	40.5598	$1,679.18	$957.55
69632	Rebuild eardrum structures	Y		A2	$717.00	40.5598	$1,679.18	$957.55
69633	Rebuild eardrum structures	Y		A2	$717.00	40.5598	$1,679.18	$957.55
69635	Repair eardrum structures	Y		A2	$995.00	40.5598	$1,679.18	$1,166.05
69636	Rebuild eardrum structures	Y		A2	$995.00	40.5598	$1,679.18	$1,166.05
69637	Rebuild eardrum structures	Y		A2	$995.00	40.5598	$1,679.18	$1,166.05
69641	Revise middle ear & mastoid	Y		A2	$995.00	40.5598	$1,679.18	$1,166.05
69642	Revise middle ear & mastoid	Y		A2	$995.00	40.5598	$1,679.18	$1,166.05
69643	Revise middle ear & mastoid	Y		A2	$995.00	40.5598	$1,679.18	$1,166.05
69644	Revise middle ear & mastoid	Y		A2	$995.00	40.5598	$1,679.18	$1,166.05
69645	Revise middle ear & mastoid	Y		A2	$995.00	40.5598	$1,679.18	$1,166.05
69646	Revise middle ear & mastoid	Y		A2	$995.00	40.5598	$1,679.18	$1,166.05
69650	Release middle ear bone	Y		A2	$995.00	24.3535	$1,008.23	$998.31
69660	Revise middle ear bone	Y		A2	$717.00	40.5598	$1,679.18	$957.55
69661	Revise middle ear bone	Y		A2	$717.00	40.5598	$1,679.18	$957.55
69662	Revise middle ear bone	Y		A2	$717.00	40.5598	$1,679.18	$957.55
69666	Repair middle ear structures	Y		A2	$630.00	40.5598	$1,679.18	$892.30
69667	Repair middle ear structures	Y		A2	$630.00	40.5598	$1,679.18	$892.30
69670	Remove mastoid air cells	Y		A2	$510.00	40.5598	$1,679.18	$802.30
69676	Remove middle ear nerve	Y		A2	$510.00	40.5598	$1,679.18	$802.30
69700	Close mastoid fistula	Y		A2	$510.00	40.5598	$1,679.18	$802.30
69711	Remove/repair hearing aid	Y		A2	$333.00	40.5598	$1,679.18	$669.55
69714	Implant temple bone w/stimul	Y		A2	$1,339.00	40.5598	$1,679.18	$1,424.05
69715	Temple bne implnt w/stimulat	Y		A2	$1,339.00	40.5598	$1,679.18	$1,424.05
69717	Temple bone implant revision	Y		A2	$1,339.00	40.5598	$1,679.18	$1,424.05
69718	Revise temple bone implant	Y		A2	$1,339.00	40.5598	$1,679.18	$1,424.05
69720	Release facial nerve	Y		A2	$717.00	40.5598	$1,679.18	$957.55
69740	Repair facial nerve	Y		A2	$717.00	40.5598	$1,679.18	$957.55
69745	Repair facial nerve	Y		A2	$717.00	40.5598	$1,679.18	$957.55
69801	Incise inner ear	Y		A2	$717.00	40.5598	$1,679.18	$957.55
69802	Incise inner ear	Y		A2	$995.00	40.5598	$1,679.18	$1,166.05
69805	Explore inner ear	Y		A2	$995.00	40.5598	$1,679.18	$1,166.05
69806	Explore inner ear	Y		A2	$995.00	40.5598	$1,679.18	$1,166.05
69820	Establish inner ear window	Y		A2	$717.00	40.5598	$1,679.18	$957.55
69840	Revise inner ear window	Y		A2	$717.00	40.5598	$1,679.18	$957.55

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS Code	Short Descriptor	Subject to multiple procedure discounting	Comment indicator	Payment indicator	CY 2007 ASC payment rate	Proposed fully implemented payment weight	Proposed CY 2008 fully implemented payment	Proposed CY 2008 first transition year payment
69905	Remove inner ear	Y		A2	$995.00	40.5598	$1,679.18	$1,166.05
69910	Remove inner ear & mastoid	Y		A2	$995.00	40.5598	$1,679.18	$1,166.05
69915	Incise inner ear nerve	Y		A2	$995.00	40.5598	$1,679.18	$1,166.05
69930	Implant cochlear device	Y		H8	$995.00	585.1167	$24,223.83	$22,839.55
69990	Microsurgery add-on	N		N1				
C9716	Radiofrequency energy to anu	Y		G2		30.5544	$1,264.95	$1,264.95
C9724	EPS gast cardia plic	Y		G2		24.6480	$1,020.43	$1,020.43
C9725	Place endorectal app	N		G2		8.6353	$357.50	$357.50
C9726	Rxt breast appl place/remov	N		G2		10.2053	$422.50	$422.50
C9727	Insert palate implants	N		G2		13.3454	$552.50	$552.50
G0104	CA screen;flexi sigmoidscope	N		P3		1.9705	$81.58	$81.58
G0105	Colorectal scrn; hi risk ind	Y		A2	$446.00	8.0134	$331.75	$417.44
G0121	Colon ca scrn not hi rsk ind	Y		A2	$446.00	8.0134	$331.75	$417.44
G0127	Trim nail(s)	Y		P3		0.2556	$10.58	$10.58
G0186	Dstry eye lesn,fdr vssl tech	Y		R2		4.0100	$166.01	$166.01
G0247	Routine footcare pt w lops	Y		P3		0.4865	$20.14	$20.14
G0260	Inj for sacroiliac jt anesth	Y		A2	$333.00	7.1370	$295.47	$323.62
G0268	Removal of impacted wax md	N	CH	N1				
G0364	Bone marrow aspirate &biopsy	Y		P3		0.1237	$5.12	$5.12
G0392	AV fistula or graft arterial	Y		A2	$1,339.00	46.0685	$1,907.24	$1,481.06
G0393	AV fistula or graft venous	Y		A2	$1,339.00	46.0685	$1,907.24	$1,481.06

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008

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					
0012F	Cap bacterial assess		M					
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					
0016T	Thermotx choroid vasc lesion		T	0235	4.01	$255.41	$58.90	$51.08
00170	Anesth, procedure on mouth		N					
00172	Anesth, cleft palate repair		N					
00174	Anesth, pharyngeal surgery		N					
00176	Anesth, pharyngeal surgery		C					
0017T	Photocoagulat macular drusen		T	0235	4.01	$255.41	$58.90	$51.08
00190	Anesth, face/skull bone surg		N					
00192	Anesth, facial bone surgery		C					
0019T	Extracorp shock wv tx,ms nos		A					
00210	Anesth, open head surgery		N					
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					
0024T	Transcath cardiac reduction		C					
0026T	Measure remnant lipoproteins		A					
0027T	Endoscopic epidural lysis		T	0220	18.5069	$1,178.76		$235.75
0028T	Dexa body composition study		N					
0029T	Magnetic tx for incontinence		A					
00300	Anesth, head/neck/ptrunk		N					
0030T	Antiprothrombin antibody		A					
0031T	Speculoscopy		N					
00320	Anesth, neck organ, 1 & over		N					
00322	Anesth, biopsy of thyroid		N					
00326	Anesth, larynx/trach, < 1 yr		N					
0032T	Speculoscopy w/direct sample		N					
00350	Anesth, neck vessel surgery		N					
00352	Anesth, neck vessel surgery		N					
00400	Anesth, skin, ext/per/atrunk		N					
00402	Anesth, surgery of breast		N					
00404	Anesth, surgery of breast		N					
00406	Anesth, surgery of breast		N					
00410	Anesth, correct heart rhythm		N					
0041T	Detect ur infect agnt w/cpas		A					
0042T	Ct perfusion w/contrast, cbf		N					
0043T	Co expired gas analysis		A					
00450	Anesth, surgery of shoulder		N					
00452	Anesth, surgery of shoulder		C					
00454	Anesth, collar bone biopsy		N					
0046T	Cath lavage, mammary duct(s)		T	0021	16.5832	$1,056.23	$219.40	$211.25
00470	Anesth, removal of rib		N					
00472	Anesth, chest wall repair		N					
00474	Anesth, surgery of rib(s)		C					
0047T	Cath lavage, mammary duct(s)		T	0021	16.5832	$1,056.23	$219.40	$211.25
0048T	Implant ventricular device		C					
0049T	External circulation assist		C					
00500	Anesth, esophageal surgery		N					
0050T	Removal circulation assist		C					
0051T	Implant total heart system		C					
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					
0052T	Replace component heart syst		C					
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					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
0053T	Replace component heart syst		C					
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					
0054T	Bone surgery using computer	CH	N					
00550	Anesth, sternal debridement		N					
0055T	Bone surgery using computer	CH	N					
00560	Anesth, heart surg w/o pump		C					
00561	Anesth, heart surg < age 1		C					
00562	Anesth, heart surg w/pump		C					
00563	Anesth, heart surg w/arrest		N					
00566	Anesth, cabg w/o pump		N					
0056T	Bone surgery using computer	CH	N					
00580	Anesth, heart/lung transplnt		C					
0058T	Cryopreservation, ovary tiss	CH	X	0344	0.8586	$54.69	$15.60	$10.94
0059T	Cryopreservation, oocyte	CH	X	0344	0.8586	$54.69	$15.60	$10.94
00600	Anesth, spine, cord surgery		N					
00604	Anesth, sitting procedure		C					
0060T	Electrical impedance scan		B					
0061T	Destruction of tumor, breast		B					
00620	Anesth, spine, cord surgery		N					
00622	Anesth, removal of nerves		C					
00625	Anes spine tranthor w/o vent		N					
00626	Anes, spine transthor w/vent		N					
0062T	Rep intradisc annulus;1 lev		T	0050	29.3263	$1,867.88		$373.58
00630	Anesth, spine, cord surgery		N					
00632	Anesth, removal of nerves		C					
00634	Anesth for chemonucleolysis		N					
00635	Anesth, lumbar puncture		N					
0063T	Rep intradisc annulus;>1lev		T	0050	29.3263	$1,867.88		$373.58
00640	Anesth, spine manipulation		N					
0064T	Spectroscop eval expired gas		X	0367	0.5955	$37.93	$14.38	$7.59
0065T	Ocular photoscreen bilat		E					
0066T	Ct colonography;screen		E					
00670	Anesth, spine, cord surgery		C					
0067T	Ct colonography;dx	CH	S	0332	3.1487	$200.55	$75.20	$40.11
0068T	Interp/rept heart sound		B					
0069T	Analysis only heart sound		N					
00700	Anesth, abdominal wall surg		N					
00702	Anesth, for liver biopsy		N					
0070T	Interp only heart sound		B					
0071T	U/s leiomyomata ablate <200	CH	S	0067	61.5205	$3,918.43		$783.69
0072T	U/s leiomyomata ablate >200	CH	S	0067	61.5205	$3,918.43		$783.69
00730	Anesth, abdominal wall surg		N					
0073T	Delivery, comp imrt		S	0412	5.7275	$364.80		$72.96
00740	Anesth, upper gi visualize		N					
0074T	Online physician e/m		E					
00750	Anesth, repair of hernia		N					
00752	Anesth, repair of hernia		N					
00754	Anesth, repair of hernia		N					
00756	Anesth, repair of hernia		N					
0075T	Perq stent/chest vert art		C					
0076T	S&i stent/chest vert art		C					
00770	Anesth, blood vessel repair		N					
0077T	Cereb therm perfusion probe		C					
0078T	Endovasc aort repr w/device		C					
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					
0079T	Endovasc visc extnsn repr		C					
00800	Anesth, abdominal wall surg		N					
00802	Anesth, fat layer removal		C					
0080T	Endovasc aort repr rad s&i		C					
00810	Anesth, low intestine scope		N					
0081T	Endovasc visc extnsn s&i		C					
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					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
00848	Anesth, pelvic organ surg		C					
0084T	Temp prostate urethral stent		T	0164	2.1659	$137.95		$27.59
00851	Anesth, tubal ligation		N					
0085T	Breath test heart reject		X	0340	0.6416	$40.87		$8.17
00860	Anesth, surgery of abdomen		N					
00862	Anesth, kidney/ureter surg		N					
00864	Anesth, removal of bladder		C					
00865	Anesth, removal of prostate		C					
00866	Anesth, removal of adrenal		C					
00868	Anesth, kidney transplant		C					
0086T	L ventricle fill pressure		N					
00870	Anesth, bladder stone surg		N					
00872	Anesth kidney stone destruct		N					
00873	Anesth kidney stone destruct		N					
0087T	Sperm eval hyaluronan	CH	X	0344	0.8586	$54.69	$15.60	$10.94
00880	Anesth, abdomen vessel surg		N					
00882	Anesth, major vein ligation		C					
0088T	Rf tongue base vol reduxn		T	0253	16.6341	$1,059.48	$282.20	$211.90
0089T	Actigraphy testing, 3-day		S	0218	1.1861	$75.55		$15.11
00902	Anesth, anorectal surgery		N					
00904	Anesth, perineal surgery		C					
00906	Anesth, removal of vulva		N					
00908	Anesth, removal of prostate		C					
0090T	Cervical artific disc		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					
0092T	Artific disc addl		C					
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					
0093T	Cervical artific diskectomy		C					
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					
0095T	Artific diskectomy addl		C					
0096T	Rev cervical artific disc		C					
0098T	Rev artific disc addl		C					
0099T	Implant corneal ring		T	0233	16.5252	$1,052.54	$266.30	$210.51
0100T	Prosth retina receive&gen		T	0672	38.1121	$2,427.47		$485.49
0101T	Extracorp shockwv tx,hi enrg		T	0050	29.3263	$1,867.88		$373.58
0102T	Extracorp shockwv tx,anesth		T	0050	29.3263	$1,867.88		$373.58
0103T	Holotranscobalamin		A					
0104T	At rest cardio gas rebreathe		A					
0105T	Exerc cardio gas rebreathe		A					
0106T	Touch quant sensory test		X	0341	0.0879	$5.60	$2.20	$1.12
0107T	Vibrate quant sensory test		X	0341	0.0879	$5.60	$2.20	$1.12
0108T	Cool quant sensory test		X	0341	0.0879	$5.60	$2.20	$1.12
0109T	Heat quant sensory test		X	0341	0.0879	$5.60	$2.20	$1.12
0110T	Nos quant sensory test		X	0341	0.0879	$5.60	$2.20	$1.12
01112	Anesth, bone aspirate/bx		N					
0111T	Rbc membranes fatty acids		A					
01120	Anesth, pelvis surgery		N					
01130	Anesth, body cast procedure		N					
01140	Anesth, amputation at pelvis		C					
01150	Anesth, pelvic tumor surgery		C					
0115T	Med tx mngmt 15 min		B					
01160	Anesth, pelvis procedure		N					
0116T	Med tx mngmt subsqt		B					
01170	Anesth, pelvis surgery		N					
01173	Anesth, fx repair, pelvis		N					
0117T	Med tx mngmt addl 15 min		B					
01180	Anesth, pelvis nerve removal		N					
01190	Anesth, pelvis nerve removal		N					
01200	Anesth, hip joint procedure		N					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
0123T	Scleral fistulization		T	0234	24.0821	$1,533.86	$511.30	$306.77
0124T	Conjunctival drug placement		T	0232	5.1145	$325.76	$81.59	$65.15
01250	Anesth, upper leg surgery		N					
01260	Anesth, upper leg veins surg		N					
0126T	Chd risk imt study	CH	Q	0340	0.6416	$40.87		$8.17
01270	Anesth, thigh arteries surg		N					
01272	Anesth, femoral artery surg		C					
01274	Anesth, femoral embolectomy		C					
0130T	Chron care drug investigatn		B					
01320	Anesth, knee area surgery		N					
0133T	Esophageal implant injexn		T	0422	24.648	$1,569.91	$445.06	$313.98
01340	Anesth, knee area procedure		N					
0135T	Perq cryoablate renal tumor		T	0423	44.1192	$2,810.08		$562.02
01360	Anesth, knee area surgery		N					
0137T	Prostate saturation sampling		T	0184	11.3168	$720.80		$144.16
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					
0140T	Exhaled breath condensate ph		A					
0141T	Perq islet transplant		E					
01420	Anesth, knee joint casting		N					
0142T	Open islet transplant		E					
01430	Anesth, knee veins surgery		N					
01432	Anesth, knee vessel surg		N					
0143T	Laparoscopic islet transplnt		E					
01440	Anesth, knee arteries surg		N					
01442	Anesth, knee artery surg		C					
01444	Anesth, knee artery repair		C					
0144T	CT heart wo dye; qual calc	CH	S	0282	1.6768	$106.80	$37.80	$21.36
0145T	CT heart w/wo dye funct	CH	S	0383	4.9887	$317.75	$124.17	$63.55
01462	Anesth, lower leg procedure		N					
01464	Anesth, ankle/ft arthroscopy		N					
0146T	CCTA w/wo dye	CH	S	0383	4.9887	$317.75	$124.17	$63.55
01470	Anesth, lower leg surgery		N					
01472	Anesth, achilles tendon surg		N					
01474	Anesth, lower leg surgery		N					
0147T	CCTA w/wo, quan calcium	CH	S	0383	4.9887	$317.75	$124.17	$63.55
01480	Anesth, lower leg bone surg		N					
01482	Anesth, radical leg surgery		N					
01484	Anesth, lower leg revision		N					
01486	Anesth, ankle replacement		C					
0148T	CCTA w/wo, strxr	CH	S	0383	4.9887	$317.75	$124.17	$63.55
01490	Anesth, lower leg casting		N					
0149T	CCTA w/wo, strxr quan calc	CH	S	0383	4.9887	$317.75	$124.17	$63.55
01500	Anesth, leg arteries surg		N					
01502	Anesth, lwr leg embolectomy		C					
0150T	CCTA w/wo, disease strxr	CH	S	0383	4.9887	$317.75	$124.17	$63.55
0151T	CT heart funct add-on		S	0282	1.6768	$106.80	$37.80	$21.36
01520	Anesth, lower leg vein surg		N					
01522	Anesth, lower leg vein surg		N					
0153T	Tcath sensor aneurysm sac		C					
0154T	Study sensor aneurysm sac		X	0097	1.0396	$66.22	$23.70	$13.24
0155T	Lap impl gast curve electrd		T	0130	34.8153	$2,217.49	$659.50	$443.50
0156T	Lap remv gast curve electrd		T	0130	34.8153	$2,217.49	$659.50	$443.50
0157T	Open impl gast curve electrd		C					
0158T	Open remv gast curve electrd		C					
0159T	Cad breast mri		N					
0160T	Tcranial magn stim tx plan		S	0216	2.768	$176.30		$35.26
01610	Anesth, surgery of shoulder		N					
0161T	Tcranial magn stim tx deliv		S	0216	2.768	$176.30		$35.26
01620	Anesth, shoulder procedure		N					
01622	Anes dx shoulder arthroscopy		N					
0162T	Anal program gast neurostim		S	0692	1.9206	$122.33	$30.10	$24.47
01630	Anesth, surgery of shoulder		N					
01632	Anesth, surgery of shoulder		C					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
01634	Anesth, shoulder joint amput		C					
01636	Anesth, forequarter amput		C					
01638	Anesth, shoulder replacement		C					
0163T	Lumb artif diskectomy addl		C					
0164T	Remove lumb artif disc addl		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					
0165T	Revise lumb artif disc addl		C					
0166T	Tcath vsd close w/o bypass		C					
01670	Anesth, shoulder vein surg		N					
0167T	Tcath vsd close w bypass		C					
01680	Anesth, shoulder casting		N					
01682	Anesth, airplane cast		N					
0168T	Rhinophototx light app bilat		T	0251	2.5765	$164.11		$32.82
0169T	Place stereo cath brain		C					
0170T	Anorectal fistula plug rpr		T	0150	30.5544	$1,946.10	$437.10	$389.22
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					
0171T	Lumbar spine proces distract		T	0050	29.3263	$1,867.88		$373.58
0172T	Lumbar spine proces addl		T	0050	29.3263	$1,867.88		$373.58
01730	Anesth, uppr arm procedure		N					
01732	Anesth, dx elbow arthroscopy		N					
0173T	Iop monit io pressure		N					
01740	Anesth, upper arm surgery		N					
01742	Anesth, humerus surgery		N					
01744	Anesth, humerus repair		N					
0174T	Cad cxr with interp		N					
01756	Anesth, radical humerus surg		C					
01758	Anesth, humeral lesion surg		N					
0175T	Cad cxr remote		N					
01760	Anesth, elbow replacement		N					
0176T	Aqu canal dilat w/o retent		T	0673	40.8481	$2,601.74	$649.50	$520.35
01770	Anesth, uppr arm artery surg		N					
01772	Anesth, uppr arm embolectomy		N					
0177T	Aqu canal dilat w retent		T	0673	40.8481	$2,601.74	$649.50	$520.35
01780	Anesth, upper arm vein surg		N					
01782	Anesth, uppr arm vein repair		N					
01810	Anesth, lower arm surgery		N					
01820	Anesth, lower arm procedure		N					
01829	Anesth, dx wrist arthroscopy		N					
01830	Anesth, lower arm surgery		N					
01832	Anesth, wrist replacement		N					
01840	Anesth, lwr arm artery surg		N					
01842	Anesth, lwr arm embolectomy		N					
01844	Anesth, vascular shunt surg		N					
01850	Anesth, lower arm vein surg		N					
01852	Anesth, lwr arm vein repair		N					
01860	Anesth, lower arm casting		N					
01905	Anes, spine inject, x-ray/re		N					
01916	Anesth, dx arteriography		N					
01920	Anesth, catheterize heart		N					
01922	Anesth, cat or MRI scan		N					
01924	Anes, ther interven rad, art		N					
01925	Anes, ther interven rad, car		N					
01926	Anes, tx interv rad hrt/cran		N					
01930	Anes, ther interven rad, vei		N					
01931	Anes, ther interven rad, tip		N					
01932	Anes, tx interv rad, th vein		N					
01933	Anes, tx interv rad, cran v		N					
01951	Anesth, burn, less 4 percent		N					
01952	Anesth, burn, 4-9 percent		N					
01953	Anesth, burn, each 9 percent		N					
01958	Anesth, antepartum manipul		N					
01960	Anesth, vaginal delivery		N					
01961	Anesth, cs delivery		N					
01962	Anesth, emer hysterectomy		N					
01963	Anesth, cs hysterectomy		N					
01965	Anesth, inc/missed ab proc		N					
01966	Anesth, induced ab procedure		N					
01967	Anesth/analg, vag delivery		N					
01968	Anes/analg cs deliver add-on		N					
01969	Anesth/analg cs hyst add-on		N					
01990	Support for organ donor		C					
01991	Anesth, nerve block/inj		N					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
01992	Anesth, n block/inj, prone		N					
01996	Hosp manage cont drug admin		N					
01999	Unlisted anesth procedure		N					
0500F	Initial prenatal care visit		M					
0501F	Prenatal flow sheet		M					
0502F	Subsequent prenatal care		M					
0503F	Postpartum care visit		M					
0505F	Hemodialysis plan doc'd		M					
0507F	Periton dialysis plan doc'd		M					
0509F	Urine incon plan doc		M					
1000F	Tobacco use assessed		M					
10021	Fna w/o image		T	0002	1.1915	$75.89		$15.18
10022	Fna w/image	CH	T	0004	4.5062	$287.01		$57.40
1002F	Assess anginal symptom/level		M					
1003F	Level of activity assess		M					
10040	Acne surgery	CH	T	0013	0.8046	$51.25		$10.25
1004F	Clin symp vol ovrld assess		M					
1005F	Asthma symptoms evaluate		M					
10060	Drainage of skin abscess		T	0006	1.463	$93.18		$18.64
10061	Drainage of skin abscess		T	0006	1.463	$93.18		$18.64
1006F	Osteoarthritis assess		M					
1007F	Anti-inflm/anlgsc otc assess		M					
10080	Drainage of pilonidal cyst		T	0006	1.463	$93.18		$18.64
10081	Drainage of pilonidal cyst		T	0007	12.5792	$801.21		$160.24
1008F	Gi/renal risk assess		M					
10120	Remove foreign body		T	0006	1.463	$93.18		$18.64
10121	Remove foreign body		T	0021	16.5832	$1,056.23	$219.40	$211.25
10140	Drainage of hematoma/fluid		T	0007	12.5792	$801.21		$160.24
1015F	Copd symptoms assess		M					
10160	Puncture drainage of lesion	CH	T	0006	1.463	$93.18		$18.64
10180	Complex drainage, wound		T	0008	19.0457	$1,213.08		$242.62
1018F	Assess dyspnea not present		M					
1019F	Assess dyspnea present		M					
1022F	Pneumo imm status assess		M					
1026F	Co-morbid condition assess		M					
1030F	Influenza imm status assess		M					
1034F	Current tobacco smoker		M					
1035F	Smokeless tobacco user		M					
1036F	Tobacco non-user		M					
1038F	Persistent asthma		M					
1039F	Intermittent asthma		M					
1040F	Dsm-iv info mdd doc'd		M					
1050F	History of mole changes		M					
1055F	Visual funct status assess		M					
1060F	Doc perm/cont/parox atr. fib		M					
1061F	Doc lack perm+cont+parox fib		M					
1065F	Ischm stroke symp <3 hrs b/4		M					
1066F	Ischm stroke symp ?3 hrs b/4		M					
1070F	Alarm symp assessed-absent		M					
1071F	Alarm symp assessed-1+ prsnt		M					
1080F	Decis mkr/advncd plan doc'd		M					
1090F	Pres/absn urine incon assess		M					
1091F	Urine incon characterized		M					
11000	Debride infected skin		T	0013	0.8046	$51.25		$10.25
11001	Debride infected skin add-on	CH	T	0013	0.8046	$51.25		$10.25
11004	Debride genitalia & perineum		C					
11005	Debride abdom wall		C					
11006	Debride genit/per/abdom wall		C					
11008	Remove mesh from abd wall		C					
1100F	Pt falls assess-doc'd?2+/yr		M					
11010	Debride skin, fx		T	0019	4.4463	$283.20	$71.80	$56.64
11011	Debride skin/muscle, fx		T	0019	4.4463	$283.20	$71.80	$56.64
11012	Debride skin/muscle/bone, fx		T	0019	4.4463	$283.20	$71.80	$56.64
1101F	Pt falls assessed-doc'd?1/yr		M					
11040	Debride skin, partial		T	0015	1.5119	$96.30		$19.26
11041	Debride skin, full		T	0015	1.5119	$96.30		$19.26
11042	Debride skin/tissue		T	0016	2.7493	$175.11		$35.02
11043	Debride tissue/muscle		T	0016	2.7493	$175.11		$35.02
11044	Debride tissue/muscle/bone		T	0682	7.1126	$453.02	$158.60	$90.60
11055	Trim skin lesion	CH	T	0013	0.8046	$51.25		$10.25
11056	Trim skin lesions, 2 to 4	CH	T	0013	0.8046	$51.25		$10.25
11057	Trim skin lesions, over 4	CH	T	0015	1.5119	$96.30		$19.26
11100	Biopsy, skin lesion	CH	T	0013	0.8046	$51.25		$10.25
11101	Biopsy, skin add-on	CH	T	0013	0.8046	$51.25		$10.25
1110F	Pt lft inpt fac w/in 60 days		M					
1111F	Dschrg med/current med merge		M					
11200	Removal of skin tags		T	0013	0.8046	$51.25		$10.25
11201	Remove skin tags add-on		T	0015	1.5119	$96.30		$19.26

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
11300	Shave skin lesion	CH	T	0013	0.8046	$51.25		$10.25
11301	Shave skin lesion	CH	T	0013	0.8046	$51.25		$10.25
11302	Shave skin lesion		T	0013	0.8046	$51.25		$10.25
11303	Shave skin lesion		T	0015	1.5119	$96.30		$19.26
11305	Shave skin lesion		T	0013	0.8046	$51.25		$10.25
11306	Shave skin lesion		T	0013	0.8046	$51.25		$10.25
11307	Shave skin lesion		T	0013	0.8046	$51.25		$10.25
11308	Shave skin lesion		T	0013	0.8046	$51.25		$10.25
11310	Shave skin lesion		T	0013	0.8046	$51.25		$10.25
11311	Shave skin lesion		T	0013	0.8046	$51.25		$10.25
11312	Shave skin lesion		T	0013	0.8046	$51.25		$10.25
11313	Shave skin lesion	CH	T	0013	0.8046	$51.25		$10.25
11400	Exc tr-ext b9+marg 0.5 < cm		T	0019	4.4463	$283.20	$71.80	$56.64
11401	Exc tr-ext b9+marg 0.6-1 cm		T	0019	4.4463	$283.20	$71.80	$56.64
11402	Exc tr-ext b9+marg 1.1-2 cm		T	0019	4.4463	$283.20	$71.80	$56.64
11403	Exc tr-ext b9+marg 2.1-3 cm		T	0020	8.7155	$555.12		$111.02
11404	Exc tr-ext b9+marg 3.1-4 cm		T	0021	16.5832	$1,056.23	$219.40	$211.25
11406	Exc tr-ext b9+marg > 4.0 cm		T	0021	16.5832	$1,056.23	$219.40	$211.25
11420	Exc h-f-nk-sp b9+marg 0.5 <		T	0020	8.7155	$555.12		$111.02
11421	Exc h-f-nk-sp b9+marg 0.6-1		T	0020	8.7155	$555.12		$111.02
11422	Exc h-f-nk-sp b9+marg 1.1-2		T	0020	8.7155	$555.12		$111.02
11423	Exc h-f-nk-sp b9+marg 2.1-3		T	0021	16.5832	$1,056.23	$219.40	$211.25
11424	Exc h-f-nk-sp b9+marg 3.1-4		T	0021	16.5832	$1,056.23	$219.40	$211.25
11426	Exc h-f-nk-sp b9+marg > 4 cm		T	0022	21.4534	$1,366.43	$354.40	$273.29
11440	Exc face-mm b9+marg 0.5 < cm		T	0019	4.4463	$283.20	$71.80	$56.64
11441	Exc face-mm b9+marg 0.6-1 cm		T	0019	4.4463	$283.20	$71.80	$56.64
11442	Exc face-mm b9+marg 1.1-2 cm		T	0020	8.7155	$555.12		$111.02
11443	Exc face-mm b9+marg 2.1-3 cm		T	0020	8.7155	$555.12		$111.02
11444	Exc face-mm b9+marg 3.1-4 cm		T	0020	8.7155	$555.12		$111.02
11446	Exc face-mm b9+marg > 4 cm		T	0022	21.4534	$1,366.43	$354.40	$273.29
11450	Removal, sweat gland lesion		T	0022	21.4534	$1,366.43	$354.40	$273.29
11451	Removal, sweat gland lesion		T	0022	21.4534	$1,366.43	$354.40	$273.29
11462	Removal, sweat gland lesion		T	0022	21.4534	$1,366.43	$354.40	$273.29
11463	Removal, sweat gland lesion		T	0022	21.4534	$1,366.43	$354.40	$273.29
11470	Removal, sweat gland lesion		T	0022	21.4534	$1,366.43	$354.40	$273.29
11471	Removal, sweat gland lesion		T	0022	21.4534	$1,366.43	$354.40	$273.29
11600	Exc tr-ext mlg+marg 0.5 < cm		T	0019	4.4463	$283.20	$71.80	$56.64
11601	Exc tr-ext mlg+marg 0.6-1 cm		T	0019	4.4463	$283.20	$71.80	$56.64
11602	Exc tr-ext mlg+marg 1.1-2 cm		T	0019	4.4463	$283.20	$71.80	$56.64
11603	Exc tr-ext mlg+marg 2.1-3 cm		T	0020	8.7155	$555.12		$111.02
11604	Exc tr-ext mlg+marg 3.1-4 cm		T	0020	8.7155	$555.12		$111.02
11606	Exc tr-ext mlg+marg > 4 cm		T	0021	16.5832	$1,056.23	$219.40	$211.25
11620	Exc h-f-nk-sp mlg+marg 0.5 <		T	0020	8.7155	$555.12		$111.02
11621	Exc h-f-nk-sp mlg+marg 0.6-1		T	0019	4.4463	$283.20	$71.80	$56.64
11622	Exc h-f-nk-sp mlg+marg 1.1-2		T	0020	8.7155	$555.12		$111.02
11623	Exc h-f-nk-sp mlg+marg 2.1-3	CH	T	0020	8.7155	$555.12		$111.02
11624	Exc h-f-nk-sp mlg+marg 3.1-4		T	0021	16.5832	$1,056.23	$219.40	$211.25
11626	Exc h-f-nk-sp mlg+mar > 4 cm		T	0022	21.4534	$1,366.43	$354.40	$273.29
11640	Exc face-mm malig+marg 0.5 <	CH	T	0019	4.4463	$283.20	$71.80	$56.64
11641	Exc face-mm malig+marg 0.6-1	CH	T	0019	4.4463	$283.20	$71.80	$56.64
11642	Exc face-mm malig+marg 1.1-2		T	0020	8.7155	$555.12		$111.02
11643	Exc face-mm malig+marg 2.1-3		T	0020	8.7155	$555.12		$111.02
11644	Exc face-mm malig+marg 3.1-4		T	0021	16.5832	$1,056.23	$219.40	$211.25
11646	Exc face-mm mlg+marg > 4 cm		T	0022	21.4534	$1,366.43	$354.40	$273.29
11719	Trim nail(s)	CH	T	0013	0.8046	$51.25		$10.25
11720	Debride nail, 1-5	CH	T	0013	0.8046	$51.25		$10.25
11721	Debride nail, 6 or more	CH	T	0013	0.8046	$51.25		$10.25
11730	Removal of nail plate		T	0013	0.8046	$51.25		$10.25
11732	Remove nail plate, add-on	CH	T	0013	0.8046	$51.25		$10.25
11740	Drain blood from under nail	CH	T	0012	0.2682	$17.08		$3.42
11750	Removal of nail bed		T	0019	4.4463	$283.20	$71.80	$56.64
11752	Remove nail bed/finger tip		T	0022	21.4534	$1,366.43	$354.40	$273.29
11755	Biopsy, nail unit		T	0019	4.4463	$283.20	$71.80	$56.64
11760	Repair of nail bed	CH	T	0134	2.1114	$134.48	$42.36	$26.90
11762	Reconstruction of nail bed	CH	T	0136	15.4399	$983.41		$196.68
11765	Excision of nail fold, toe		T	0015	1.5119	$96.30		$19.26
11770	Removal of pilonidal lesion		T	0022	21.4534	$1,366.43	$354.40	$273.29
11771	Removal of pilonidal lesion		T	0022	21.4534	$1,366.43	$354.40	$273.29
11772	Removal of pilonidal lesion		T	0022	21.4534	$1,366.43	$354.40	$273.29
11900	Injection into skin lesions	CH	T	0013	0.8046	$51.25		$10.25
11901	Added skin lesions injection	CH	T	0013	0.8046	$51.25		$10.25
11920	Correct skin color defects	CH	T	0134	2.1114	$134.48	$42.36	$26.90
11921	Correct skin color defects	CH	T	0134	2.1114	$134.48	$42.36	$26.90
11922	Correct skin color defects	CH	T	0134	2.1114	$134.48	$42.36	$26.90
11950	Therapy for contour defects	CH	T	0133	1.334	$84.97	$26.76	$16.99
11951	Therapy for contour defects	CH	T	0133	1.334	$84.97	$26.76	$16.99
11952	Therapy for contour defects	CH	T	0133	1.334	$84.97	$26.76	$16.99
11954	Therapy for contour defects	CH	T	0133	1.334	$84.97	$26.76	$16.99

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
11960	Insert tissue expander(s)	CH	T	0137	20.9338	$1,333.34		$266.67
11970	Replace tissue expander		T	0051	43.5953	$2,776.72		$555.34
11971	Remove tissue expander(s)		T	0022	21.4534	$1,366.43	$354.40	$273.29
11975	Insert contraceptive cap		E					
11976	Removal of contraceptive cap		T	0019	4.4463	$283.20	$71.80	$56.64
11977	Removal/reinsert contra cap		E					
11980	Implant hormone pellet(s)		X	0340	0.6416	$40.87		$8.17
11981	Insert drug implant device		X	0340	0.6416	$40.87		$8.17
11982	Remove drug implant device		X	0340	0.6416	$40.87		$8.17
11983	Remove/insert drug implant		X	0340	0.6416	$40.87		$8.17
12001	Repair superficial wound(s)	CH	T	0133	1.334	$84.97	$26.76	$16.99
12002	Repair superficial wound(s)	CH	T	0133	1.334	$84.97	$26.76	$16.99
12004	Repair superficial wound(s)	CH	T	0133	1.334	$84.97	$26.76	$16.99
12005	Repair superficial wound(s)	CH	T	0133	1.334	$84.97	$26.76	$16.99
12006	Repair superficial wound(s)	CH	T	0133	1.334	$84.97	$26.76	$16.99
12007	Repair superficial wound(s)	CH	T	0133	1.334	$84.97	$26.76	$16.99
12011	Repair superficial wound(s)	CH	T	0133	1.334	$84.97	$26.76	$16.99
12013	Repair superficial wound(s)	CH	T	0133	1.334	$84.97	$26.76	$16.99
12014	Repair superficial wound(s)	CH	T	0133	1.334	$84.97	$26.76	$16.99
12015	Repair superficial wound(s)	CH	T	0133	1.334	$84.97	$26.76	$16.99
12016	Repair superficial wound(s)	CH	T	0133	1.334	$84.97	$26.76	$16.99
12017	Repair superficial wound(s)	CH	T	0133	1.334	$84.97	$26.76	$16.99
12018	Repair superficial wound(s)	CH	T	0133	1.334	$84.97	$26.76	$16.99
12020	Closure of split wound	CH	T	0135	4.6816	$298.19		$59.64
12021	Closure of split wound	CH	T	0135	4.6816	$298.19		$59.64
12031	Layer closure of wound(s)	CH	T	0134	2.1114	$134.48	$42.36	$26.90
12032	Layer closure of wound(s)	CH	T	0134	2.1114	$134.48	$42.36	$26.90
12034	Layer closure of wound(s)	CH	T	0134	2.1114	$134.48	$42.36	$26.90
12035	Layer closure of wound(s)	CH	T	0134	2.1114	$134.48	$42.36	$26.90
12036	Layer closure of wound(s)	CH	T	0134	2.1114	$134.48	$42.36	$26.90
12037	Layer closure of wound(s)	CH	T	0134	2.1114	$134.48	$42.36	$26.90
12041	Layer closure of wound(s)	CH	T	0134	2.1114	$134.48	$42.36	$26.90
12042	Layer closure of wound(s)	CH	T	0134	2.1114	$134.48	$42.36	$26.90
12044	Layer closure of wound(s)	CH	T	0134	2.1114	$134.48	$42.36	$26.90
12045	Layer closure of wound(s)	CH	T	0134	2.1114	$134.48	$42.36	$26.90
12046	Layer closure of wound(s)	CH	T	0134	2.1114	$134.48	$42.36	$26.90
12047	Layer closure of wound(s)	CH	T	0134	2.1114	$134.48	$42.36	$26.90
12051	Layer closure of wound(s)	CH	T	0134	2.1114	$134.48	$42.36	$26.90
12052	Layer closure of wound(s)	CH	T	0134	2.1114	$134.48	$42.36	$26.90
12053	Layer closure of wound(s)	CH	T	0134	2.1114	$134.48	$42.36	$26.90
12054	Layer closure of wound(s)	CH	T	0134	2.1114	$134.48	$42.36	$26.90
12055	Layer closure of wound(s)	CH	T	0134	2.1114	$134.48	$42.36	$26.90
12056	Layer closure of wound(s)	CH	T	0134	2.1114	$134.48	$42.36	$26.90
12057	Layer closure of wound(s)	CH	T	0134	2.1114	$134.48	$42.36	$26.90
13100	Repair of wound or lesion	CH	T	0135	4.6816	$298.19		$59.64
13101	Repair of wound or lesion	CH	T	0135	4.6816	$298.19		$59.64
13102	Repair wound/lesion add-on	CH	T	0135	4.6816	$298.19		$59.64
13120	Repair of wound or lesion	CH	T	0134	2.1114	$134.48	$42.36	$26.90
13121	Repair of wound or lesion	CH	T	0135	4.6816	$298.19		$59.64
13122	Repair wound/lesion add-on	CH	T	0134	2.1114	$134.48	$42.36	$26.90
13131	Repair of wound or lesion	CH	T	0135	4.6816	$298.19		$59.64
13132	Repair of wound or lesion	CH	T	0135	4.6816	$298.19		$59.64
13133	Repair wound/lesion add-on	CH	T	0135	4.6816	$298.19		$59.64
13150	Repair of wound or lesion	CH	T	0135	4.6816	$298.19		$59.64
13151	Repair of wound or lesion	CH	T	0135	4.6816	$298.19		$59.64
13152	Repair of wound or lesion	CH	T	0135	4.6816	$298.19		$59.64
13153	Repair wound/lesion add-on	CH	T	0134	2.1114	$134.48	$42.36	$26.90
13160	Late closure of wound	CH	T	0137	20.9338	$1,333.34		$266.67
14000	Skin tissue rearrangement	CH	T	0136	15.4399	$983.41		$196.68
14001	Skin tissue rearrangement	CH	T	0136	15.4399	$983.41		$196.68
14020	Skin tissue rearrangement	CH	T	0136	15.4399	$983.41		$196.68
14021	Skin tissue rearrangement	CH	T	0136	15.4399	$983.41		$196.68
14040	Skin tissue rearrangement	CH	T	0136	15.4399	$983.41		$196.68
14041	Skin tissue rearrangement	CH	T	0136	15.4399	$983.41		$196.68
14060	Skin tissue rearrangement	CH	T	0136	15.4399	$983.41		$196.68
14061	Skin tissue rearrangement	CH	T	0136	15.4399	$983.41		$196.68
14300	Skin tissue rearrangement	CH	T	0137	20.9338	$1,333.34		$266.67
14350	Skin tissue rearrangement	CH	T	0137	20.9338	$1,333.34		$266.67
15002	Wnd prep, ch/inf, trk/arm/lg	CH	T	0135	4.6816	$298.19		$59.64
15003	Wnd prep, ch/inf addl 100 cm	CH	T	0135	4.6816	$298.19		$59.64
15004	Wnd prep ch/inf, f/n/hf/g	CH	T	0135	4.6816	$298.19		$59.64
15005	Wnd prep, f/n/hf/g, addl cm	CH	T	0135	4.6816	$298.19		$59.64
15040	Harvest cultured skin graft	CH	T	0134	2.1114	$134.48	$42.36	$26.90
15050	Skin pinch graft	CH	T	0135	4.6816	$298.19		$59.64
15100	Skin splt grft, trnk/arm/leg	CH	T	0137	20.9338	$1,333.34		$266.67
15101	Skin splt grft t/a/l, add-on	CH	T	0137	20.9338	$1,333.34		$266.67
15110	Epidrm autogrft trnk/arm/leg	CH	T	0135	4.6816	$298.19		$59.64
15111	Epidrm autogrft t/a/l add-on	CH	T	0135	4.6816	$298.19		$59.64

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
15115	Epidrm a-grft face/nck/hf/g	CH	T	0135	4.6816	$298.19		$59.64
15116	Epidrm a-grft f/n/hf/g addl	CH	T	0135	4.6816	$298.19		$59.64
15120	Skn splt a-grft fac/nck/hf/g	CH	T	0137	20.9338	$1,333.34		$266.67
15121	Skn splt a-grft f/n/hf/g add	CH	T	0137	20.9338	$1,333.34		$266.67
15130	Derm autograft, trnk/arm/leg	CH	T	0136	15.4399	$983.41		$196.68
15131	Derm autograft t/a/l add-on	CH	T	0136	15.4399	$983.41		$196.68
15135	Derm autograft face/nck/hf/g	CH	T	0136	15.4399	$983.41		$196.68
15136	Derm autograft, f/n/hf/g add	CH	T	0136	15.4399	$983.41		$196.68
15150	Cult epiderm grft t/arm/leg	CH	T	0135	4.6816	$298.19		$59.64
15151	Cult epiderm grft t/a/l addl	CH	T	0135	4.6816	$298.19		$59.64
15152	Cult epiderm graft t/a/l +%	CH	T	0135	4.6816	$298.19		$59.64
15155	Cult epiderm graft, f/n/hf/g	CH	T	0135	4.6816	$298.19		$59.64
15156	Cult epidrm grft f/n/hfg add	CH	T	0135	4.6816	$298.19		$59.64
15157	Cult epiderm grft f/n/hfg +%	CH	T	0135	4.6816	$298.19		$59.64
15170	Acell graft trunk/arms/legs	CH	T	0134	2.1114	$134.48	$42.36	$26.90
15171	Acell graft t/arm/leg add-on	CH	T	0134	2.1114	$134.48	$42.36	$26.90
15175	Acellular graft, f/n/hf/g	CH	T	0135	4.6816	$298.19		$59.64
15176	Acell graft, f/n/hf/g add-on	CH	T	0135	4.6816	$298.19		$59.64
15200	Skin full graft, trunk	CH	T	0136	15.4399	$983.41		$196.68
15201	Skin full graft trunk add-on	CH	T	0136	15.4399	$983.41		$196.68
15220	Skin full graft sclp/arm/leg	CH	T	0136	15.4399	$983.41		$196.68
15221	Skin full graft add-on	CH	T	0135	4.6816	$298.19		$59.64
15240	Skin full grft face/genit/hf	CH	T	0136	15.4399	$983.41		$196.68
15241	Skin full graft add-on	CH	T	0135	4.6816	$298.19		$59.64
15260	Skin full graft een & lips	CH	T	0136	15.4399	$983.41		$196.68
15261	Skin full graft add-on	CH	T	0136	15.4399	$983.41		$196.68
15300	Apply skinallogrft, t/arm/lg	CH	T	0135	4.6816	$298.19		$59.64
15301	Apply sknallogrft t/a/l addl	CH	T	0135	4.6816	$298.19		$59.64
15320	Apply skin allogrft f/n/hf/g	CH	T	0135	4.6816	$298.19		$59.64
15321	Aply sknallogrft f/n/hfg add	CH	T	0135	4.6816	$298.19		$59.64
15330	Aply acell alogrft t/arm/leg	CH	T	0135	4.6816	$298.19		$59.64
15331	Aply acell grft t/a/l add-on	CH	T	0135	4.6816	$298.19		$59.64
15335	Apply acell graft, f/n/hf/g	CH	T	0135	4.6816	$298.19		$59.64
15336	Aply acell grft f/n/hf/g add	CH	T	0135	4.6816	$298.19		$59.64
15340	Apply cult skin substitute	CH	T	0134	2.1114	$134.48	$42.36	$26.90
15341	Apply cult skin sub add-on	CH	T	0134	2.1114	$134.48	$42.36	$26.90
15360	Apply cult derm sub, t/a/l	CH	T	0134	2.1114	$134.48	$42.36	$26.90
15361	Aply cult derm sub t/a/l add	CH	T	0134	2.1114	$134.48	$42.36	$26.90
15365	Apply cult derm sub f/n/hf/g	CH	T	0134	2.1114	$134.48	$42.36	$26.90
15366	Apply cult derm f/hf/g add	CH	T	0134	2.1114	$134.48	$42.36	$26.90
15400	Apply skin xenograft, t/a/l	CH	T	0135	4.6816	$298.19		$59.64
15401	Apply skn xenogrft t/a/l add	CH	T	0135	4.6816	$298.19		$59.64
15420	Apply skin xgraft, f/n/hf/g	CH	T	0135	4.6816	$298.19		$59.64
15421	Apply skn xgrft f/n/hf/g add	CH	T	0135	4.6816	$298.19		$59.64
15430	Apply acellular xenograft	CH	T	0135	4.6816	$298.19		$59.64
15431	Apply acellular xgraft add	CH	T	0135	4.6816	$298.19		$59.64
15570	Form skin pedicle flap	CH	T	0137	20.9338	$1,333.34		$266.67
15572	Form skin pedicle flap	CH	T	0137	20.9338	$1,333.34		$266.67
15574	Form skin pedicle flap	CH	T	0137	20.9338	$1,333.34		$266.67
15576	Form skin pedicle flap	CH	T	0137	20.9338	$1,333.34		$266.67
15600	Skin graft	CH	T	0137	20.9338	$1,333.34		$266.67
15610	Skin graft	CH	T	0137	20.9338	$1,333.34		$266.67
15620	Skin graft	CH	T	0137	20.9338	$1,333.34		$266.67
15630	Skin graft	CH	T	0137	20.9338	$1,333.34		$266.67
15650	Transfer skin pedicle flap	CH	T	0137	20.9338	$1,333.34		$266.67
15731	Forehead flap w/vasc pedicle	CH	T	0137	20.9338	$1,333.34		$266.67
15732	Muscle-skin graft, head/neck	CH	T	0137	20.9338	$1,333.34		$266.67
15734	Muscle-skin graft, trunk	CH	T	0137	20.9338	$1,333.34		$266.67
15736	Muscle-skin graft, arm	CH	T	0137	20.9338	$1,333.34		$266.67
15738	Muscle-skin graft, leg	CH	T	0137	20.9338	$1,333.34		$266.67
15740	Island pedicle flap graft	CH	T	0136	15.4399	$983.41		$196.68
15750	Neurovascular pedicle graft	CH	T	0137	20.9338	$1,333.34		$266.67
15756	Free myo/skin flap microvasc		C					
15757	Free skin flap, microvasc		C					
15758	Free fascial flap, microvasc		C					
15760	Composite skin graft	CH	T	0137	20.9338	$1,333.34		$266.67
15770	Derma-fat-fascia graft	CH	T	0137	20.9338	$1,333.34		$266.67
15775	Hair transplant punch grafts	CH	T	0133	1.334	$84.97	$26.76	$16.99
15776	Hair transplant punch grafts	CH	T	0133	1.334	$84.97	$26.76	$16.99
15780	Abrasion treatment of skin		T	0022	21.4534	$1,366.43	$354.40	$273.29
15781	Abrasion treatment of skin		T	0019	4.4463	$283.20	$71.80	$56.64
15782	Abrasion treatment of skin		T	0019	4.4463	$283.20	$71.80	$56.64
15783	Abrasion treatment of skin		T	0016	2.7493	$175.11		$35.02
15786	Abrasion, lesion, single		T	0013	0.8046	$51.25		$10.25
15787	Abrasion, lesions, add-on		T	0013	0.8046	$51.25		$10.25
15788	Chemical peel, face, epiderm	CH	T	0013	0.8046	$51.25		$10.25
15789	Chemical peel, face, dermal		T	0015	1.5119	$96.30		$19.26
15792	Chemical peel, nonfacial	CH	T	0015	1.5119	$96.30		$19.26

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
15793	Chemical peel, nonfacial	CH	T	0013	0.8046	$51.25		$10.25
15819	Plastic surgery, neck	CH	T	0134	2.1114	$134.48	$42.36	$26.90
15820	Revision of lower eyelid	CH	T	0137	20.9338	$1,333.34		$266.67
15821	Revision of lower eyelid	CH	T	0137	20.9338	$1,333.34		$266.67
15822	Revision of upper eyelid	CH	T	0137	20.9338	$1,333.34		$266.67
15823	Revision of upper eyelid	CH	T	0137	20.9338	$1,333.34		$266.67
15824	Removal of forehead wrinkles	CH	T	0137	20.9338	$1,333.34		$266.67
15825	Removal of neck wrinkles	CH	T	0137	20.9338	$1,333.34		$266.67
15826	Removal of brow wrinkles	CH	T	0137	20.9338	$1,333.34		$266.67
15828	Removal of face wrinkles	CH	T	0137	20.9338	$1,333.34		$266.67
15829	Removal of skin wrinkles	CH	T	0137	20.9338	$1,333.34		$266.67
15830	Exc skin abd		T	0022	21.4534	$1,366.43	$354.40	$273.29
15832	Excise excessive skin tissue		T	0022	21.4534	$1,366.43	$354.40	$273.29
15833	Excise excessive skin tissue		T	0022	21.4534	$1,366.43	$354.40	$273.29
15834	Excise excessive skin tissue		T	0022	21.4534	$1,366.43	$354.40	$273.29
15835	Excise excessive skin tissue	CH	T	0022	21.4534	$1,366.43	$354.40	$273.29
15836	Excise excessive skin tissue		T	0021	16.5832	$1,056.23	$219.40	$211.25
15837	Excise excessive skin tissue		T	0021	16.5832	$1,056.23	$219.40	$211.25
15838	Excise excessive skin tissue		T	0021	16.5832	$1,056.23	$219.40	$211.25
15839	Excise excessive skin tissue		T	0021	16.5832	$1,056.23	$219.40	$211.25
15840	Graft for face nerve palsy	CH	T	0137	20.9338	$1,333.34		$266.67
15841	Graft for face nerve palsy	CH	T	0137	20.9338	$1,333.34		$266.67
15842	Flap for face nerve palsy	CH	T	0137	20.9338	$1,333.34		$266.67
15845	Skin and muscle repair, face	CH	T	0137	20.9338	$1,333.34		$266.67
15847	Exc skin abd add-on		T	0022	21.4534	$1,366.43	$354.40	$273.29
15850	Removal of sutures		T	0016	2.7493	$175.11		$35.02
15851	Removal of sutures		T	0016	2.7493	$175.11		$35.02
15852	Dressing change not for burn		X	0340	0.6416	$40.87		$8.17
15860	Test for blood flow in graft		X	0340	0.6416	$40.87		$8.17
15876	Suction assisted lipectomy	CH	T	0137	20.9338	$1,333.34		$266.67
15877	Suction assisted lipectomy	CH	T	0137	20.9338	$1,333.34		$266.67
15878	Suction assisted lipectomy	CH	T	0137	20.9338	$1,333.34		$266.67
15879	Suction assisted lipectomy	CH	T	0137	20.9338	$1,333.34		$266.67
15920	Removal of tail bone ulcer		T	0019	4.4463	$283.20	$71.80	$56.64
15922	Removal of tail bone ulcer	CH	T	0137	20.9338	$1,333.34		$266.67
15931	Remove sacrum pressure sore		T	0022	21.4534	$1,366.43	$354.40	$273.29
15933	Remove sacrum pressure sore		T	0022	21.4534	$1,366.43	$354.40	$273.29
15934	Remove sacrum pressure sore	CH	T	0137	20.9338	$1,333.34		$266.67
15935	Remove sacrum pressure sore	CH	T	0137	20.9338	$1,333.34		$266.67
15936	Remove sacrum pressure sore	CH	T	0136	15.4399	$983.41		$196.68
15937	Remove sacrum pressure sore	CH	T	0137	20.9338	$1,333.34		$266.67
15940	Remove hip pressure sore		T	0022	21.4534	$1,366.43	$354.40	$273.29
15941	Remove hip pressure sore		T	0022	21.4534	$1,366.43	$354.40	$273.29
15944	Remove hip pressure sore	CH	T	0137	20.9338	$1,333.34		$266.67
15945	Remove hip pressure sore	CH	T	0137	20.9338	$1,333.34		$266.67
15946	Remove hip pressure sore	CH	T	0137	20.9338	$1,333.34		$266.67
15950	Remove thigh pressure sore		T	0022	21.4534	$1,366.43	$354.40	$273.29
15951	Remove thigh pressure sore		T	0022	21.4534	$1,366.43	$354.40	$273.29
15952	Remove thigh pressure sore	CH	T	0136	15.4399	$983.41		$196.68
15953	Remove thigh pressure sore	CH	T	0136	15.4399	$983.41		$196.68
15956	Remove thigh pressure sore	CH	T	0136	15.4399	$983.41		$196.68
15958	Remove thigh pressure sore	CH	T	0136	15.4399	$983.41		$196.68
15999	Removal of pressure sore		T	0019	4.4463	$283.20	$71.80	$56.64
16000	Initial treatment of burn(s)	CH	T	0013	0.8046	$51.25		$10.25
16020	Dress/debrid p-thick burn, s	CH	T	0015	1.5119	$96.30		$19.26
16025	Dress/debrid p-thick burn, m	CH	T	0016	2.7493	$175.11		$35.02
16030	Dress/debrid p-thick burn, l	CH	T	0016	2.7493	$175.11		$35.02
16035	Incision of burn scab, initi		T	0016	2.7493	$175.11		$35.02
16036	Escharotomy; add'l incision		C					
17000	Destruct premalg lesion	CH	T	0013	0.8046	$51.25		$10.25
17003	Destruct premalg les, 2-14	CH	T	0012	0.2682	$17.08		$3.42
17004	Destroy premlg lesions 15+	CH	T	0016	2.7493	$175.11		$35.02
17106	Destruction of skin lesions	CH	T	0016	2.7493	$175.11		$35.02
17107	Destruction of skin lesions	CH	T	0016	2.7493	$175.11		$35.02
17108	Destruction of skin lesions	CH	T	0016	2.7493	$175.11		$35.02
17110	Destruct b9 lesion, 1-14	CH	T	0013	0.8046	$51.25		$10.25
17111	Destruct lesion, 15 or more	CH	T	0015	1.5119	$96.30		$19.26
17250	Chemical cautery, tissue	CH	T	0015	1.5119	$96.30		$19.26
17260	Destruction of skin lesions		T	0015	1.5119	$96.30		$19.26
17261	Destruction of skin lesions		T	0015	1.5119	$96.30		$19.26
17262	Destruction of skin lesions		T	0015	1.5119	$96.30		$19.26
17263	Destruction of skin lesions		T	0015	1.5119	$96.30		$19.26
17264	Destruction of skin lesions		T	0015	1.5119	$96.30		$19.26
17266	Destruction of skin lesions		T	0016	2.7493	$175.11		$35.02
17270	Destruction of skin lesions		T	0015	1.5119	$96.30		$19.26
17271	Destruction of skin lesions	CH	T	0015	1.5119	$96.30		$19.26
17272	Destruction of skin lesions		T	0015	1.5119	$96.30		$19.26
17273	Destruction of skin lesions	CH	T	0016	2.7493	$175.11		$35.02

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
17274	Destruction of skin lesions		T	0016	2.7493	$175.11		$35.02
17276	Destruction of skin lesions		T	0016	2.7493	$175.11		$35.02
17280	Destruction of skin lesions		T	0015	1.5119	$96.30		$19.26
17281	Destruction of skin lesions	CH	T	0016	2.7493	$175.11		$35.02
17282	Destruction of skin lesions	CH	T	0016	2.7493	$175.11		$35.02
17283	Destruction of skin lesions	CH	T	0016	2.7493	$175.11		$35.02
17284	Destruction of skin lesions		T	0016	2.7493	$175.11		$35.02
17286	Destruction of skin lesions	CH	T	0016	2.7493	$175.11		$35.02
17311	Mohs, 1 stage, h/n/hf/g		T	0694	3.9713	$252.94	$91.60	$50.59
17312	Mohs addl stage		T	0694	3.9713	$252.94	$91.60	$50.59
17313	Mohs, 1 stage, t/a/l		T	0694	3.9713	$252.94	$91.60	$50.59
17314	Mohs, addl stage, t/a/l		T	0694	3.9713	$252.94	$91.60	$50.59
17315	Mohs surg, addl block		T	0694	3.9713	$252.94	$91.60	$50.59
17340	Cryotherapy of skin	CH	T	0013	0.8046	$51.25		$10.25
17360	Skin peel therapy		T	0013	0.8046	$51.25		$10.25
17380	Hair removal by electrolysis		T	0013	0.8046	$51.25		$10.25
17999	Skin tissue procedure		T	0012	0.2682	$17.08		$3.42
19000	Drainage of breast lesion		T	0004	4.5062	$287.01		$57.40
19001	Drain breast lesion add-on		T	0002	1.1915	$75.89		$15.18
19020	Incision of breast lesion		T	0008	19.0457	$1,213.08		$242.62
19030	Injection for breast x-ray		N					
19100	Bx breast percut w/o image	CH	T	0004	4.5062	$287.01		$57.40
19101	Biopsy of breast, open		T	0028	20.998	$1,337.43	$303.70	$267.49
19102	Bx breast percut w/image		T	0005	7.3012	$465.04		$93.01
19103	Bx breast percut w/device	CH	T	0037	13.9599	$889.15	$228.70	$177.83
19105	Cryosurg ablate fa, each		T	0029	32.494	$2,069.64	$581.50	$413.93
19110	Nipple exploration		T	0028	20.998	$1,337.43	$303.70	$267.49
19112	Excise breast duct fistula		T	0028	20.998	$1,337.43	$303.70	$267.49
19120	Removal of breast lesion		T	0028	20.998	$1,337.43	$303.70	$267.49
19125	Excision, breast lesion		T	0028	20.998	$1,337.43	$303.70	$267.49
19126	Excision, addl breast lesion		T	0028	20.998	$1,337.43	$303.70	$267.49
19260	Removal of chest wall lesion		T	0021	16.5832	$1,056.23	$219.40	$211.25
19271	Revision of chest wall		C					
19272	Extensive chest wall surgery		C					
19290	Place needle wire, breast		N					
19291	Place needle wire, breast		N					
19295	Place breast clip, percut	CH	N					
19296	Place po breast cath for rad		T	0648	52.9438	$3,372.15		$674.43
19297	Place breast cath for rad		T	0648	52.9438	$3,372.15		$674.43
19298	Place breast rad tube/caths	CH	T	0648	52.9438	$3,372.15		$674.43
19300	Removal of breast tissue		T	0028	20.998	$1,337.43	$303.70	$267.49
19301	Partical mastectomy		T	0028	20.998	$1,337.43	$303.70	$267.49
19302	P-mastectomy w/ln removal	CH	T	0030	40.4634	$2,577.24	$747.00	$515.45
19303	Mast, simple, complete		T	0029	32.494	$2,069.64	$581.50	$413.93
19304	Mast, subq		T	0029	32.494	$2,069.64	$581.50	$413.93
19305	Mast, radical		C					
19306	Mast, rad, urban type		C					
19307	Mast, mod rad		T	0030	40.4634	$2,577.24	$747.00	$515.45
19316	Suspension of breast		T	0029	32.494	$2,069.64	$581.50	$413.93
19318	Reduction of large breast	CH	T	0030	40.4634	$2,577.24	$747.00	$515.45
19324	Enlarge breast	CH	T	0030	40.4634	$2,577.24	$747.00	$515.45
19325	Enlarge breast with implant		T	0648	52.9438	$3,372.15		$674.43
19328	Removal of breast implant		T	0029	32.494	$2,069.64	$581.50	$413.93
19330	Removal of implant material		T	0029	32.494	$2,069.64	$581.50	$413.93
19340	Immediate breast prosthesis		T	0030	40.4634	$2,577.24	$747.00	$515.45
19342	Delayed breast prosthesis		T	0648	52.9438	$3,372.15		$674.43
19350	Breast reconstruction		T	0028	20.998	$1,337.43	$303.70	$267.49
19355	Correct inverted nipple(s)		T	0029	32.494	$2,069.64	$581.50	$413.93
19357	Breast reconstruction		T	0648	52.9438	$3,372.15		$674.43
19361	Breast reconstr w/lat flap		C					
19364	Breast reconstruction		C					
19366	Breast reconstruction		T	0029	32.494	$2,069.64	$581.50	$413.93
19367	Breast reconstruction		C					
19368	Breast reconstruction		C					
19369	Breast reconstruction		C					
19370	Surgery of breast capsule		T	0029	32.494	$2,069.64	$581.50	$413.93
19371	Removal of breast capsule		T	0029	32.494	$2,069.64	$581.50	$413.93
19380	Revise breast reconstruction		T	0030	40.4634	$2,577.24	$747.00	$515.45
19396	Design custom breast implant		T	0029	32.494	$2,069.64	$581.50	$413.93
19499	Breast surgery procedure		T	0028	20.998	$1,337.43	$303.70	$267.49
20000	Incision of abscess		T	0006	1.463	$93.18		$18.64
20005	Incision of deep abscess		T	0049	21.5761	$1,374.25		$274.85
2000F	Blood pressure measure		M					
2001F	Weight record		M					
2002F	Clin sign vol ovrld assess		M					
2004F	Initial exam involved joints		M					
20100	Explore wound, neck		T	0023	9.5721	$609.68		$121.94
20101	Explore wound, chest	CH	T	0137	20.9338	$1,333.34		$266.67

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
20102	Explore wound, abdomen	CH	T	0137	20.9338	$1,333.34		$266.67
20103	Explore wound, extremity		T	0023	9.5721	$609.68		$121.94
2010F	Vital signs recorded		M					
2014F	Mental status assess		M					
20150	Excise epiphyseal bar		T	0051	43.5953	$2,776.72		$555.34
2018F	Hydration status assess		M					
2019F	Dilated macul exam done		M					
20200	Muscle biopsy		T	0021	16.5832	$1,056.23	$219.40	$211.25
20205	Deep muscle biopsy		T	0021	16.5832	$1,056.23	$219.40	$211.25
20206	Needle biopsy, muscle		T	0005	7.3012	$465.04		$93.01
2020F	Dilated fundus eval done		M					
2021F	Dilat macul+exam done		M					
20220	Bone biopsy, trocar/needle	CH	T	0020	8.7155	$555.12		$111.02
20225	Bone biopsy, trocar/needle		T	0020	8.7155	$555.12		$111.02
2022F	Dil retina exam interp rev		M					
20240	Bone biopsy, excisional		T	0022	21.4534	$1,366.43	$354.40	$273.29
20245	Bone biopsy, excisional		T	0022	21.4534	$1,366.43	$354.40	$273.29
2024F	7 field photo interp doc rev		M					
20250	Open bone biopsy		T	0049	21.5761	$1,374.25		$274.85
20251	Open bone biopsy		T	0049	21.5761	$1,374.25		$274.85
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		M					
2030F	H2O stat doc'd, normal		M					
2031F	H2O stat doc'd, dehydrated		M					
20500	Injection of sinus tract		T	0251	2.5765	$164.11		$32.82
20501	Inject sinus tract for x-ray		N					
20520	Removal of foreign body		T	0019	4.4463	$283.20	$71.80	$56.64
20525	Removal of foreign body		T	0022	21.4534	$1,366.43	$354.40	$273.29
20526	Ther injection, carp tunnel		T	0204	2.3254	$148.11	$40.10	$29.62
20550	Inj tendon sheath/ligament		T	0204	2.3254	$148.11	$40.10	$29.62
20551	Inj tendon origin/insertion		T	0204	2.3254	$148.11	$40.10	$29.62
20552	Inj trigger point, 1/2 muscl		T	0204	2.3254	$148.11	$40.10	$29.62
20553	Inject trigger points, =/> 3		T	0204	2.3254	$148.11	$40.10	$29.62
20600	Drain/inject, joint/bursa		T	0204	2.3254	$148.11	$40.10	$29.62
20605	Drain/inject, joint/bursa		T	0204	2.3254	$148.11	$40.10	$29.62
20610	Drain/inject, joint/bursa		T	0204	2.3254	$148.11	$40.10	$29.62
20612	Aspirate/inj ganglion cyst		T	0204	2.3254	$148.11	$40.10	$29.62
20615	Treatment of bone cyst		T	0004	4.5062	$287.01		$57.40
20650	Insert and remove bone pin		T	0049	21.5761	$1,374.25		$274.85
20660	Apply, rem fixation device		C					
20661	Application of head brace		C					
20662	Application of pelvis brace		T	0049	21.5761	$1,374.25		$274.85
20663	Application of thigh brace		T	0049	21.5761	$1,374.25		$274.85
20664	Halo brace application		C					
20665	Removal of fixation device		X	0340	0.6416	$40.87		$8.17
20670	Removal of support implant		T	0021	16.5832	$1,056.23	$219.40	$211.25
20680	Removal of support implant		T	0022	21.4534	$1,366.43	$354.40	$273.29
20690	Apply bone fixation device		T	0050	29.3263	$1,867.88		$373.58
20692	Apply bone fixation device		T	0050	29.3263	$1,867.88		$373.58
20693	Adjust bone fixation device		T	0049	21.5761	$1,374.25		$274.85
20694	Remove bone fixation device		T	0049	21.5761	$1,374.25		$274.85
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	26.7322	$1,702.65		$340.53
20824	Replantation thumb, complete		C					
20827	Replantation thumb, complete		C					
20838	Replantation foot, complete		C					
20900	Removal of bone for graft		T	0050	29.3263	$1,867.88		$373.58
20902	Removal of bone for graft		T	0050	29.3263	$1,867.88		$373.58
20910	Remove cartilage for graft	CH	T	0137	20.9338	$1,333.34		$266.67
20912	Remove cartilage for graft	CH	T	0137	20.9338	$1,333.34		$266.67
20920	Removal of fascia for graft	CH	T	0136	15.4399	$983.41		$196.68
20922	Removal of fascia for graft	CH	T	0136	15.4399	$983.41		$196.68
20924	Removal of tendon for graft		T	0050	29.3263	$1,867.88		$373.58
20926	Removal of tissue for graft	CH	T	0135	4.6816	$298.19		$59.64
20930	Spinal bone allograft		C					
20931	Spinal bone allograft		C					
20936	Spinal bone autograft		C					
20937	Spinal bone autograft		C					
20938	Spinal bone autograft		C					
20950	Fluid pressure, muscle		T	0006	1.463	$93.18		$18.64
20955	Fibula bone graft, microvasc		C					
20956	Iliac bone graft, microvasc		C					
20957	Mt bone graft, microvasc		C					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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	44.471	$2,832.49		$566.50
20973	Bone/skin graft, great toe		T	0056	44.471	$2,832.49		$566.50
20974	Electrical bone stimulation		A					
20975	Electrical bone stimulation	CH	N					
20979	Us bone stimulation		X	0340	0.6416	$40.87		$8.17
20982	Ablate, bone tumor(s) perq		T	0051	43.5953	$2,776.72		$555.34
20999	Musculoskeletal surgery		T	0049	21.5761	$1,374.25		$274.85
21010	Incision of jaw joint		T	0254	24.3535	$1,551.15	$321.30	$310.23
21015	Resection of facial tumor		T	0253	16.6341	$1,059.48	$282.20	$211.90
21025	Excision of bone, lower jaw		T	0256	40.5598	$2,583.38		$516.68
21026	Excision of facial bone(s)		T	0256	40.5598	$2,583.38		$516.68
21029	Contour of face bone lesion		T	0256	40.5598	$2,583.38		$516.68
21030	Excise max/zygoma b9 tumor		T	0254	24.3535	$1,551.15	$321.30	$310.23
21031	Remove exostosis, mandible		T	0254	24.3535	$1,551.15	$321.30	$310.23
21032	Remove exostosis, maxilla		T	0254	24.3535	$1,551.15	$321.30	$310.23
21034	Excise max/zygoma mlg tumor		T	0256	40.5598	$2,583.38		$516.68
21040	Excise mandible lesion		T	0254	24.3535	$1,551.15	$321.30	$310.23
21044	Removal of jaw bone lesion		T	0256	40.5598	$2,583.38		$516.68
21045	Extensive jaw surgery		C					
21046	Remove mandible cyst complex		T	0256	40.5598	$2,583.38		$516.68
21047	Excise lwr jaw cyst w/repair		T	0256	40.5598	$2,583.38		$516.68
21048	Remove maxilla cyst complex		T	0256	40.5598	$2,583.38		$516.68
21049	Excis uppr jaw cyst w/repair		T	0256	40.5598	$2,583.38		$516.68
21050	Removal of jaw joint		T	0256	40.5598	$2,583.38		$516.68
21060	Remove jaw joint cartilage		T	0256	40.5598	$2,583.38		$516.68
21070	Remove coronoid process		T	0256	40.5598	$2,583.38		$516.68
21076	Prepare face/oral prosthesis		T	0254	24.3535	$1,551.15	$321.30	$310.23
21077	Prepare face/oral prosthesis		T	0256	40.5598	$2,583.38		$516.68
21079	Prepare face/oral prosthesis		T	0256	40.5598	$2,583.38		$516.68
21080	Prepare face/oral prosthesis		T	0256	40.5598	$2,583.38		$516.68
21081	Prepare face/oral prosthesis		T	0256	40.5598	$2,583.38		$516.68
21082	Prepare face/oral prosthesis		T	0256	40.5598	$2,583.38		$516.68
21083	Prepare face/oral prosthesis		T	0256	40.5598	$2,583.38		$516.68
21084	Prepare face/oral prosthesis		T	0256	40.5598	$2,583.38		$516.68
21085	Prepare face/oral prosthesis		T	0253	16.6341	$1,059.48	$282.20	$211.90
21086	Prepare face/oral prosthesis		T	0256	40.5598	$2,583.38		$516.68
21087	Prepare face/oral prosthesis		T	0256	40.5598	$2,583.38		$516.68
21088	Prepare face/oral prosthesis		T	0256	40.5598	$2,583.38		$516.68
21089	Prepare face/oral prosthesis		T	0251	2.5765	$164.11		$32.82
21100	Maxillofacial fixation		T	0256	40.5598	$2,583.38		$516.68
21110	Interdental fixation		T	0252	7.6539	$487.50	$109.10	$97.50
21116	Injection, jaw joint x-ray		N					
21120	Reconstruction of chin		T	0254	24.3535	$1,551.15	$321.30	$310.23
21121	Reconstruction of chin		T	0254	24.3535	$1,551.15	$321.30	$310.23
21122	Reconstruction of chin		T	0254	24.3535	$1,551.15	$321.30	$310.23
21123	Reconstruction of chin		T	0254	24.3535	$1,551.15	$321.30	$310.23
21125	Augmentation, lower jaw bone		T	0254	24.3535	$1,551.15	$321.30	$310.23
21127	Augmentation, lower jaw bone		T	0256	40.5598	$2,583.38		$516.68
21137	Reduction of forehead		T	0254	24.3535	$1,551.15	$321.30	$310.23
21138	Reduction of forehead		T	0256	40.5598	$2,583.38		$516.68
21139	Reduction of forehead		T	0256	40.5598	$2,583.38		$516.68
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	40.5598	$2,583.38		$516.68
21151	Reconstruct midface, lefort		C					
21154	Reconstruct midface, lefort		C					
21155	Reconstruct midface, lefort		C					
21159	Reconstruct midface, lefort		C					
21160	Reconstruct midface, lefort		C					
21172	Reconstruct orbit/forehead		C					
21175	Reconstruct orbit/forehead		T	0256	40.5598	$2,583.38		$516.68
21179	Reconstruct entire forehead		C					
21180	Reconstruct entire forehead		C					
21181	Contour cranial bone lesion		T	0254	24.3535	$1,551.15	$321.30	$310.23
21182	Reconstruct cranial bone		C					
21183	Reconstruct cranial bone		C					
21184	Reconstruct cranial bone		C					
21188	Reconstruction of midface		C					
21193	Reconst lwr jaw w/o graft		C					
21194	Reconst lwr jaw w/graft		C					
21195	Reconst lwr jaw w/o fixation		T	0256	40.5598	$2,583.38		$516.68

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
21196	Reconst lwr jaw w/fixation		C					
21198	Reconstr lwr jaw segment		T	0256	40.5598	$2,583.38		$516.68
21199	Reconstr lwr jaw w/advance		T	0256	40.5598	$2,583.38		$516.68
21206	Reconstruct upper jaw bone		T	0256	40.5598	$2,583.38		$516.68
21208	Augmentation of facial bones		T	0256	40.5598	$2,583.38		$516.68
21209	Reduction of facial bones		T	0256	40.5598	$2,583.38		$516.68
21210	Face bone graft		T	0256	40.5598	$2,583.38		$516.68
21215	Lower jaw bone graft		T	0256	40.5598	$2,583.38		$516.68
21230	Rib cartilage graft		T	0256	40.5598	$2,583.38		$516.68
21235	Ear cartilage graft		T	0254	24.3535	$1,551.15	$321.30	$310.23
21240	Reconstruction of jaw joint		T	0256	40.5598	$2,583.38		$516.68
21242	Reconstruction of jaw joint		T	0256	40.5598	$2,583.38		$516.68
21243	Reconstruction of jaw joint		T	0256	40.5598	$2,583.38		$516.68
21244	Reconstruction of lower jaw		T	0256	40.5598	$2,583.38		$516.68
21245	Reconstruction of jaw		T	0256	40.5598	$2,583.38		$516.68
21246	Reconstruction of jaw		T	0256	40.5598	$2,583.38		$516.68
21247	Reconstruct lower jaw bone		C					
21248	Reconstruction of jaw		T	0256	40.5598	$2,583.38		$516.68
21249	Reconstruction of jaw		T	0256	40.5598	$2,583.38		$516.68
21255	Reconstruct lower jaw bone		C					
21256	Reconstruction of orbit		C					
21260	Revise eye sockets		T	0256	40.5598	$2,583.38		$516.68
21261	Revise eye sockets		T	0256	40.5598	$2,583.38		$516.68
21263	Revise eye sockets		T	0256	40.5598	$2,583.38		$516.68
21267	Revise eye sockets		T	0256	40.5598	$2,583.38		$516.68
21268	Revise eye sockets		C					
21270	Augmentation, cheek bone		T	0256	40.5598	$2,583.38		$516.68
21275	Revision, orbitofacial bones		T	0256	40.5598	$2,583.38		$516.68
21280	Revision of eyelid		T	0256	40.5598	$2,583.38		$516.68
21282	Revision of eyelid		T	0253	16.6341	$1,059.48	$282.20	$211.90
21295	Revision of jaw muscle/bone		T	0252	7.6539	$487.50	$109.10	$97.50
21296	Revision of jaw muscle/bone		T	0254	24.3535	$1,551.15	$321.30	$310.23
21299	Cranio/maxillofacial surgery		T	0251	2.5765	$164.11		$32.82
21310	Treatment of nose fracture		T	0251	2.5765	$164.11		$32.82
21315	Treatment of nose fracture		T	0251	2.5765	$164.11		$32.82
21320	Treatment of nose fracture	CH	T	0253	16.6341	$1,059.48	$282.20	$211.90
21325	Treatment of nose fracture		T	0254	24.3535	$1,551.15	$321.30	$310.23
21330	Treatment of nose fracture		T	0254	24.3535	$1,551.15	$321.30	$310.23
21335	Treatment of nose fracture		T	0254	24.3535	$1,551.15	$321.30	$310.23
21336	Treat nasal septal fracture		T	0063	40.3466	$2,569.80	$548.30	$513.96
21337	Treat nasal septal fracture		T	0253	16.6341	$1,059.48	$282.20	$211.90
21338	Treat nasoethmoid fracture		T	0254	24.3535	$1,551.15	$321.30	$310.23
21339	Treat nasoethmoid fracture		T	0254	24.3535	$1,551.15	$321.30	$310.23
21340	Treatment of nose fracture		T	0256	40.5598	$2,583.38		$516.68
21343	Treatment of sinus fracture		C					
21344	Treatment of sinus fracture		C					
21345	Treat nose/jaw fracture		T	0254	24.3535	$1,551.15	$321.30	$310.23
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	40.5598	$2,583.38		$516.68
21356	Treat cheek bone fracture		T	0254	24.3535	$1,551.15	$321.30	$310.23
21360	Treat cheek bone fracture	CH	T	0254	24.3535	$1,551.15	$321.30	$310.23
21365	Treat cheek bone fracture	CH	T	0256	40.5598	$2,583.38		$516.68
21366	Treat cheek bone fracture		C					
21385	Treat eye socket fracture	CH	T	0256	40.5598	$2,583.38		$516.68
21386	Treat eye socket fracture		C					
21387	Treat eye socket fracture		C					
21390	Treat eye socket fracture		T	0256	40.5598	$2,583.38		$516.68
21395	Treat eye socket fracture		C					
21400	Treat eye socket fracture		T	0252	7.6539	$487.50	$109.10	$97.50
21401	Treat eye socket fracture		T	0253	16.6341	$1,059.48	$282.20	$211.90
21406	Treat eye socket fracture		T	0256	40.5598	$2,583.38		$516.68
21407	Treat eye socket fracture		T	0256	40.5598	$2,583.38		$516.68
21408	Treat eye socket fracture		T	0256	40.5598	$2,583.38		$516.68
21421	Treat mouth roof fracture		T	0254	24.3535	$1,551.15	$321.30	$310.23
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	24.3535	$1,551.15	$321.30	$310.23
21445	Treat dental ridge fracture		T	0254	24.3535	$1,551.15	$321.30	$310.23
21450	Treat lower jaw fracture		T	0251	2.5765	$164.11		$32.82
21451	Treat lower jaw fracture		T	0252	7.6539	$487.50	$109.10	$97.50
21452	Treat lower jaw fracture		T	0253	16.6341	$1,059.48	$282.20	$211.90

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
21453	Treat lower jaw fracture		T	0256	40.5598	$2,583.38		$516.68
21454	Treat lower jaw fracture		T	0254	24.3535	$1,551.15	$321.30	$310.23
21461	Treat lower jaw fracture		T	0256	40.5598	$2,583.38		$516.68
21462	Treat lower jaw fracture		T	0256	40.5598	$2,583.38		$516.68
21465	Treat lower jaw fracture		T	0256	40.5598	$2,583.38		$516.68
21470	Treat lower jaw fracture		T	0256	40.5598	$2,583.38		$516.68
21480	Reset dislocated jaw		T	0251	2.5765	$164.11		$32.82
21485	Reset dislocated jaw		T	0253	16.6341	$1,059.48	$282.20	$211.90
21490	Repair dislocated jaw		T	0256	40.5598	$2,583.38		$516.68
21495	Treat hyoid bone fracture		T	0253	16.6341	$1,059.48	$282.20	$211.90
21497	Interdental wiring		T	0253	16.6341	$1,059.48	$282.20	$211.90
21499	Head surgery procedure		T	0251	2.5765	$164.11		$32.82
21501	Drain neck/chest lesion		T	0008	19.0457	$1,213.08		$242.62
21502	Drain chest lesion		T	0049	21.5761	$1,374.25		$274.85
21510	Drainage of bone lesion		C					
21550	Biopsy of neck/chest		T	0020	8.7155	$555.12		$111.02
21555	Remove lesion, neck/chest		T	0022	21.4534	$1,366.43	$354.40	$273.29
21556	Remove lesion, neck/chest		T	0022	21.4534	$1,366.43	$354.40	$273.29
21557	Remove tumor, neck/chest		T	0022	21.4534	$1,366.43	$354.40	$273.29
21600	Partial removal of rib		T	0050	29.3263	$1,867.88		$373.58
21610	Partial removal of rib		T	0050	29.3263	$1,867.88		$373.58
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	7.6539	$487.50	$109.10	$97.50
21700	Revision of neck muscle		T	0049	21.5761	$1,374.25		$274.85
21705	Revision of neck muscle/rib		C					
21720	Revision of neck muscle		T	0049	21.5761	$1,374.25		$274.85
21725	Revision of neck muscle		T	0006	1.463	$93.18		$18.64
21740	Reconstruction of sternum		C					
21742	Repair stern/nuss w/o scope		T	0051	43.5953	$2,776.72		$555.34
21743	Repair sternum/nuss w/scope		T	0051	43.5953	$2,776.72		$555.34
21750	Repair of sternum separation		C					
21800	Treatment of rib fracture		T	0043	1.8742	$119.37		$23.87
21805	Treatment of rib fracture		T	0062	26.3092	$1,675.71	$372.80	$335.14
21810	Treatment of rib fracture(s)		C					
21820	Treat sternum fracture		T	0043	1.8742	$119.37		$23.87
21825	Treat sternum fracture		C					
21899	Neck/chest surgery procedure		T	0251	2.5765	$164.11		$32.82
21920	Biopsy soft tissue of back		T	0020	8.7155	$555.12		$111.02
21925	Biopsy soft tissue of back		T	0022	21.4534	$1,366.43	$354.40	$273.29
21930	Remove lesion, back or flank		T	0022	21.4534	$1,366.43	$354.40	$273.29
21935	Remove tumor, back		T	0022	21.4534	$1,366.43	$354.40	$273.29
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	47.6714	$3,036.33		$607.27
22101	Remove part, thorax vertebra		T	0208	47.6714	$3,036.33		$607.27
22102	Remove part, lumbar vertebra		T	0208	47.6714	$3,036.33		$607.27
22103	Remove extra spine segment		T	0208	47.6714	$3,036.33		$607.27
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					
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	47.6714	$3,036.33		$607.27
22224	Revision of lumbar spine		C					
22226	Revise, extra spine segment		C					
22305	Treat spine process fracture		T	0043	1.8742	$119.37		$23.87
22310	Treat spine fracture		T	0043	1.8742	$119.37		$23.87
22315	Treat spine fracture		T	0043	1.8742	$119.37		$23.87
22318	Treat odontoid fx w/o graft		C					
22319	Treat odontoid fx w/graft		C					
22325	Treat spine fracture		C					
22326	Treat neck spine fracture		C					
22327	Treat thorax spine fracture		C					
22328	Treat each add spine fx		C					
22505	Manipulation of spine		T	0045	15.0176	$956.52	$268.40	$191.30
22520	Percut vertebroplasty thor		T	0050	29.3263	$1,867.88		$373.58
22521	Percut vertebroplasty lumb		T	0050	29.3263	$1,867.88		$373.58
22522	Percut vertebroplasty add'l		T	0050	29.3263	$1,867.88		$373.58
22523	Percut kyphoplasty, thor		T	0052	78.6518	$5,009.57		$1,001.91

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
22524	Percut kyphoplasty, lumbar		T	0052	78.6518	$5,009.57		$1,001.91
22525	Percut kyphoplasty, add-on		T	0052	78.6518	$5,009.57		$1,001.91
22526	Idet, single level		T	0050	29.3263	$1,867.88		$373.58
22527	Idet, 1 or more levels		T	0050	29.3263	$1,867.88		$373.58
22532	Lat thorax spine fusion		C					
22533	Lat lumbar spine fusion		C					
22534	Lat thor/lumb, add'l seg		C					
22548	Neck spine fusion		C					
22554	Neck spine fusion		C					
22556	Thorax spine fusion		C					
22558	Lumbar spine fusion		C					
22585	Additional spinal fusion		C					
22590	Spine & skull spinal fusion		C					
22595	Neck spinal fusion		C					
22600	Neck spine fusion		C					
22610	Thorax spine fusion		C					
22612	Lumbar spine fusion		T	0208	47.6714	$3,036.33		$607.27
22614	Spine fusion, extra segment		T	0208	47.6714	$3,036.33		$607.27
22630	Lumbar spine fusion		C					
22632	Spine fusion, extra segment		C					
22800	Fusion of spine		C					
22802	Fusion of spine		C					
22804	Fusion of spine		C					
22808	Fusion of spine		C					
22810	Fusion of spine		C					
22812	Fusion of spine		C					
22818	Kyphectomy, 1-2 segments		C					
22819	Kyphectomy, 3 or more		C					
22830	Exploration of spinal fusion		C					
22840	Insert spine fixation device		C					
22841	Insert spine fixation device		C					
22842	Insert spine fixation device		C					
22843	Insert spine fixation device		C					
22844	Insert spine fixation device		C					
22845	Insert spine fixation device		C					
22846	Insert spine fixation device		C					
22847	Insert spine fixation device		C					
22848	Insert pelv fixation device		C					
22849	Reinsert spinal fixation		C					
22850	Remove spine fixation device		C					
22851	Apply spine prosth device		T	0049	21.5761	$1,374.25		$274.85
22852	Remove spine fixation device		C					
22855	Remove spine fixation device		C					
22857	Lumbar artif diskectomy		C					
22862	Revise lumbar artif disc		C					
22865	Remove lumb artif disc		C					
22899	Spine surgery procedure		T	0049	21.5761	$1,374.25		$274.85
22900	Remove abdominal wall lesion		T	0022	21.4534	$1,366.43	$354.40	$273.29
22999	Abdomen surgery procedure		T	0049	21.5761	$1,374.25		$274.85
23000	Removal of calcium deposits		T	0021	16.5832	$1,056.23	$219.40	$211.25
23020	Release shoulder joint		T	0051	43.5953	$2,776.72		$555.34
23030	Drain shoulder lesion		T	0008	19.0457	$1,213.08		$242.62
23031	Drain shoulder bursa		T	0008	19.0457	$1,213.08		$242.62
23035	Drain shoulder bone lesion		T	0049	21.5761	$1,374.25		$274.85
23040	Exploratory shoulder surgery		T	0050	29.3263	$1,867.88		$373.58
23044	Exploratory shoulder surgery		T	0050	29.3263	$1,867.88		$373.58
23065	Biopsy shoulder tissues		T	0020	8.7155	$555.12		$111.02
23066	Biopsy shoulder tissues		T	0022	21.4534	$1,366.43	$354.40	$273.29
23075	Removal of shoulder lesion		T	0021	16.5832	$1,056.23	$219.40	$211.25
23076	Removal of shoulder lesion		T	0022	21.4534	$1,366.43	$354.40	$273.29
23077	Remove tumor of shoulder		T	0022	21.4534	$1,366.43	$354.40	$273.29
23100	Biopsy of shoulder joint		T	0049	21.5761	$1,374.25		$274.85
23101	Shoulder joint surgery		T	0050	29.3263	$1,867.88		$373.58
23105	Remove shoulder joint lining		T	0050	29.3263	$1,867.88		$373.58
23106	Incision of collarbone joint		T	0050	29.3263	$1,867.88		$373.58
23107	Explore treat shoulder joint		T	0050	29.3263	$1,867.88		$373.58
23120	Partial removal, collar bone	CH	T	0050	29.3263	$1,867.88		$373.58
23125	Removal of collar bone	CH	T	0050	29.3263	$1,867.88		$373.58
23130	Remove shoulder bone, part		T	0051	43.5953	$2,776.72		$555.34
23140	Removal of bone lesion		T	0049	21.5761	$1,374.25		$274.85
23145	Removal of bone lesion		T	0050	29.3263	$1,867.88		$373.58
23146	Removal of bone lesion		T	0050	29.3263	$1,867.88		$373.58
23150	Removal of humerus lesion		T	0050	29.3263	$1,867.88		$373.58
23155	Removal of humerus lesion		T	0050	29.3263	$1,867.88		$373.58
23156	Removal of humerus lesion		T	0050	29.3263	$1,867.88		$373.58
23170	Remove collar bone lesion		T	0050	29.3263	$1,867.88		$373.58
23172	Remove shoulder blade lesion		T	0050	29.3263	$1,867.88		$373.58
23174	Remove humerus lesion		T	0050	29.3263	$1,867.88		$373.58

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
23180	Remove collar bone lesion		T	0050	29.3263	$1,867.88		$373.58
23182	Remove shoulder blade lesion		T	0050	29.3263	$1,867.88		$373.58
23184	Remove humerus lesion		T	0050	29.3263	$1,867.88		$373.58
23190	Partial removal of scapula		T	0050	29.3263	$1,867.88		$373.58
23195	Removal of head of humerus		T	0050	29.3263	$1,867.88		$373.58
23200	Removal of collar bone		C					
23210	Removal of shoulder blade		C					
23220	Partial removal of humerus		C					
23221	Partial removal of humerus		C					
23222	Partial removal of humerus		C					
23330	Remove shoulder foreign body		T	0020	8.7155	$555.12		$111.02
23331	Remove shoulder foreign body		T	0022	21.4534	$1,366.43	$354.40	$273.29
23332	Remove shoulder foreign body		C					
23350	Injection for shoulder x-ray		N					
23395	Muscle transfer,shoulder/arm		T	0051	43.5953	$2,776.72		$555.34
23397	Muscle transfers		T	0052	78.6518	$5,009.57		$1,001.91
23400	Fixation of shoulder blade		T	0050	29.3263	$1,867.88		$373.58
23405	Incision of tendon & muscle		T	0050	29.3263	$1,867.88		$373.58
23406	Incise tendon(s) & muscle(s)		T	0050	29.3263	$1,867.88		$373.58
23410	Repair rotator cuff, acute		T	0051	43.5953	$2,776.72		$555.34
23412	Repair rotator cuff, chronic		T	0051	43.5953	$2,776.72		$555.34
23415	Release of shoulder ligament		T	0051	43.5953	$2,776.72		$555.34
23420	Repair of shoulder		T	0051	43.5953	$2,776.72		$555.34
23430	Repair biceps tendon		T	0051	43.5953	$2,776.72		$555.34
23440	Remove/transplant tendon		T	0051	43.5953	$2,776.72		$555.34
23450	Repair shoulder capsule		T	0052	78.6518	$5,009.57		$1,001.91
23455	Repair shoulder capsule		T	0052	78.6518	$5,009.57		$1,001.91
23460	Repair shoulder capsule		T	0052	78.6518	$5,009.57		$1,001.91
23462	Repair shoulder capsule		T	0051	43.5953	$2,776.72		$555.34
23465	Repair shoulder capsule		T	0052	78.6518	$5,009.57		$1,001.91
23466	Repair shoulder capsule		T	0051	43.5953	$2,776.72		$555.34
23470	Reconstruct shoulder joint		T	0425	113.6713	$7,240.07		$1,448.01
23472	Reconstruct shoulder joint		C					
23480	Revision of collar bone		T	0051	43.5953	$2,776.72		$555.34
23485	Revision of collar bone		T	0052	78.6518	$5,009.57		$1,001.91
23490	Reinforce clavicle		T	0051	43.5953	$2,776.72		$555.34
23491	Reinforce shoulder bones		T	0052	78.6518	$5,009.57		$1,001.91
23500	Treat clavicle fracture		T	0043	1.8742	$119.37		$23.87
23505	Treat clavicle fracture		T	0043	1.8742	$119.37		$23.87
23515	Treat clavicle fracture		T	0064	60.0595	$3,825.37	$835.70	$765.07
23520	Treat clavicle dislocation		T	0043	1.8742	$119.37		$23.87
23525	Treat clavicle dislocation		T	0043	1.8742	$119.37		$23.87
23530	Treat clavicle dislocation		T	0063	40.3466	$2,569.80	$548.30	$513.96
23532	Treat clavicle dislocation		T	0062	26.3092	$1,675.71	$372.80	$335.14
23540	Treat clavicle dislocation		T	0043	1.8742	$119.37		$23.87
23545	Treat clavicle dislocation		T	0043	1.8742	$119.37		$23.87
23550	Treat clavicle dislocation		T	0063	40.3466	$2,569.80	$548.30	$513.96
23552	Treat clavicle dislocation		T	0063	40.3466	$2,569.80	$548.30	$513.96
23570	Treat shoulder blade fx		T	0043	1.8742	$119.37		$23.87
23575	Treat shoulder blade fx		T	0043	1.8742	$119.37		$23.87
23585	Treat scapula fracture		T	0064	60.0595	$3,825.37	$835.70	$765.07
23600	Treat humerus fracture		T	0043	1.8742	$119.37		$23.87
23605	Treat humerus fracture		T	0043	1.8742	$119.37		$23.87
23615	Treat humerus fracture		T	0064	60.0595	$3,825.37	$835.70	$765.07
23616	Treat humerus fracture		T	0064	60.0595	$3,825.37	$835.70	$765.07
23620	Treat humerus fracture		T	0043	1.8742	$119.37		$23.87
23625	Treat humerus fracture		T	0043	1.8742	$119.37		$23.87
23630	Treat humerus fracture		T	0064	60.0595	$3,825.37	$835.70	$765.07
23650	Treat shoulder dislocation		T	0043	1.8742	$119.37		$23.87
23655	Treat shoulder dislocation		T	0045	15.0176	$956.52	$268.40	$191.30
23660	Treat shoulder dislocation		T	0063	40.3466	$2,569.80	$548.30	$513.96
23665	Treat dislocation/fracture		T	0043	1.8742	$119.37		$23.87
23670	Treat dislocation/fracture		T	0064	60.0595	$3,825.37	$835.70	$765.07
23675	Treat dislocation/fracture		T	0043	1.8742	$119.37		$23.87
23680	Treat dislocation/fracture		T	0063	40.3466	$2,569.80	$548.30	$513.96
23700	Fixation of shoulder		T	0045	15.0176	$956.52	$268.40	$191.30
23800	Fusion of shoulder joint		T	0052	78.6518	$5,009.57		$1,001.91
23802	Fusion of shoulder joint		T	0051	43.5953	$2,776.72		$555.34
23900	Amputation of arm & girdle		C					
23920	Amputation at shoulder joint		C					
23921	Amputation follow-up surgery	CH	T	0136	15.4399	$983.41		$196.68
23929	Shoulder surgery procedure		T	0043	1.8742	$119.37		$23.87
23930	Drainage of arm lesion		T	0008	19.0457	$1,213.08		$242.62
23931	Drainage of arm bursa		T	0008	19.0457	$1,213.08		$242.62
23935	Drain arm/elbow bone lesion		T	0049	21.5761	$1,374.25		$274.85
24000	Exploratory elbow surgery		T	0050	29.3263	$1,867.88		$373.58
24006	Release elbow joint		T	0050	29.3263	$1,867.88		$373.58
24065	Biopsy arm/elbow soft tissue		T	0021	16.5832	$1,056.23	$219.40	$211.25

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
24066	Biopsy arm/elbow soft tissue		T	0021	16.5832	$1,056.23	$219.40	$211.25
24075	Remove arm/elbow lesion		T	0021	16.5832	$1,056.23	$219.40	$211.25
24076	Remove arm/elbow lesion		T	0022	21.4534	$1,366.43	$354.40	$273.29
24077	Remove tumor of arm/elbow		T	0022	21.4534	$1,366.43	$354.40	$273.29
24100	Biopsy elbow joint lining		T	0049	21.5761	$1,374.25		$274.85
24101	Explore/treat elbow joint		T	0050	29.3263	$1,867.88		$373.58
24102	Remove elbow joint lining		T	0050	29.3263	$1,867.88		$373.58
24105	Removal of elbow bursa		T	0049	21.5761	$1,374.25		$274.85
24110	Remove humerus lesion		T	0049	21.5761	$1,374.25		$274.85
24115	Remove/graft bone lesion		T	0050	29.3263	$1,867.88		$373.58
24116	Remove/graft bone lesion		T	0050	29.3263	$1,867.88		$373.58
24120	Remove elbow lesion		T	0049	21.5761	$1,374.25		$274.85
24125	Remove/graft bone lesion		T	0050	29.3263	$1,867.88		$373.58
24126	Remove/graft bone lesion		T	0050	29.3263	$1,867.88		$373.58
24130	Removal of head of radius		T	0050	29.3263	$1,867.88		$373.58
24134	Removal of arm bone lesion		T	0050	29.3263	$1,867.88		$373.58
24136	Remove radius bone lesion		T	0050	29.3263	$1,867.88		$373.58
24138	Remove elbow bone lesion		T	0050	29.3263	$1,867.88		$373.58
24140	Partial removal of arm bone		T	0050	29.3263	$1,867.88		$373.58
24145	Partial removal of radius		T	0050	29.3263	$1,867.88		$373.58
24147	Partial removal of elbow		T	0050	29.3263	$1,867.88		$373.58
24149	Radical resection of elbow		T	0050	29.3263	$1,867.88		$373.58
24150	Extensive humerus surgery		T	0051	43.5953	$2,776.72		$555.34
24151	Extensive humerus surgery		T	0052	78.6518	$5,009.57		$1,001.91
24152	Extensive radius surgery		T	0051	43.5953	$2,776.72		$555.34
24153	Extensive radius surgery		T	0052	78.6518	$5,009.57		$1,001.91
24155	Removal of elbow joint		T	0051	43.5953	$2,776.72		$555.34
24160	Remove elbow joint implant		T	0050	29.3263	$1,867.88		$373.58
24164	Remove radius head implant		T	0050	29.3263	$1,867.88		$373.58
24200	Removal of arm foreign body		T	0019	4.4463	$283.20	$71.80	$56.64
24201	Removal of arm foreign body		T	0021	16.5832	$1,056.23	$219.40	$211.25
24220	Injection for elbow x-ray		N					
24300	Manipulate elbow w/anesth		T	0045	15.0176	$956.52	$268.40	$191.30
24301	Muscle/tendon transfer		T	0050	29.3263	$1,867.88		$373.58
24305	Arm tendon lengthening		T	0050	29.3263	$1,867.88		$373.58
24310	Revision of arm tendon		T	0049	21.5761	$1,374.25		$274.85
24320	Repair of arm tendon		T	0051	43.5953	$2,776.72		$555.34
24330	Revision of arm muscles		T	0052	78.6518	$5,009.57		$1,001.91
24331	Revision of arm muscles		T	0051	43.5953	$2,776.72		$555.34
24332	Tenolysis, triceps		T	0049	21.5761	$1,374.25		$274.85
24340	Repair of biceps tendon		T	0051	43.5953	$2,776.72		$555.34
24341	Repair arm tendon/muscle		T	0051	43.5953	$2,776.72		$555.34
24342	Repair of ruptured tendon		T	0051	43.5953	$2,776.72		$555.34
24343	Repr elbow lat ligmnt w/tiss		T	0050	29.3263	$1,867.88		$373.58
24344	Reconstruct elbow lat ligmnt		T	0052	78.6518	$5,009.57		$1,001.91
24345	Repr elbw med ligmnt w/tissu		T	0050	29.3263	$1,867.88		$373.58
24346	Reconstruct elbow med ligmnt		T	0051	43.5953	$2,776.72		$555.34
24350	Repair of tennis elbow		T	0050	29.3263	$1,867.88		$373.58
24351	Repair of tennis elbow		T	0050	29.3263	$1,867.88		$373.58
24352	Repair of tennis elbow		T	0050	29.3263	$1,867.88		$373.58
24354	Repair of tennis elbow		T	0050	29.3263	$1,867.88		$373.58
24356	Revision of tennis elbow		T	0050	29.3263	$1,867.88		$373.58
24360	Reconstruct elbow joint		T	0047	35.9249	$2,288.16	$537.00	$457.63
24361	Reconstruct elbow joint		T	0425	113.6713	$7,240.07		$1,448.01
24362	Reconstruct elbow joint		T	0048	51.0431	$3,251.09		$650.22
24363	Replace elbow joint		T	0425	113.6713	$7,240.07		$1,448.01
24365	Reconstruct head of radius		T	0047	35.9249	$2,288.16	$537.00	$457.63
24366	Reconstruct head of radius		T	0425	113.6713	$7,240.07		$1,448.01
24400	Revision of humerus		T	0050	29.3263	$1,867.88		$373.58
24410	Revision of humerus		T	0050	29.3263	$1,867.88		$373.58
24420	Revision of humerus		T	0051	43.5953	$2,776.72		$555.34
24430	Repair of humerus		T	0052	78.6518	$5,009.57		$1,001.91
24435	Repair humerus with graft		T	0052	78.6518	$5,009.57		$1,001.91
24470	Revision of elbow joint		T	0051	43.5953	$2,776.72		$555.34
24495	Decompression of forearm		T	0050	29.3263	$1,867.88		$373.58
24498	Reinforce humerus		T	0052	78.6518	$5,009.57		$1,001.91
24500	Treat humerus fracture		T	0043	1.8742	$119.37		$23.87
24505	Treat humerus fracture		T	0043	1.8742	$119.37		$23.87
24515	Treat humerus fracture		T	0064	60.0595	$3,825.37	$835.70	$765.07
24516	Treat humerus fracture		T	0064	60.0595	$3,825.37	$835.70	$765.07
24530	Treat humerus fracture		T	0043	1.8742	$119.37		$23.87
24535	Treat humerus fracture		T	0043	1.8742	$119.37		$23.87
24538	Treat humerus fracture		T	0062	26.3092	$1,675.71	$372.80	$335.14
24545	Treat humerus fracture		T	0064	60.0595	$3,825.37	$835.70	$765.07
24546	Treat humerus fracture		T	0064	60.0595	$3,825.37	$835.70	$765.07
24560	Treat humerus fracture		T	0043	1.8742	$119.37		$23.87
24565	Treat humerus fracture		T	0043	1.8742	$119.37		$23.87
24566	Treat humerus fracture		T	0062	26.3092	$1,675.71	$372.80	$335.14

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
24575	Treat humerus fracture		T	0064	60.0595	$3,825.37	$835.70	$765.07
24576	Treat humerus fracture		T	0043	1.8742	$119.37		$23.87
24577	Treat humerus fracture		T	0043	1.8742	$119.37		$23.87
24579	Treat humerus fracture		T	0064	60.0595	$3,825.37	$835.70	$765.07
24582	Treat humerus fracture		T	0062	26.3092	$1,675.71	$372.80	$335.14
24586	Treat elbow fracture		T	0064	60.0595	$3,825.37	$835.70	$765.07
24587	Treat elbow fracture		T	0064	60.0595	$3,825.37	$835.70	$765.07
24600	Treat elbow dislocation		T	0043	1.8742	$119.37		$23.87
24605	Treat elbow dislocation		T	0045	15.0176	$956.52	$268.40	$191.30
24615	Treat elbow dislocation		T	0064	60.0595	$3,825.37	$835.70	$765.07
24620	Treat elbow fracture		T	0043	1.8742	$119.37		$23.87
24635	Treat elbow fracture		T	0064	60.0595	$3,825.37	$835.70	$765.07
24640	Treat elbow dislocation		T	0043	1.8742	$119.37		$23.87
24650	Treat radius fracture		T	0043	1.8742	$119.37		$23.87
24655	Treat radius fracture		T	0043	1.8742	$119.37		$23.87
24665	Treat radius fracture		T	0063	40.3466	$2,569.80	$548.30	$513.96
24666	Treat radius fracture		T	0064	60.0595	$3,825.37	$835.70	$765.07
24670	Treat ulnar fracture		T	0043	1.8742	$119.37		$23.87
24675	Treat ulnar fracture		T	0043	1.8742	$119.37		$23.87
24685	Treat ulnar fracture		T	0063	40.3466	$2,569.80	$548.30	$513.96
24800	Fusion of elbow joint		T	0051	43.5953	$2,776.72		$555.34
24802	Fusion/graft of elbow joint		T	0051	43.5953	$2,776.72		$555.34
24900	Amputation of upper arm		C					
24920	Amputation of upper arm		C					
24925	Amputation follow-up surgery		T	0049	21.5761	$1,374.25		$274.85
24930	Amputation follow-up surgery		C					
24931	Amputate upper arm & implant		C					
24935	Revision of amputation		T	0052	78.6518	$5,009.57		$1,001.91
24940	Revision of upper arm		C					
24999	Upper arm/elbow surgery		T	0043	1.8742	$119.37		$23.87
25000	Incision of tendon sheath		T	0049	21.5761	$1,374.25		$274.85
25001	Incise flexor carpi radialis		T	0049	21.5761	$1,374.25		$274.85
25020	Decompress forearm 1 space		T	0049	21.5761	$1,374.25		$274.85
25023	Decompress forearm 1 space		T	0050	29.3263	$1,867.88		$373.58
25024	Decompress forearm 2 spaces		T	0050	29.3263	$1,867.88		$373.58
25025	Decompress forearm 2 spaces		T	0050	29.3263	$1,867.88		$373.58
25028	Drainage of forearm lesion		T	0049	21.5761	$1,374.25		$274.85
25031	Drainage of forearm bursa		T	0049	21.5761	$1,374.25		$274.85
25035	Treat forearm bone lesion		T	0049	21.5761	$1,374.25		$274.85
25040	Explore/treat wrist joint		T	0050	29.3263	$1,867.88		$373.58
25065	Biopsy forearm soft tissues		T	0020	8.7155	$555.12		$111.02
25066	Biopsy forearm soft tissues		T	0022	21.4534	$1,366.43	$354.40	$273.29
25075	Removal forearm lesion subcu		T	0021	16.5832	$1,056.23	$219.40	$211.25
25076	Removal forearm lesion deep		T	0022	21.4534	$1,366.43	$354.40	$273.29
25077	Remove tumor, forearm/wrist		T	0022	21.4534	$1,366.43	$354.40	$273.29
25085	Incision of wrist capsule		T	0049	21.5761	$1,374.25		$274.85
25100	Biopsy of wrist joint		T	0049	21.5761	$1,374.25		$274.85
25101	Explore/treat wrist joint		T	0050	29.3263	$1,867.88		$373.58
25105	Remove wrist joint lining		T	0050	29.3263	$1,867.88		$373.58
25107	Remove wrist joint cartilage		T	0050	29.3263	$1,867.88		$373.58
25109	Excise tendon forearm/wrist		T	0049	21.5761	$1,374.25		$274.85
25110	Remove wrist tendon lesion		T	0049	21.5761	$1,374.25		$274.85
25111	Remove wrist tendon lesion		T	0053	16.822	$1,071.44	$253.40	$214.29
25112	Reremove wrist tendon lesion		T	0053	16.822	$1,071.44	$253.40	$214.29
25115	Remove wrist/forearm lesion		T	0049	21.5761	$1,374.25		$274.85
25116	Remove wrist/forearm lesion		T	0049	21.5761	$1,374.25		$274.85
25118	Excise wrist tendon sheath		T	0050	29.3263	$1,867.88		$373.58
25119	Partial removal of ulna		T	0050	29.3263	$1,867.88		$373.58
25120	Removal of forearm lesion		T	0050	29.3263	$1,867.88		$373.58
25125	Remove/graft forearm lesion		T	0050	29.3263	$1,867.88		$373.58
25126	Remove/graft forearm lesion		T	0050	29.3263	$1,867.88		$373.58
25130	Removal of wrist lesion		T	0050	29.3263	$1,867.88		$373.58
25135	Remove & graft wrist lesion		T	0050	29.3263	$1,867.88		$373.58
25136	Remove & graft wrist lesion		T	0050	29.3263	$1,867.88		$373.58
25145	Remove forearm bone lesion		T	0050	29.3263	$1,867.88		$373.58
25150	Partial removal of ulna		T	0050	29.3263	$1,867.88		$373.58
25151	Partial removal of radius		T	0050	29.3263	$1,867.88		$373.58
25170	Extensive forearm surgery		T	0051	43.5953	$2,776.72		$555.34
25210	Removal of wrist bone		T	0054	26.7322	$1,702.65		$340.53
25215	Removal of wrist bones		T	0054	26.7322	$1,702.65		$340.53
25230	Partial removal of radius		T	0050	29.3263	$1,867.88		$373.58
25240	Partial removal of ulna		T	0050	29.3263	$1,867.88		$373.58
25246	Injection for wrist x-ray		N					
25248	Remove forearm foreign body		T	0049	21.5761	$1,374.25		$274.85
25250	Removal of wrist prosthesis		T	0050	29.3263	$1,867.88		$373.58
25251	Removal of wrist prosthesis		T	0050	29.3263	$1,867.88		$373.58
25259	Manipulate wrist w/anesthes		T	0043	1.8742	$119.37		$23.87
25260	Repair forearm tendon/muscle		T	0050	29.3263	$1,867.88		$373.58

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
25263	Repair forearm tendon/muscle		T	0050	29.3263	$1,867.88		$373.58
25265	Repair forearm tendon/muscle		T	0050	29.3263	$1,867.88		$373.58
25270	Repair forearm tendon/muscle		T	0050	29.3263	$1,867.88		$373.58
25272	Repair forearm tendon/muscle		T	0050	29.3263	$1,867.88		$373.58
25274	Repair forearm tendon/muscle		T	0050	29.3263	$1,867.88		$373.58
25275	Repair forearm tendon sheath		T	0050	29.3263	$1,867.88		$373.58
25280	Revise wrist/forearm tendon		T	0050	29.3263	$1,867.88		$373.58
25290	Incise wrist/forearm tendon		T	0050	29.3263	$1,867.88		$373.58
25295	Release wrist/forearm tendon		T	0049	21.5761	$1,374.25		$274.85
25300	Fusion of tendons at wrist		T	0050	29.3263	$1,867.88		$373.58
25301	Fusion of tendons at wrist		T	0050	29.3263	$1,867.88		$373.58
25310	Transplant forearm tendon		T	0051	43.5953	$2,776.72		$555.34
25312	Transplant forearm tendon		T	0051	43.5953	$2,776.72		$555.34
25315	Revise palsy hand tendon(s)		T	0051	43.5953	$2,776.72		$555.34
25316	Revise palsy hand tendon(s)		T	0052	78.6518	$5,009.57		$1,001.91
25320	Repair/revise wrist joint		T	0051	43.5953	$2,776.72		$555.34
25332	Revise wrist joint		T	0047	35.9249	$2,288.16	$537.00	$457.63
25335	Realignment of hand		T	0051	43.5953	$2,776.72		$555.34
25337	Reconstruct ulna/radioulnar		T	0051	43.5953	$2,776.72		$555.34
25350	Revision of radius		T	0052	78.6518	$5,009.57		$1,001.91
25355	Revision of radius		T	0051	43.5953	$2,776.72		$555.34
25360	Revision of ulna		T	0050	29.3263	$1,867.88		$373.58
25365	Revise radius & ulna		T	0050	29.3263	$1,867.88		$373.58
25370	Revise radius or ulna		T	0051	43.5953	$2,776.72		$555.34
25375	Revise radius & ulna		T	0051	43.5953	$2,776.72		$555.34
25390	Shorten radius or ulna		T	0050	29.3263	$1,867.88		$373.58
25391	Lengthen radius or ulna		T	0051	43.5953	$2,776.72		$555.34
25392	Shorten radius & ulna		T	0050	29.3263	$1,867.88		$373.58
25393	Lengthen radius & ulna		T	0051	43.5953	$2,776.72		$555.34
25394	Repair carpal bone, shorten		T	0053	16.822	$1,071.44	$253.40	$214.29
25400	Repair radius or ulna	CH	T	0052	78.6518	$5,009.57		$1,001.91
25405	Repair/graft radius or ulna	CH	T	0052	78.6518	$5,009.57		$1,001.91
25415	Repair radius & ulna	CH	T	0052	78.6518	$5,009.57		$1,001.91
25420	Repair/graft radius & ulna		T	0052	78.6518	$5,009.57		$1,001.91
25425	Repair/graft radius or ulna		T	0051	43.5953	$2,776.72		$555.34
25426	Repair/graft radius & ulna		T	0051	43.5953	$2,776.72		$555.34
25430	Vasc graft into carpal bone		T	0054	26.7322	$1,702.65		$340.53
25431	Repair nonunion carpal bone		T	0054	26.7322	$1,702.65		$340.53
25440	Repair/graft wrist bone		T	0052	78.6518	$5,009.57		$1,001.91
25441	Reconstruct wrist joint		T	0425	113.6713	$7,240.07		$1,448.01
25442	Reconstruct wrist joint		T	0425	113.6713	$7,240.07		$1,448.01
25443	Reconstruct wrist joint		T	0048	51.0431	$3,251.09		$650.22
25444	Reconstruct wrist joint		T	0048	51.0431	$3,251.09		$650.22
25445	Reconstruct wrist joint		T	0048	51.0431	$3,251.09		$650.22
25446	Wrist replacement		T	0425	113.6713	$7,240.07		$1,448.01
25447	Repair wrist joint(s)		T	0047	35.9249	$2,288.16	$537.00	$457.63
25449	Remove wrist joint implant		T	0047	35.9249	$2,288.16	$537.00	$457.63
25450	Revision of wrist joint		T	0051	43.5953	$2,776.72		$555.34
25455	Revision of wrist joint		T	0051	43.5953	$2,776.72		$555.34
25490	Reinforce radius		T	0051	43.5953	$2,776.72		$555.34
25491	Reinforce ulna		T	0051	43.5953	$2,776.72		$555.34
25492	Reinforce radius and ulna		T	0051	43.5953	$2,776.72		$555.34
25500	Treat fracture of radius		T	0043	1.8742	$119.37		$23.87
25505	Treat fracture of radius		T	0043	1.8742	$119.37		$23.87
25515	Treat fracture of radius		T	0063	40.3466	$2,569.80	$548.30	$513.96
25520	Treat fracture of radius		T	0043	1.8742	$119.37		$23.87
25525	Treat fracture of radius		T	0063	40.3466	$2,569.80	$548.30	$513.96
25526	Treat fracture of radius		T	0063	40.3466	$2,569.80	$548.30	$513.96
25530	Treat fracture of ulna		T	0043	1.8742	$119.37		$23.87
25535	Treat fracture of ulna		T	0043	1.8742	$119.37		$23.87
25545	Treat fracture of ulna		T	0063	40.3466	$2,569.80	$548.30	$513.96
25560	Treat fracture radius & ulna		T	0043	1.8742	$119.37		$23.87
25565	Treat fracture radius & ulna		T	0043	1.8742	$119.37		$23.87
25574	Treat fracture radius & ulna		T	0064	60.0595	$3,825.37	$835.70	$765.07
25575	Treat fracture radius/ulna		T	0064	60.0595	$3,825.37	$835.70	$765.07
25600	Treat fracture radius/ulna		T	0043	1.8742	$119.37		$23.87
25605	Treat fracture radius/ulna		T	0043	1.8742	$119.37		$23.87
25606	Treat fx distal radial		T	0062	26.3092	$1,675.71	$372.80	$335.14
25607	Treat fx rad extra-articul		T	0064	60.0595	$3,825.37	$835.70	$765.07
25608	Treat fx rad intra-articul		T	0064	60.0595	$3,825.37	$835.70	$765.07
25609	Treat fx radial 3+ frag		T	0064	60.0595	$3,825.37	$835.70	$765.07
25622	Treat wrist bone fracture		T	0043	1.8742	$119.37		$23.87
25624	Treat wrist bone fracture		T	0043	1.8742	$119.37		$23.87
25628	Treat wrist bone fracture		T	0063	40.3466	$2,569.80	$548.30	$513.96
25630	Treat wrist bone fracture		T	0043	1.8742	$119.37		$23.87
25635	Treat wrist bone fracture		T	0043	1.8742	$119.37		$23.87
25645	Treat wrist bone fracture		T	0063	40.3466	$2,569.80	$548.30	$513.96
25650	Treat wrist bone fracture		T	0043	1.8742	$119.37		$23.87

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
25651	Pin ulnar styloid fracture		T	0062	26.3092	$1,675.71	$372.80	$335.14
25652	Treat fracture ulnar styloid		T	0063	40.3466	$2,569.80	$548.30	$513.96
25660	Treat wrist dislocation		T	0043	1.8742	$119.37		$23.87
25670	Treat wrist dislocation		T	0062	26.3092	$1,675.71	$372.80	$335.14
25671	Pin radioulnar dislocation		T	0062	26.3092	$1,675.71	$372.80	$335.14
25675	Treat wrist dislocation		T	0043	1.8742	$119.37		$23.87
25676	Treat wrist dislocation		T	0062	26.3092	$1,675.71	$372.80	$335.14
25680	Treat wrist fracture		T	0043	1.8742	$119.37		$23.87
25685	Treat wrist fracture		T	0062	26.3092	$1,675.71	$372.80	$335.14
25690	Treat wrist dislocation		T	0043	1.8742	$119.37		$23.87
25695	Treat wrist dislocation		T	0062	26.3092	$1,675.71	$372.80	$335.14
25800	Fusion of wrist joint		T	0052	78.6518	$5,009.57		$1,001.91
25805	Fusion/graft of wrist joint		T	0051	43.5953	$2,776.72		$555.34
25810	Fusion/graft of wrist joint		T	0052	78.6518	$5,009.57		$1,001.91
25820	Fusion of hand bones		T	0053	16.822	$1,071.44	$253.40	$214.29
25825	Fuse hand bones with graft	CH	T	0052	78.6518	$5,009.57		$1,001.91
25830	Fusion, radioulnar jnt/ulna		T	0052	78.6518	$5,009.57		$1,001.91
25900	Amputation of forearm		C					
25905	Amputation of forearm		C					
25907	Amputation follow-up surgery		T	0049	21.5761	$1,374.25		$274.85
25909	Amputation follow-up surgery		C					
25915	Amputation of forearm		C					
25920	Amputate hand at wrist		C					
25922	Amputate hand at wrist		T	0049	21.5761	$1,374.25		$274.85
25924	Amputation follow-up surgery		C					
25927	Amputation of hand		C					
25929	Amputation follow-up surgery	CH	T	0136	15.4399	$983.41		$196.68
25931	Amputation follow-up surgery	CH	T	0049	21.5761	$1,374.25		$274.85
25999	Forearm or wrist surgery		T	0043	1.8742	$119.37		$23.87
26010	Drainage of finger abscess		T	0006	1.463	$93.18		$18.64
26011	Drainage of finger abscess		T	0007	12.5792	$801.21		$160.24
26020	Drain hand tendon sheath		T	0053	16.822	$1,071.44	$253.40	$214.29
26025	Drainage of palm bursa		T	0053	16.822	$1,071.44	$253.40	$214.29
26030	Drainage of palm bursa(s)		T	0053	16.822	$1,071.44	$253.40	$214.29
26034	Treat hand bone lesion		T	0053	16.822	$1,071.44	$253.40	$214.29
26035	Decompress fingers/hand		T	0053	16.822	$1,071.44	$253.40	$214.29
26037	Decompress fingers/hand		T	0053	16.822	$1,071.44	$253.40	$214.29
26040	Release palm contracture		T	0054	26.7322	$1,702.65		$340.53
26045	Release palm contracture		T	0054	26.7322	$1,702.65		$340.53
26055	Incise finger tendon sheath		T	0053	16.822	$1,071.44	$253.40	$214.29
26060	Incision of finger tendon		T	0053	16.822	$1,071.44	$253.40	$214.29
26070	Explore/treat hand joint		T	0053	16.822	$1,071.44	$253.40	$214.29
26075	Explore/treat finger joint		T	0053	16.822	$1,071.44	$253.40	$214.29
26080	Explore/treat finger joint		T	0053	16.822	$1,071.44	$253.40	$214.29
26100	Biopsy hand joint lining		T	0053	16.822	$1,071.44	$253.40	$214.29
26105	Biopsy finger joint lining		T	0053	16.822	$1,071.44	$253.40	$214.29
26110	Biopsy finger joint lining		T	0053	16.822	$1,071.44	$253.40	$214.29
26115	Removal hand lesion subcut		T	0022	21.4534	$1,366.43	$354.40	$273.29
26116	Removal hand lesion, deep		T	0022	21.4534	$1,366.43	$354.40	$273.29
26117	Remove tumor, hand/finger		T	0022	21.4534	$1,366.43	$354.40	$273.29
26121	Release palm contracture		T	0054	26.7322	$1,702.65		$340.53
26123	Release palm contracture		T	0054	26.7322	$1,702.65		$340.53
26125	Release palm contracture		T	0053	16.822	$1,071.44	$253.40	$214.29
26130	Remove wrist joint lining		T	0053	16.822	$1,071.44	$253.40	$214.29
26135	Revise finger joint, each		T	0054	26.7322	$1,702.65		$340.53
26140	Revise finger joint, each		T	0053	16.822	$1,071.44	$253.40	$214.29
26145	Tendon excision, palm/finger		T	0053	16.822	$1,071.44	$253.40	$214.29
26160	Remove tendon sheath lesion		T	0053	16.822	$1,071.44	$253.40	$214.29
26170	Removal of palm tendon, each		T	0053	16.822	$1,071.44	$253.40	$214.29
26180	Removal of finger tendon		T	0053	16.822	$1,071.44	$253.40	$214.29
26185	Remove finger bone		T	0053	16.822	$1,071.44	$253.40	$214.29
26200	Remove hand bone lesion		T	0053	16.822	$1,071.44	$253.40	$214.29
26205	Remove/graft bone lesion		T	0054	26.7322	$1,702.65		$340.53
26210	Removal of finger lesion		T	0053	16.822	$1,071.44	$253.40	$214.29
26215	Remove/graft finger lesion		T	0053	16.822	$1,071.44	$253.40	$214.29
26230	Partial removal of hand bone		T	0053	16.822	$1,071.44	$253.40	$214.29
26235	Partial removal, finger bone		T	0053	16.822	$1,071.44	$253.40	$214.29
26236	Partial removal, finger bone		T	0053	16.822	$1,071.44	$253.40	$214.29
26250	Extensive hand surgery		T	0053	16.822	$1,071.44	$253.40	$214.29
26255	Extensive hand surgery		T	0054	26.7322	$1,702.65		$340.53
26260	Extensive finger surgery		T	0053	16.822	$1,071.44	$253.40	$214.29
26261	Extensive finger surgery		T	0053	16.822	$1,071.44	$253.40	$214.29
26262	Partial removal of finger		T	0053	16.822	$1,071.44	$253.40	$214.29
26320	Removal of implant from hand		T	0021	16.5832	$1,056.23	$219.40	$211.25
26340	Manipulate finger w/anesth		T	0043	1.8742	$119.37		$23.87
26350	Repair finger/hand tendon		T	0054	26.7322	$1,702.65		$340.53
26352	Repair/graft hand tendon		T	0054	26.7322	$1,702.65		$340.53
26356	Repair finger/hand tendon		T	0054	26.7322	$1,702.65		$340.53

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
26357	Repair finger/hand tendon		T	0054	26.7322	$1,702.65		$340.53
26358	Repair/graft hand tendon		T	0054	26.7322	$1,702.65		$340.53
26370	Repair finger/hand tendon		T	0054	26.7322	$1,702.65		$340.53
26372	Repair/graft hand tendon		T	0054	26.7322	$1,702.65		$340.53
26373	Repair finger/hand tendon		T	0054	26.7322	$1,702.65		$340.53
26390	Revise hand/finger tendon		T	0054	26.7322	$1,702.65		$340.53
26392	Repair/graft hand tendon		T	0054	26.7322	$1,702.65		$340.53
26410	Repair hand tendon		T	0053	16.822	$1,071.44	$253.40	$214.29
26412	Repair/graft hand tendon		T	0054	26.7322	$1,702.65		$340.53
26415	Excision, hand/finger tendon		T	0054	26.7322	$1,702.65		$340.53
26416	Graft hand or finger tendon		T	0054	26.7322	$1,702.65		$340.53
26418	Repair finger tendon		T	0053	16.822	$1,071.44	$253.40	$214.29
26420	Repair/graft finger tendon		T	0054	26.7322	$1,702.65		$340.53
26426	Repair finger/hand tendon		T	0054	26.7322	$1,702.65		$340.53
26428	Repair/graft finger tendon		T	0054	26.7322	$1,702.65		$340.53
26432	Repair finger tendon		T	0053	16.822	$1,071.44	$253.40	$214.29
26433	Repair finger tendon		T	0053	16.822	$1,071.44	$253.40	$214.29
26434	Repair/graft finger tendon		T	0054	26.7322	$1,702.65		$340.53
26437	Realignment of tendons		T	0053	16.822	$1,071.44	$253.40	$214.29
26440	Release palm/finger tendon		T	0053	16.822	$1,071.44	$253.40	$214.29
26442	Release palm & finger tendon		T	0054	26.7322	$1,702.65		$340.53
26445	Release hand/finger tendon		T	0053	16.822	$1,071.44	$253.40	$214.29
26449	Release forearm/hand tendon		T	0054	26.7322	$1,702.65		$340.53
26450	Incision of palm tendon		T	0053	16.822	$1,071.44	$253.40	$214.29
26455	Incision of finger tendon		T	0053	16.822	$1,071.44	$253.40	$214.29
26460	Incise hand/finger tendon		T	0053	16.822	$1,071.44	$253.40	$214.29
26471	Fusion of finger tendons		T	0053	16.822	$1,071.44	$253.40	$214.29
26474	Fusion of finger tendons		T	0053	16.822	$1,071.44	$253.40	$214.29
26476	Tendon lengthening		T	0053	16.822	$1,071.44	$253.40	$214.29
26477	Tendon shortening		T	0053	16.822	$1,071.44	$253.40	$214.29
26478	Lengthening of hand tendon		T	0053	16.822	$1,071.44	$253.40	$214.29
26479	Shortening of hand tendon		T	0053	16.822	$1,071.44	$253.40	$214.29
26480	Transplant hand tendon		T	0054	26.7322	$1,702.65		$340.53
26483	Transplant/graft hand tendon		T	0054	26.7322	$1,702.65		$340.53
26485	Transplant palm tendon		T	0054	26.7322	$1,702.65		$340.53
26489	Transplant/graft palm tendon		T	0054	26.7322	$1,702.65		$340.53
26490	Revise thumb tendon		T	0054	26.7322	$1,702.65		$340.53
26492	Tendon transfer with graft		T	0054	26.7322	$1,702.65		$340.53
26494	Hand tendon/muscle transfer		T	0054	26.7322	$1,702.65		$340.53
26496	Revise thumb tendon		T	0054	26.7322	$1,702.65		$340.53
26497	Finger tendon transfer		T	0054	26.7322	$1,702.65		$340.53
26498	Finger tendon transfer		T	0054	26.7322	$1,702.65		$340.53
26499	Revision of finger		T	0054	26.7322	$1,702.65		$340.53
26500	Hand tendon reconstruction		T	0053	16.822	$1,071.44	$253.40	$214.29
26502	Hand tendon reconstruction		T	0054	26.7322	$1,702.65		$340.53
26508	Release thumb contracture		T	0053	16.822	$1,071.44	$253.40	$214.29
26510	Thumb tendon transfer		T	0054	26.7322	$1,702.65		$340.53
26516	Fusion of knuckle joint		T	0054	26.7322	$1,702.65		$340.53
26517	Fusion of knuckle joints		T	0054	26.7322	$1,702.65		$340.53
26518	Fusion of knuckle joints		T	0054	26.7322	$1,702.65		$340.53
26520	Release knuckle contracture		T	0053	16.822	$1,071.44	$253.40	$214.29
26525	Release finger contracture		T	0053	16.822	$1,071.44	$253.40	$214.29
26530	Revise knuckle joint		T	0047	35.9249	$2,288.16	$537.00	$457.63
26531	Revise knuckle with implant		T	0048	51.0431	$3,251.09		$650.22
26535	Revise finger joint		T	0047	35.9249	$2,288.16	$537.00	$457.63
26536	Revise/implant finger joint		T	0048	51.0431	$3,251.09		$650.22
26540	Repair hand joint		T	0053	16.822	$1,071.44	$253.40	$214.29
26541	Repair hand joint with graft		T	0054	26.7322	$1,702.65		$340.53
26542	Repair hand joint with graft		T	0053	16.822	$1,071.44	$253.40	$214.29
26545	Reconstruct finger joint		T	0054	26.7322	$1,702.65		$340.53
26546	Repair nonunion hand		T	0054	26.7322	$1,702.65		$340.53
26548	Reconstruct finger joint		T	0054	26.7322	$1,702.65		$340.53
26550	Construct thumb replacement		T	0054	26.7322	$1,702.65		$340.53
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	26.7322	$1,702.65		$340.53
26556	Toe joint transfer		C					
26560	Repair of web finger		T	0053	16.822	$1,071.44	$253.40	$214.29
26561	Repair of web finger		T	0054	26.7322	$1,702.65		$340.53
26562	Repair of web finger		T	0054	26.7322	$1,702.65		$340.53
26565	Correct metacarpal flaw		T	0054	26.7322	$1,702.65		$340.53
26567	Correct finger deformity		T	0054	26.7322	$1,702.65		$340.53
26568	Lengthen metacarpal/finger		T	0054	26.7322	$1,702.65		$340.53
26580	Repair hand deformity		T	0053	16.822	$1,071.44	$253.40	$214.29
26587	Reconstruct extra finger		T	0053	16.822	$1,071.44	$253.40	$214.29
26590	Repair finger deformity		T	0053	16.822	$1,071.44	$253.40	$214.29
26591	Repair muscles of hand		T	0054	26.7322	$1,702.65		$340.53

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
26593	Release muscles of hand		T	0053	16.822	$1,071.44	$253.40	$214.29
26596	Excision constricting tissue		T	0053	16.822	$1,071.44	$253.40	$214.29
26600	Treat metacarpal fracture		T	0043	1.8742	$119.37		$23.87
26605	Treat metacarpal fracture		T	0043	1.8742	$119.37		$23.87
26607	Treat metacarpal fracture		T	0043	1.8742	$119.37		$23.87
26608	Treat metacarpal fracture		T	0062	26.3092	$1,675.71	$372.80	$335.14
26615	Treat metacarpal fracture		T	0063	40.3466	$2,569.80	$548.30	$513.96
26641	Treat thumb dislocation		T	0043	1.8742	$119.37		$23.87
26645	Treat thumb fracture		T	0043	1.8742	$119.37		$23.87
26650	Treat thumb fracture		T	0062	26.3092	$1,675.71	$372.80	$335.14
26665	Treat thumb fracture		T	0063	40.3466	$2,569.80	$548.30	$513.96
26670	Treat hand dislocation		T	0043	1.8742	$119.37		$23.87
26675	Treat hand dislocation		T	0043	1.8742	$119.37		$23.87
26676	Pin hand dislocation		T	0062	26.3092	$1,675.71	$372.80	$335.14
26685	Treat hand dislocation		T	0063	40.3466	$2,569.80	$548.30	$513.96
26686	Treat hand dislocation		T	0064	60.0595	$3,825.37	$835.70	$765.07
26700	Treat knuckle dislocation		T	0043	1.8742	$119.37		$23.87
26705	Treat knuckle dislocation		T	0043	1.8742	$119.37		$23.87
26706	Pin knuckle dislocation		T	0043	1.8742	$119.37		$23.87
26715	Treat knuckle dislocation		T	0063	40.3466	$2,569.80	$548.30	$513.96
26720	Treat finger fracture, each		T	0043	1.8742	$119.37		$23.87
26725	Treat finger fracture, each		T	0043	1.8742	$119.37		$23.87
26727	Treat finger fracture, each		T	0062	26.3092	$1,675.71	$372.80	$335.14
26735	Treat finger fracture, each		T	0063	40.3466	$2,569.80	$548.30	$513.96
26740	Treat finger fracture, each		T	0043	1.8742	$119.37		$23.87
26742	Treat finger fracture, each		T	0043	1.8742	$119.37		$23.87
26746	Treat finger fracture, each		T	0063	40.3466	$2,569.80	$548.30	$513.96
26750	Treat finger fracture, each		T	0043	1.8742	$119.37		$23.87
26755	Treat finger fracture, each		T	0043	1.8742	$119.37		$23.87
26756	Pin finger fracture, each		T	0062	26.3092	$1,675.71	$372.80	$335.14
26765	Treat finger fracture, each		T	0063	40.3466	$2,569.80	$548.30	$513.96
26770	Treat finger dislocation		T	0043	1.8742	$119.37		$23.87
26775	Treat finger dislocation		T	0045	15.0176	$956.52	$268.40	$191.30
26776	Pin finger dislocation		T	0062	26.3092	$1,675.71	$372.80	$335.14
26785	Treat finger dislocation		T	0062	26.3092	$1,675.71	$372.80	$335.14
26820	Thumb fusion with graft		T	0054	26.7322	$1,702.65		$340.53
26841	Fusion of thumb		T	0054	26.7322	$1,702.65		$340.53
26842	Thumb fusion with graft		T	0054	26.7322	$1,702.65		$340.53
26843	Fusion of hand joint		T	0054	26.7322	$1,702.65		$340.53
26844	Fusion/graft of hand joint		T	0054	26.7322	$1,702.65		$340.53
26850	Fusion of knuckle		T	0054	26.7322	$1,702.65		$340.53
26852	Fusion of knuckle with graft		T	0054	26.7322	$1,702.65		$340.53
26860	Fusion of finger joint		T	0054	26.7322	$1,702.65		$340.53
26861	Fusion of finger jnt, add-on		T	0054	26.7322	$1,702.65		$340.53
26862	Fusion/graft of finger joint		T	0054	26.7322	$1,702.65		$340.53
26863	Fuse/graft added joint		T	0054	26.7322	$1,702.65		$340.53
26910	Amputate metacarpal bone		T	0054	26.7322	$1,702.65		$340.53
26951	Amputation of finger/thumb		T	0053	16.822	$1,071.44	$253.40	$214.29
26952	Amputation of finger/thumb		T	0053	16.822	$1,071.44	$253.40	$214.29
26989	Hand/finger surgery		T	0043	1.8742	$119.37		$23.87
26990	Drainage of pelvis lesion		T	0049	21.5761	$1,374.25		$274.85
26991	Drainage of pelvis bursa		T	0049	21.5761	$1,374.25		$274.85
26992	Drainage of bone lesion		C					
27000	Incision of hip tendon		T	0049	21.5761	$1,374.25		$274.85
27001	Incision of hip tendon		T	0050	29.3263	$1,867.88		$373.58
27003	Incision of hip tendon		T	0050	29.3263	$1,867.88		$373.58
27005	Incision of hip tendon		C					
27006	Incision of hip tendons	CH	T	0050	29.3263	$1,867.88		$373.58
27025	Incision of hip/thigh fascia		C					
27030	Drainage of hip joint		C					
27033	Exploration of hip joint		T	0051	43.5953	$2,776.72		$555.34
27035	Denervation of hip joint		T	0051	43.5953	$2,776.72		$555.34
27036	Excision of hip joint/muscle		C					
27040	Biopsy of soft tissues		T	0020	8.7155	$555.12		$111.02
27041	Biopsy of soft tissues		T	0020	8.7155	$555.12		$111.02
27047	Remove hip/pelvis lesion		T	0022	21.4534	$1,366.43	$354.40	$273.29
27048	Remove hip/pelvis lesion		T	0022	21.4534	$1,366.43	$354.40	$273.29
27049	Remove tumor, hip/pelvis		T	0022	21.4534	$1,366.43	$354.40	$273.29
27050	Biopsy of sacroiliac joint		T	0049	21.5761	$1,374.25		$274.85
27052	Biopsy of hip joint		T	0049	21.5761	$1,374.25		$274.85
27054	Removal of hip joint lining		C					
27060	Removal of ischial bursa		T	0049	21.5761	$1,374.25		$274.85
27062	Remove femur lesion/bursa		T	0049	21.5761	$1,374.25		$274.85
27065	Removal of hip bone lesion		T	0049	21.5761	$1,374.25		$274.85
27066	Removal of hip bone lesion		T	0050	29.3263	$1,867.88		$373.58
27067	Remove/graft hip bone lesion		T	0050	29.3263	$1,867.88		$373.58
27070	Partial removal of hip bone		C					
27071	Partial removal of hip bone		C					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
27075	Extensive hip surgery		C					
27076	Extensive hip surgery		C					
27077	Extensive hip surgery		C					
27078	Extensive hip surgery		C					
27079	Extensive hip surgery		C					
27080	Removal of tail bone		T	0050	29.3263	$1,867.88		$373.58
27086	Remove hip foreign body		T	0020	8.7155	$555.12		$111.02
27087	Remove hip foreign body		T	0049	21.5761	$1,374.25		$274.85
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					
27096	Inject sacroiliac joint		B					
27097	Revision of hip tendon		T	0050	29.3263	$1,867.88		$373.58
27098	Transfer tendon to pelvis		T	0050	29.3263	$1,867.88		$373.58
27100	Transfer of abdominal muscle		T	0051	43.5953	$2,776.72		$555.34
27105	Transfer of spinal muscle		T	0051	43.5953	$2,776.72		$555.34
27110	Transfer of iliopsoas muscle		T	0051	43.5953	$2,776.72		$555.34
27111	Transfer of iliopsoas muscle		T	0051	43.5953	$2,776.72		$555.34
27120	Reconstruction of hip socket		C					
27122	Reconstruction of hip socket		C					
27125	Partial hip replacement		C					
27130	Total hip arthroplasty		C					
27132	Total hip arthroplasty		C					
27134	Revise hip joint replacement		C					
27137	Revise hip joint replacement		C					
27138	Revise hip joint replacement		C					
27140	Transplant femur ridge		C					
27146	Incision of hip bone		C					
27147	Revision of hip bone		C					
27151	Incision of hip bones		C					
27156	Revision of hip bones		C					
27158	Revision of pelvis		C					
27161	Incision of neck of femur		C					
27165	Incision/fixation of femur		C					
27170	Repair/graft femur head/neck		C					
27175	Treat slipped epiphysis		C					
27176	Treat slipped epiphysis		C					
27177	Treat slipped epiphysis		C					
27178	Treat slipped epiphysis		C					
27179	Revise head/neck of femur		C					
27181	Treat slipped epiphysis		C					
27185	Revision of femur epiphysis		C					
27187	Reinforce hip bones		C					
27193	Treat pelvic ring fracture		T	0043	1.8742	$119.37		$23.87
27194	Treat pelvic ring fracture		T	0045	15.0176	$956.52	$268.40	$191.30
27200	Treat tail bone fracture		T	0043	1.8742	$119.37		$23.87
27202	Treat tail bone fracture		T	0063	40.3466	$2,569.80	$548.30	$513.96
27215	Treat pelvic fracture(s)		C					
27216	Treat pelvic ring fracture		T	0050	29.3263	$1,867.88		$373.58
27217	Treat pelvic ring fracture		C					
27218	Treat pelvic ring fracture		C					
27220	Treat hip socket fracture		T	0043	1.8742	$119.37		$23.87
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	0043	1.8742	$119.37		$23.87
27232	Treat thigh fracture		C					
27235	Treat thigh fracture		T	0050	29.3263	$1,867.88		$373.58
27236	Treat thigh fracture		C					
27238	Treat thigh fracture		T	0043	1.8742	$119.37		$23.87
27240	Treat thigh fracture		C					
27244	Treat thigh fracture		C					
27245	Treat thigh fracture		C					
27246	Treat thigh fracture		T	0043	1.8742	$119.37		$23.87
27248	Treat thigh fracture		C					
27250	Treat hip dislocation		T	0043	1.8742	$119.37		$23.87
27252	Treat hip dislocation		T	0045	15.0176	$956.52	$268.40	$191.30
27253	Treat hip dislocation		C					
27254	Treat hip dislocation		C					
27256	Treat hip dislocation		T	0043	1.8742	$119.37		$23.87
27257	Treat hip dislocation		T	0045	15.0176	$956.52	$268.40	$191.30
27258	Treat hip dislocation		C					
27259	Treat hip dislocation		C					
27265	Treat hip dislocation		T	0043	1.8742	$119.37		$23.87
27266	Treat hip dislocation		T	0045	15.0176	$956.52	$268.40	$191.30
27275	Manipulation of hip joint		T	0045	15.0176	$956.52	$268.40	$191.30

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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	0043	1.8742	$119.37		$23.87
27301	Drain thigh/knee lesion		T	0008	19.0457	$1,213.08		$242.62
27303	Drainage of bone lesion		C					
27305	Incise thigh tendon & fascia		T	0049	21.5761	$1,374.25		$274.85
27306	Incision of thigh tendon		T	0049	21.5761	$1,374.25		$274.85
27307	Incision of thigh tendons		T	0049	21.5761	$1,374.25		$274.85
27310	Exploration of knee joint		T	0050	29.3263	$1,867.88		$373.58
27323	Biopsy, thigh soft tissues		T	0020	8.7155	$555.12		$111.02
27324	Biopsy, thigh soft tissues		T	0022	21.4534	$1,366.43	$354.40	$273.29
27325	Neurectomy, hamstring		T	0220	18.5069	$1,178.76		$235.75
27326	Neurectomy, popliteal		T	0220	18.5069	$1,178.76		$235.75
27327	Removal of thigh lesion		T	0022	21.4534	$1,366.43	$354.40	$273.29
27328	Removal of thigh lesion		T	0022	21.4534	$1,366.43	$354.40	$273.29
27329	Remove tumor, thigh/knee		T	0022	21.4534	$1,366.43	$354.40	$273.29
27330	Biopsy, knee joint lining		T	0050	29.3263	$1,867.88		$373.58
27331	Explore/treat knee joint		T	0050	29.3263	$1,867.88		$373.58
27332	Removal of knee cartilage		T	0050	29.3263	$1,867.88		$373.58
27333	Removal of knee cartilage		T	0050	29.3263	$1,867.88		$373.58
27334	Remove knee joint lining		T	0050	29.3263	$1,867.88		$373.58
27335	Remove knee joint lining		T	0050	29.3263	$1,867.88		$373.58
27340	Removal of kneecap bursa		T	0049	21.5761	$1,374.25		$274.85
27345	Removal of knee cyst		T	0049	21.5761	$1,374.25		$274.85
27347	Remove knee cyst		T	0049	21.5761	$1,374.25		$274.85
27350	Removal of kneecap		T	0050	29.3263	$1,867.88		$373.58
27355	Remove femur lesion		T	0050	29.3263	$1,867.88		$373.58
27356	Remove femur lesion/graft		T	0050	29.3263	$1,867.88		$373.58
27357	Remove femur lesion/graft		T	0050	29.3263	$1,867.88		$373.58
27358	Remove femur lesion/fixation		T	0050	29.3263	$1,867.88		$373.58
27360	Partial removal, leg bone(s)		T	0050	29.3263	$1,867.88		$373.58
27365	Extensive leg surgery		C					
27370	Injection for knee x-ray		N					
27372	Removal of foreign body		T	0022	21.4534	$1,366.43	$354.40	$273.29
27380	Repair of kneecap tendon		T	0049	21.5761	$1,374.25		$274.85
27381	Repair/graft kneecap tendon		T	0049	21.5761	$1,374.25		$274.85
27385	Repair of thigh muscle		T	0049	21.5761	$1,374.25		$274.85
27386	Repair/graft of thigh muscle		T	0049	21.5761	$1,374.25		$274.85
27390	Incision of thigh tendon		T	0049	21.5761	$1,374.25		$274.85
27391	Incision of thigh tendons		T	0049	21.5761	$1,374.25		$274.85
27392	Incision of thigh tendons		T	0049	21.5761	$1,374.25		$274.85
27393	Lengthening of thigh tendon		T	0050	29.3263	$1,867.88		$373.58
27394	Lengthening of thigh tendons		T	0050	29.3263	$1,867.88		$373.58
27395	Lengthening of thigh tendons		T	0051	43.5953	$2,776.72		$555.34
27396	Transplant of thigh tendon		T	0050	29.3263	$1,867.88		$373.58
27397	Transplants of thigh tendons		T	0051	43.5953	$2,776.72		$555.34
27400	Revise thigh muscles/tendons		T	0051	43.5953	$2,776.72		$555.34
27403	Repair of knee cartilage		T	0050	29.3263	$1,867.88		$373.58
27405	Repair of knee ligament		T	0051	43.5953	$2,776.72		$555.34
27407	Repair of knee ligament		T	0052	78.6518	$5,009.57		$1,001.91
27409	Repair of knee ligaments		T	0051	43.5953	$2,776.72		$555.34
27412	Autochondrocyte implant knee		T	0042	47.7765	$3,043.03	$804.70	$608.61
27415	Osteochondral knee allograft		T	0042	47.7765	$3,043.03	$804.70	$608.61
27418	Repair degenerated kneecap		T	0051	43.5953	$2,776.72		$555.34
27420	Revision of unstable kneecap		T	0051	43.5953	$2,776.72		$555.34
27422	Revision of unstable kneecap		T	0051	43.5953	$2,776.72		$555.34
27424	Revision/removal of kneecap		T	0051	43.5953	$2,776.72		$555.34
27425	Lat retinacular release open		T	0050	29.3263	$1,867.88		$373.58
27427	Reconstruction, knee		T	0051	43.5953	$2,776.72		$555.34
27428	Reconstruction, knee		T	0052	78.6518	$5,009.57		$1,001.91
27429	Reconstruction, knee		T	0052	78.6518	$5,009.57		$1,001.91
27430	Revision of thigh muscles		T	0051	43.5953	$2,776.72		$555.34
27435	Incision of knee joint		T	0051	43.5953	$2,776.72		$555.34
27437	Revise kneecap		T	0047	35.9249	$2,288.16	$537.00	$457.63
27438	Revise kneecap with implant		T	0048	51.0431	$3,251.09		$650.22
27440	Revision of knee joint		T	0047	35.9249	$2,288.16	$537.00	$457.63
27441	Revision of knee joint		T	0047	35.9249	$2,288.16	$537.00	$457.63
27442	Revision of knee joint		T	0047	35.9249	$2,288.16	$537.00	$457.63
27443	Revision of knee joint		T	0047	35.9249	$2,288.16	$537.00	$457.63
27445	Revision of knee joint		C					
27446	Revision of knee joint		T	0681	191.2387	$12,180.57		$2,436.11
27447	Total knee arthroplasty		C					
27448	Incision of thigh		C					
27450	Incision of thigh		C					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
27475	Surgery to stop leg growth		T	0050	29.3263	$1,867.88		$373.58
27477	Surgery to stop leg growth		C					
27479	Surgery to stop leg growth		C					
27485	Surgery to stop leg growth		C					
27486	Revise/replace knee joint		C					
27487	Revise/replace knee joint		C					
27488	Removal of knee prosthesis		C					
27495	Reinforce thigh		C					
27496	Decompression of thigh/knee		T	0049	21.5761	$1,374.25		$274.85
27497	Decompression of thigh/knee		T	0049	21.5761	$1,374.25		$274.85
27498	Decompression of thigh/knee		T	0049	21.5761	$1,374.25		$274.85
27499	Decompression of thigh/knee		T	0049	21.5761	$1,374.25		$274.85
27500	Treatment of thigh fracture		T	0043	1.8742	$119.37		$23.87
27501	Treatment of thigh fracture		T	0043	1.8742	$119.37		$23.87
27502	Treatment of thigh fracture		T	0043	1.8742	$119.37		$23.87
27503	Treatment of thigh fracture		T	0043	1.8742	$119.37		$23.87
27506	Treatment of thigh fracture		C					
27507	Treatment of thigh fracture		C					
27508	Treatment of thigh fracture		T	0043	1.8742	$119.37		$23.87
27509	Treatment of thigh fracture		T	0062	26.3092	$1,675.71	$372.80	$335.14
27510	Treatment of thigh fracture		T	0043	1.8742	$119.37		$23.87
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	0043	1.8742	$119.37		$23.87
27517	Treat thigh fx growth plate		T	0043	1.8742	$119.37		$23.87
27519	Treat thigh fx growth plate		C					
27520	Treat kneecap fracture		T	0043	1.8742	$119.37		$23.87
27524	Treat kneecap fracture		T	0063	40.3466	$2,569.80	$548.30	$513.96
27530	Treat knee fracture		T	0043	1.8742	$119.37		$23.87
27532	Treat knee fracture		T	0043	1.8742	$119.37		$23.87
27535	Treat knee fracture		C					
27536	Treat knee fracture		C					
27538	Treat knee fracture(s)		T	0043	1.8742	$119.37		$23.87
27540	Treat knee fracture		C					
27550	Treat knee dislocation		T	0043	1.8742	$119.37		$23.87
27552	Treat knee dislocation		T	0045	15.0176	$956.52	$268.40	$191.30
27556	Treat knee dislocation		C					
27557	Treat knee dislocation		C					
27558	Treat knee dislocation		C					
27560	Treat kneecap dislocation		T	0043	1.8742	$119.37		$23.87
27562	Treat kneecap dislocation		T	0045	15.0176	$956.52	$268.40	$191.30
27566	Treat kneecap dislocation		T	0063	40.3466	$2,569.80	$548.30	$513.96
27570	Fixation of knee joint		T	0045	15.0176	$956.52	$268.40	$191.30
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	21.5761	$1,374.25		$274.85
27596	Amputation follow-up surgery		C					
27598	Amputate lower leg at knee		C					
27599	Leg surgery procedure		T	0043	1.8742	$119.37		$23.87
27600	Decompression of lower leg		T	0049	21.5761	$1,374.25		$274.85
27601	Decompression of lower leg		T	0049	21.5761	$1,374.25		$274.85
27602	Decompression of lower leg		T	0049	21.5761	$1,374.25		$274.85
27603	Drain lower leg lesion		T	0008	19.0457	$1,213.08		$242.62
27604	Drain lower leg bursa		T	0049	21.5761	$1,374.25		$274.85
27605	Incision of achilles tendon		T	0055	21.1762	$1,348.78	$355.30	$269.76
27606	Incision of achilles tendon		T	0049	21.5761	$1,374.25		$274.85
27607	Treat lower leg bone lesion		T	0049	21.5761	$1,374.25		$274.85
27610	Explore/treat ankle joint		T	0050	29.3263	$1,867.88		$373.58
27612	Exploration of ankle joint		T	0050	29.3263	$1,867.88		$373.58
27613	Biopsy lower leg soft tissue		T	0020	8.7155	$555.12		$111.02
27614	Biopsy lower leg soft tissue		T	0022	21.4534	$1,366.43	$354.40	$273.29
27615	Remove tumor, lower leg		T	0050	29.3263	$1,867.88		$373.58
27618	Remove lower leg lesion		T	0021	16.5832	$1,056.23	$219.40	$211.25
27619	Remove lower leg lesion		T	0022	21.4534	$1,366.43	$354.40	$273.29
27620	Explore/treat ankle joint		T	0050	29.3263	$1,867.88		$373.58
27625	Remove ankle joint lining		T	0050	29.3263	$1,867.88		$373.58
27626	Remove ankle joint lining		T	0050	29.3263	$1,867.88		$373.58

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
27630	Removal of tendon lesion		T	0049	21.5761	$1,374.25		$274.85
27635	Remove lower leg bone lesion		T	0050	29.3263	$1,867.88		$373.58
27637	Remove/graft leg bone lesion		T	0050	29.3263	$1,867.88		$373.58
27638	Remove/graft leg bone lesion		T	0050	29.3263	$1,867.88		$373.58
27640	Partial removal of tibia		T	0051	43.5953	$2,776.72		$555.34
27641	Partial removal of fibula		T	0050	29.3263	$1,867.88		$373.58
27645	Extensive lower leg surgery		C					
27646	Extensive lower leg surgery		C					
27647	Extensive ankle/heel surgery		T	0051	43.5953	$2,776.72		$555.34
27648	Injection for ankle x-ray		N					
27650	Repair achilles tendon		T	0051	43.5953	$2,776.72		$555.34
27652	Repair/graft achilles tendon		T	0052	78.6518	$5,009.57		$1,001.91
27654	Repair of achilles tendon		T	0051	43.5953	$2,776.72		$555.34
27656	Repair leg fascia defect		T	0049	21.5761	$1,374.25		$274.85
27658	Repair of leg tendon, each		T	0049	21.5761	$1,374.25		$274.85
27659	Repair of leg tendon, each		T	0049	21.5761	$1,374.25		$274.85
27664	Repair of leg tendon, each		T	0049	21.5761	$1,374.25		$274.85
27665	Repair of leg tendon, each		T	0050	29.3263	$1,867.88		$373.58
27675	Repair lower leg tendons		T	0049	21.5761	$1,374.25		$274.85
27676	Repair lower leg tendons		T	0050	29.3263	$1,867.88		$373.58
27680	Release of lower leg tendon		T	0050	29.3263	$1,867.88		$373.58
27681	Release of lower leg tendons		T	0050	29.3263	$1,867.88		$373.58
27685	Revision of lower leg tendon		T	0050	29.3263	$1,867.88		$373.58
27686	Revise lower leg tendons		T	0050	29.3263	$1,867.88		$373.58
27687	Revision of calf tendon		T	0050	29.3263	$1,867.88		$373.58
27690	Revise lower leg tendon		T	0051	43.5953	$2,776.72		$555.34
27691	Revise lower leg tendon		T	0051	43.5953	$2,776.72		$555.34
27692	Revise additional leg tendon		T	0051	43.5953	$2,776.72		$555.34
27695	Repair of ankle ligament		T	0050	29.3263	$1,867.88		$373.58
27696	Repair of ankle ligaments		T	0050	29.3263	$1,867.88		$373.58
27698	Repair of ankle ligament		T	0050	29.3263	$1,867.88		$373.58
27700	Revision of ankle joint		T	0047	35.9249	$2,288.16	$537.00	$457.63
27702	Reconstruct ankle joint		C					
27703	Reconstruction, ankle joint		C					
27704	Removal of ankle implant		T	0049	21.5761	$1,374.25		$274.85
27705	Incision of tibia		T	0051	43.5953	$2,776.72		$555.34
27707	Incision of fibula		T	0049	21.5761	$1,374.25		$274.85
27709	Incision of tibia & fibula		T	0050	29.3263	$1,867.88		$373.58
27712	Realignment of lower leg		C					
27715	Revision of lower leg		C					
27720	Repair of tibia	CH	T	0063	40.3466	$2,569.80	$548.30	$513.96
27722	Repair/graft of tibia	CH	T	0064	60.0595	$3,825.37	$835.70	$765.07
27724	Repair/graft of tibia		C					
27725	Repair of lower leg		C					
27727	Repair of lower leg		C					
27730	Repair of tibia epiphysis		T	0050	29.3263	$1,867.88		$373.58
27732	Repair of fibula epiphysis		T	0050	29.3263	$1,867.88		$373.58
27734	Repair lower leg epiphyses		T	0050	29.3263	$1,867.88		$373.58
27740	Repair of leg epiphyses		T	0050	29.3263	$1,867.88		$373.58
27742	Repair of leg epiphyses		T	0051	43.5953	$2,776.72		$555.34
27745	Reinforce tibia		T	0052	78.6518	$5,009.57		$1,001.91
27750	Treatment of tibia fracture		T	0043	1.8742	$119.37		$23.87
27752	Treatment of tibia fracture		T	0043	1.8742	$119.37		$23.87
27756	Treatment of tibia fracture		T	0062	26.3092	$1,675.71	$372.80	$335.14
27758	Treatment of tibia fracture		T	0063	40.3466	$2,569.80	$548.30	$513.96
27759	Treatment of tibia fracture		T	0064	60.0595	$3,825.37	$835.70	$765.07
27760	Treatment of ankle fracture		T	0043	1.8742	$119.37		$23.87
27762	Treatment of ankle fracture		T	0043	1.8742	$119.37		$23.87
27766	Treatment of ankle fracture		T	0063	40.3466	$2,569.80	$548.30	$513.96
27780	Treatment of fibula fracture		T	0043	1.8742	$119.37		$23.87
27781	Treatment of fibula fracture		T	0043	1.8742	$119.37		$23.87
27784	Treatment of fibula fracture		T	0063	40.3466	$2,569.80	$548.30	$513.96
27786	Treatment of ankle fracture		T	0043	1.8742	$119.37		$23.87
27788	Treatment of ankle fracture		T	0043	1.8742	$119.37		$23.87
27792	Treatment of ankle fracture		T	0063	40.3466	$2,569.80	$548.30	$513.96
27808	Treatment of ankle fracture		T	0043	1.8742	$119.37		$23.87
27810	Treatment of ankle fracture		T	0043	1.8742	$119.37		$23.87
27814	Treatment of ankle fracture		T	0063	40.3466	$2,569.80	$548.30	$513.96
27816	Treatment of ankle fracture		T	0043	1.8742	$119.37		$23.87
27818	Treatment of ankle fracture		T	0043	1.8742	$119.37		$23.87
27822	Treatment of ankle fracture		T	0063	40.3466	$2,569.80	$548.30	$513.96
27823	Treatment of ankle fracture		T	0064	60.0595	$3,825.37	$835.70	$765.07
27824	Treat lower leg fracture		T	0043	1.8742	$119.37		$23.87
27825	Treat lower leg fracture		T	0043	1.8742	$119.37		$23.87
27826	Treat lower leg fracture		T	0063	40.3466	$2,569.80	$548.30	$513.96
27827	Treat lower leg fracture		T	0064	60.0595	$3,825.37	$835.70	$765.07
27828	Treat lower leg fracture		T	0064	60.0595	$3,825.37	$835.70	$765.07
27829	Treat lower leg joint		T	0063	40.3466	$2,569.80	$548.30	$513.96

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
27830	Treat lower leg dislocation		T	0043	1.8742	$119.37		$23.87
27831	Treat lower leg dislocation		T	0043	1.8742	$119.37		$23.87
27832	Treat lower leg dislocation		T	0063	40.3466	$2,569.80	$548.30	$513.96
27840	Treat ankle dislocation		T	0043	1.8742	$119.37		$23.87
27842	Treat ankle dislocation		T	0045	15.0176	$956.52	$268.40	$191.30
27846	Treat ankle dislocation		T	0063	40.3466	$2,569.80	$548.30	$513.96
27848	Treat ankle dislocation		T	0063	40.3466	$2,569.80	$548.30	$513.96
27860	Fixation of ankle joint		T	0045	15.0176	$956.52	$268.40	$191.30
27870	Fusion of ankle joint, open		T	0052	78.6518	$5,009.57		$1,001.91
27871	Fusion of tibiofibular joint		T	0052	78.6518	$5,009.57		$1,001.91
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	21.5761	$1,374.25		$274.85
27886	Amputation follow-up surgery		C					
27888	Amputation of foot at ankle		C					
27889	Amputation of foot at ankle		T	0050	29.3263	$1,867.88		$373.58
27892	Decompression of leg		T	0049	21.5761	$1,374.25		$274.85
27893	Decompression of leg		T	0049	21.5761	$1,374.25		$274.85
27894	Decompression of leg		T	0049	21.5761	$1,374.25		$274.85
27899	Leg/ankle surgery procedure		T	0043	1.8742	$119.37		$23.87
28001	Drainage of bursa of foot		T	0007	12.5792	$801.21		$160.24
28002	Treatment of foot infection		T	0049	21.5761	$1,374.25		$274.85
28003	Treatment of foot infection		T	0049	21.5761	$1,374.25		$274.85
28005	Treat foot bone lesion		T	0055	21.1762	$1,348.78	$355.30	$269.76
28008	Incision of foot fascia		T	0055	21.1762	$1,348.78	$355.30	$269.76
28010	Incision of toe tendon		T	0055	21.1762	$1,348.78	$355.30	$269.76
28011	Incision of toe tendons		T	0055	21.1762	$1,348.78	$355.30	$269.76
28020	Exploration of foot joint		T	0055	21.1762	$1,348.78	$355.30	$269.76
28022	Exploration of foot joint		T	0055	21.1762	$1,348.78	$355.30	$269.76
28024	Exploration of toe joint		T	0055	21.1762	$1,348.78	$355.30	$269.76
28035	Decompression of tibia nerve		T	0220	18.5069	$1,178.76		$235.75
28043	Excision of foot lesion		T	0022	21.4534	$1,366.43	$354.40	$273.29
28045	Excision of foot lesion		T	0055	21.1762	$1,348.78	$355.30	$269.76
28046	Resection of tumor, foot		T	0055	21.1762	$1,348.78	$355.30	$269.76
28050	Biopsy of foot joint lining		T	0055	21.1762	$1,348.78	$355.30	$269.76
28052	Biopsy of foot joint lining		T	0055	21.1762	$1,348.78	$355.30	$269.76
28054	Biopsy of toe joint lining		T	0055	21.1762	$1,348.78	$355.30	$269.76
28055	Neurectomy, foot		T	0220	18.5069	$1,178.76		$235.75
28060	Partial removal, foot fascia		T	0055	21.1762	$1,348.78	$355.30	$269.76
28062	Removal of foot fascia		T	0055	21.1762	$1,348.78	$355.30	$269.76
28070	Removal of foot joint lining		T	0055	21.1762	$1,348.78	$355.30	$269.76
28072	Removal of foot joint lining		T	0055	21.1762	$1,348.78	$355.30	$269.76
28080	Removal of foot lesion		T	0055	21.1762	$1,348.78	$355.30	$269.76
28086	Excise foot tendon sheath		T	0055	21.1762	$1,348.78	$355.30	$269.76
28088	Excise foot tendon sheath		T	0055	21.1762	$1,348.78	$355.30	$269.76
28090	Removal of foot lesion		T	0055	21.1762	$1,348.78	$355.30	$269.76
28092	Removal of toe lesions		T	0055	21.1762	$1,348.78	$355.30	$269.76
28100	Removal of ankle/heel lesion		T	0055	21.1762	$1,348.78	$355.30	$269.76
28102	Remove/graft foot lesion		T	0056	44.471	$2,832.49		$566.50
28103	Remove/graft foot lesion		T	0056	44.471	$2,832.49		$566.50
28104	Removal of foot lesion		T	0055	21.1762	$1,348.78	$355.30	$269.76
28106	Remove/graft foot lesion		T	0056	44.471	$2,832.49		$566.50
28107	Remove/graft foot lesion		T	0056	44.471	$2,832.49		$566.50
28108	Removal of toe lesions		T	0055	21.1762	$1,348.78	$355.30	$269.76
28110	Part removal of metatarsal		T	0055	21.1762	$1,348.78	$355.30	$269.76
28111	Part removal of metatarsal		T	0055	21.1762	$1,348.78	$355.30	$269.76
28112	Part removal of metatarsal		T	0055	21.1762	$1,348.78	$355.30	$269.76
28113	Part removal of metatarsal		T	0055	21.1762	$1,348.78	$355.30	$269.76
28114	Removal of metatarsal heads		T	0055	21.1762	$1,348.78	$355.30	$269.76
28116	Revision of foot		T	0055	21.1762	$1,348.78	$355.30	$269.76
28118	Removal of heel bone		T	0055	21.1762	$1,348.78	$355.30	$269.76
28119	Removal of heel spur		T	0055	21.1762	$1,348.78	$355.30	$269.76
28120	Part removal of ankle/heel		T	0055	21.1762	$1,348.78	$355.30	$269.76
28122	Partial removal of foot bone		T	0055	21.1762	$1,348.78	$355.30	$269.76
28124	Partial removal of toe		T	0055	21.1762	$1,348.78	$355.30	$269.76
28126	Partial removal of toe		T	0055	21.1762	$1,348.78	$355.30	$269.76
28130	Removal of ankle bone		T	0055	21.1762	$1,348.78	$355.30	$269.76
28140	Removal of metatarsal		T	0055	21.1762	$1,348.78	$355.30	$269.76
28150	Removal of toe		T	0055	21.1762	$1,348.78	$355.30	$269.76
28153	Partial removal of toe		T	0055	21.1762	$1,348.78	$355.30	$269.76
28160	Partial removal of toe		T	0055	21.1762	$1,348.78	$355.30	$269.76
28171	Extensive foot surgery		T	0055	21.1762	$1,348.78	$355.30	$269.76
28173	Extensive foot surgery		T	0055	21.1762	$1,348.78	$355.30	$269.76
28175	Extensive foot surgery		T	0055	21.1762	$1,348.78	$355.30	$269.76
28190	Removal of foot foreign body		T	0019	4.4463	$283.20	$71.80	$56.64
28192	Removal of foot foreign body		T	0021	16.5832	$1,056.23	$219.40	$211.25
28193	Removal of foot foreign body		T	0020	8.7155	$555.12		$111.02

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
28200	Repair of foot tendon		T	0055	21.1762	$1,348.78	$355.30	$269.76
28202	Repair/graft of foot tendon		T	0055	21.1762	$1,348.78	$355.30	$269.76
28208	Repair of foot tendon		T	0055	21.1762	$1,348.78	$355.30	$269.76
28210	Repair/graft of foot tendon		T	0056	44.471	$2,832.49		$566.50
28220	Release of foot tendon		T	0055	21.1762	$1,348.78	$355.30	$269.76
28222	Release of foot tendons		T	0055	21.1762	$1,348.78	$355.30	$269.76
28225	Release of foot tendon		T	0055	21.1762	$1,348.78	$355.30	$269.76
28226	Release of foot tendons		T	0055	21.1762	$1,348.78	$355.30	$269.76
28230	Incision of foot tendon(s)		T	0055	21.1762	$1,348.78	$355.30	$269.76
28232	Incision of toe tendon		T	0055	21.1762	$1,348.78	$355.30	$269.76
28234	Incision of foot tendon		T	0055	21.1762	$1,348.78	$355.30	$269.76
28238	Revision of foot tendon		T	0056	44.471	$2,832.49		$566.50
28240	Release of big toe		T	0055	21.1762	$1,348.78	$355.30	$269.76
28250	Revision of foot fascia		T	0055	21.1762	$1,348.78	$355.30	$269.76
28260	Release of midfoot joint		T	0055	21.1762	$1,348.78	$355.30	$269.76
28261	Revision of foot tendon		T	0055	21.1762	$1,348.78	$355.30	$269.76
28262	Revision of foot and ankle		T	0055	21.1762	$1,348.78	$355.30	$269.76
28264	Release of midfoot joint		T	0056	44.471	$2,832.49		$566.50
28270	Release of foot contracture		T	0055	21.1762	$1,348.78	$355.30	$269.76
28272	Release of toe joint, each		T	0055	21.1762	$1,348.78	$355.30	$269.76
28280	Fusion of toes		T	0055	21.1762	$1,348.78	$355.30	$269.76
28285	Repair of hammertoe		T	0055	21.1762	$1,348.78	$355.30	$269.76
28286	Repair of hammertoe		T	0055	21.1762	$1,348.78	$355.30	$269.76
28288	Partial removal of foot bone		T	0055	21.1762	$1,348.78	$355.30	$269.76
28289	Repair hallux rigidus		T	0055	21.1762	$1,348.78	$355.30	$269.76
28290	Correction of bunion		T	0057	29.8356	$1,900.32	$475.90	$380.06
28292	Correction of bunion		T	0057	29.8356	$1,900.32	$475.90	$380.06
28293	Correction of bunion		T	0057	29.8356	$1,900.32	$475.90	$380.06
28294	Correction of bunion		T	0057	29.8356	$1,900.32	$475.90	$380.06
28296	Correction of bunion		T	0057	29.8356	$1,900.32	$475.90	$380.06
28297	Correction of bunion		T	0057	29.8356	$1,900.32	$475.90	$380.06
28298	Correction of bunion		T	0057	29.8356	$1,900.32	$475.90	$380.06
28299	Correction of bunion		T	0057	29.8356	$1,900.32	$475.90	$380.06
28300	Incision of heel bone		T	0056	44.471	$2,832.49		$566.50
28302	Incision of ankle bone		T	0055	21.1762	$1,348.78	$355.30	$269.76
28304	Incision of midfoot bones		T	0056	44.471	$2,832.49		$566.50
28305	Incise/graft midfoot bones		T	0056	44.471	$2,832.49		$566.50
28306	Incision of metatarsal		T	0055	21.1762	$1,348.78	$355.30	$269.76
28307	Incision of metatarsal		T	0055	21.1762	$1,348.78	$355.30	$269.76
28308	Incision of metatarsal		T	0055	21.1762	$1,348.78	$355.30	$269.76
28309	Incision of metatarsals		T	0056	44.471	$2,832.49		$566.50
28310	Revision of big toe		T	0055	21.1762	$1,348.78	$355.30	$269.76
28312	Revision of toe		T	0055	21.1762	$1,348.78	$355.30	$269.76
28313	Repair deformity of toe		T	0055	21.1762	$1,348.78	$355.30	$269.76
28315	Removal of sesamoid bone		T	0055	21.1762	$1,348.78	$355.30	$269.76
28320	Repair of foot bones		T	0056	44.471	$2,832.49		$566.50
28322	Repair of metatarsals		T	0056	44.471	$2,832.49		$566.50
28340	Resect enlarged toe tissue		T	0055	21.1762	$1,348.78	$355.30	$269.76
28341	Resect enlarged toe		T	0055	21.1762	$1,348.78	$355.30	$269.76
28344	Repair extra toe(s)		T	0055	21.1762	$1,348.78	$355.30	$269.76
28345	Repair webbed toe(s)		T	0055	21.1762	$1,348.78	$355.30	$269.76
28360	Reconstruct cleft foot		T	0056	44.471	$2,832.49		$566.50
28400	Treatment of heel fracture		T	0043	1.8742	$119.37		$23.87
28405	Treatment of heel fracture		T	0043	1.8742	$119.37		$23.87
28406	Treatment of heel fracture		T	0062	26.3092	$1,675.71	$372.80	$335.14
28415	Treat heel fracture		T	0063	40.3466	$2,569.80	$548.30	$513.96
28420	Treat/graft heel fracture		T	0063	40.3466	$2,569.80	$548.30	$513.96
28430	Treatment of ankle fracture		T	0043	1.8742	$119.37		$23.87
28435	Treatment of ankle fracture		T	0043	1.8742	$119.37		$23.87
28436	Treatment of ankle fracture		T	0062	26.3092	$1,675.71	$372.80	$335.14
28445	Treat ankle fracture		T	0063	40.3466	$2,569.80	$548.30	$513.96
28450	Treat midfoot fracture, each		T	0043	1.8742	$119.37		$23.87
28455	Treat midfoot fracture, each		T	0043	1.8742	$119.37		$23.87
28456	Treat midfoot fracture		T	0062	26.3092	$1,675.71	$372.80	$335.14
28465	Treat midfoot fracture, each		T	0063	40.3466	$2,569.80	$548.30	$513.96
28470	Treat metatarsal fracture		T	0043	1.8742	$119.37		$23.87
28475	Treat metatarsal fracture		T	0043	1.8742	$119.37		$23.87
28476	Treat metatarsal fracture		T	0062	26.3092	$1,675.71	$372.80	$335.14
28485	Treat metatarsal fracture		T	0063	40.3466	$2,569.80	$548.30	$513.96
28490	Treat big toe fracture		T	0043	1.8742	$119.37		$23.87
28495	Treat big toe fracture		T	0043	1.8742	$119.37		$23.87
28496	Treat big toe fracture		T	0062	26.3092	$1,675.71	$372.80	$335.14
28505	Treat big toe fracture		T	0063	40.3466	$2,569.80	$548.30	$513.96
28510	Treatment of toe fracture		T	0043	1.8742	$119.37		$23.87
28515	Treatment of toe fracture		T	0043	1.8742	$119.37		$23.87
28525	Treat toe fracture		T	0063	40.3466	$2,569.80	$548.30	$513.96
28530	Treat sesamoid bone fracture		T	0043	1.8742	$119.37		$23.87
28531	Treat sesamoid bone fracture		T	0063	40.3466	$2,569.80	$548.30	$513.96

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
28540	Treat foot dislocation		T	0043	1.8742	$119.37		$23.87
28545	Treat foot dislocation		T	0062	26.3092	$1,675.71	$372.80	$335.14
28546	Treat foot dislocation		T	0062	26.3092	$1,675.71	$372.80	$335.14
28555	Repair foot dislocation		T	0063	40.3466	$2,569.80	$548.30	$513.96
28570	Treat foot dislocation		T	0043	1.8742	$119.37		$23.87
28575	Treat foot dislocation		T	0043	1.8742	$119.37		$23.87
28576	Treat foot dislocation		T	0062	26.3092	$1,675.71	$372.80	$335.14
28585	Repair foot dislocation		T	0063	40.3466	$2,569.80	$548.30	$513.96
28600	Treat foot dislocation		T	0043	1.8742	$119.37		$23.87
28605	Treat foot dislocation		T	0043	1.8742	$119.37		$23.87
28606	Treat foot dislocation		T	0062	26.3092	$1,675.71	$372.80	$335.14
28615	Repair foot dislocation		T	0063	40.3466	$2,569.80	$548.30	$513.96
28630	Treat toe dislocation		T	0043	1.8742	$119.37		$23.87
28635	Treat toe dislocation		T	0045	15.0176	$956.52	$268.40	$191.30
28636	Treat toe dislocation		T	0062	26.3092	$1,675.71	$372.80	$335.14
28645	Repair toe dislocation		T	0063	40.3466	$2,569.80	$548.30	$513.96
28660	Treat toe dislocation		T	0043	1.8742	$119.37		$23.87
28665	Treat toe dislocation		T	0045	15.0176	$956.52	$268.40	$191.30
28666	Treat toe dislocation		T	0062	26.3092	$1,675.71	$372.80	$335.14
28675	Repair of toe dislocation		T	0063	40.3466	$2,569.80	$548.30	$513.96
28705	Fusion of foot bones		T	0056	44.471	$2,832.49		$566.50
28715	Fusion of foot bones	CH	T	0052	78.6518	$5,009.57		$1,001.91
28725	Fusion of foot bones		T	0056	44.471	$2,832.49		$566.50
28730	Fusion of foot bones		T	0056	44.471	$2,832.49		$566.50
28735	Fusion of foot bones		T	0056	44.471	$2,832.49		$566.50
28737	Revision of foot bones		T	0056	44.471	$2,832.49		$566.50
28740	Fusion of foot bones		T	0056	44.471	$2,832.49		$566.50
28750	Fusion of big toe joint		T	0056	44.471	$2,832.49		$566.50
28755	Fusion of big toe joint		T	0055	21.1762	$1,348.78	$355.30	$269.76
28760	Fusion of big toe joint		T	0056	44.471	$2,832.49		$566.50
28800	Amputation of midfoot		C					
28805	Amputation thru metatarsal		C					
28810	Amputation toe & metatarsal		T	0055	21.1762	$1,348.78	$355.30	$269.76
28820	Amputation of toe		T	0055	21.1762	$1,348.78	$355.30	$269.76
28825	Partial amputation of toe		T	0055	21.1762	$1,348.78	$355.30	$269.76
28890	High energy eswt, plantar f		T	0050	29.3263	$1,867.88		$373.58
28899	Foot/toes surgery procedure		T	0043	1.8742	$119.37		$23.87
29000	Application of body cast		S	0058	1.1272	$71.79		$14.36
29010	Application of body cast		S	0426	2.2383	$142.56		$28.51
29015	Application of body cast		S	0426	2.2383	$142.56		$28.51
29020	Application of body cast		S	0058	1.1272	$71.79		$14.36
29025	Application of body cast		S	0058	1.1272	$71.79		$14.36
29035	Application of body cast		S	0426	2.2383	$142.56		$28.51
29040	Application of body cast		S	0058	1.1272	$71.79		$14.36
29044	Application of body cast		S	0426	2.2383	$142.56		$28.51
29046	Application of body cast		S	0426	2.2383	$142.56		$28.51
29049	Application of figure eight		S	0058	1.1272	$71.79		$14.36
29055	Application of shoulder cast		S	0426	2.2383	$142.56		$28.51
29058	Application of shoulder cast		S	0058	1.1272	$71.79		$14.36
29065	Application of long arm cast		S	0426	2.2383	$142.56		$28.51
29075	Application of forearm cast		S	0426	2.2383	$142.56		$28.51
29085	Apply hand/wrist cast		S	0058	1.1272	$71.79		$14.36
29086	Apply finger cast		S	0058	1.1272	$71.79		$14.36
29105	Apply long arm splint		S	0058	1.1272	$71.79		$14.36
29125	Apply forearm splint		S	0058	1.1272	$71.79		$14.36
29126	Apply forearm splint		S	0058	1.1272	$71.79		$14.36
29130	Application of finger splint		S	0058	1.1272	$71.79		$14.36
29131	Application of finger splint		S	0058	1.1272	$71.79		$14.36
29200	Strapping of chest		S	0058	1.1272	$71.79		$14.36
29220	Strapping of low back		S	0058	1.1272	$71.79		$14.36
29240	Strapping of shoulder		S	0058	1.1272	$71.79		$14.36
29260	Strapping of elbow or wrist		S	0058	1.1272	$71.79		$14.36
29280	Strapping of hand or finger		S	0058	1.1272	$71.79		$14.36
29305	Application of hip cast		S	0426	2.2383	$142.56		$28.51
29325	Application of hip casts		S	0426	2.2383	$142.56		$28.51
29345	Application of long leg cast		S	0426	2.2383	$142.56		$28.51
29355	Application of long leg cast		S	0426	2.2383	$142.56		$28.51
29358	Apply long leg cast brace		S	0426	2.2383	$142.56		$28.51
29365	Application of long leg cast		S	0426	2.2383	$142.56		$28.51
29405	Apply short leg cast		S	0426	2.2383	$142.56		$28.51
29425	Apply short leg cast		S	0426	2.2383	$142.56		$28.51
29435	Apply short leg cast		S	0426	2.2383	$142.56		$28.51
29440	Addition of walker to cast		S	0058	1.1272	$71.79		$14.36
29445	Apply rigid leg cast		S	0426	2.2383	$142.56		$28.51
29450	Application of leg cast		S	0058	1.1272	$71.79		$14.36
29505	Application, long leg splint		S	0058	1.1272	$71.79		$14.36
29515	Application lower leg splint		S	0058	1.1272	$71.79		$14.36
29520	Strapping of hip		S	0058	1.1272	$71.79		$14.36

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
29530	Strapping of knee		S	0058	1.1272	$71.79		$14.36
29540	Strapping of ankle and/or ft		S	0058	1.1272	$71.79		$14.36
29550	Strapping of toes		S	0058	1.1272	$71.79		$14.36
29580	Application of paste boot		S	0058	1.1272	$71.79		$14.36
29590	Application of foot splint		S	0058	1.1272	$71.79		$14.36
29700	Removal/revision of cast		S	0058	1.1272	$71.79		$14.36
29705	Removal/revision of cast		S	0058	1.1272	$71.79		$14.36
29710	Removal/revision of cast		S	0426	2.2383	$142.56		$28.51
29715	Removal/revision of cast		S	0058	1.1272	$71.79		$14.36
29720	Repair of body cast		S	0058	1.1272	$71.79		$14.36
29730	Windowing of cast		S	0058	1.1272	$71.79		$14.36
29740	Wedging of cast		S	0058	1.1272	$71.79		$14.36
29750	Wedging of clubfoot cast		S	0058	1.1272	$71.79		$14.36
29799	Casting/strapping procedure		S	0058	1.1272	$71.79		$14.36
29800	Jaw arthroscopy/surgery		T	0041	29.4467	$1,875.55		$375.11
29804	Jaw arthroscopy/surgery		T	0041	29.4467	$1,875.55		$375.11
29805	Shoulder arthroscopy, dx		T	0041	29.4467	$1,875.55		$375.11
29806	Shoulder arthroscopy/surgery		T	0042	47.7765	$3,043.03	$804.70	$608.61
29807	Shoulder arthroscopy/surgery		T	0042	47.7765	$3,043.03	$804.70	$608.61
29819	Shoulder arthroscopy/surgery		T	0041	29.4467	$1,875.55		$375.11
29820	Shoulder arthroscopy/surgery		T	0041	29.4467	$1,875.55		$375.11
29821	Shoulder arthroscopy/surgery		T	0041	29.4467	$1,875.55		$375.11
29822	Shoulder arthroscopy/surgery		T	0041	29.4467	$1,875.55		$375.11
29823	Shoulder arthroscopy/surgery		T	0041	29.4467	$1,875.55		$375.11
29824	Shoulder arthroscopy/surgery		T	0041	29.4467	$1,875.55		$375.11
29825	Shoulder arthroscopy/surgery		T	0041	29.4467	$1,875.55		$375.11
29826	Shoulder arthroscopy/surgery		T	0042	47.7765	$3,043.03	$804.70	$608.61
29827	Arthroscop rotator cuff repr		T	0042	47.7765	$3,043.03	$804.70	$608.61
29830	Elbow arthroscopy		T	0041	29.4467	$1,875.55		$375.11
29834	Elbow arthroscopy/surgery		T	0041	29.4467	$1,875.55		$375.11
29835	Elbow arthroscopy/surgery		T	0041	29.4467	$1,875.55		$375.11
29836	Elbow arthroscopy/surgery		T	0041	29.4467	$1,875.55		$375.11
29837	Elbow arthroscopy/surgery		T	0041	29.4467	$1,875.55		$375.11
29838	Elbow arthroscopy/surgery		T	0041	29.4467	$1,875.55		$375.11
29840	Wrist arthroscopy		T	0041	29.4467	$1,875.55		$375.11
29843	Wrist arthroscopy/surgery		T	0041	29.4467	$1,875.55		$375.11
29844	Wrist arthroscopy/surgery		T	0041	29.4467	$1,875.55		$375.11
29845	Wrist arthroscopy/surgery		T	0041	29.4467	$1,875.55		$375.11
29846	Wrist arthroscopy/surgery		T	0041	29.4467	$1,875.55		$375.11
29847	Wrist arthroscopy/surgery		T	0041	29.4467	$1,875.55		$375.11
29848	Wrist endoscopy/surgery		T	0041	29.4467	$1,875.55		$375.11
29850	Knee arthroscopy/surgery		T	0041	29.4467	$1,875.55		$375.11
29851	Knee arthroscopy/surgery		T	0042	47.7765	$3,043.03	$804.70	$608.61
29855	Tibial arthroscopy/surgery		T	0042	47.7765	$3,043.03	$804.70	$608.61
29856	Tibial arthroscopy/surgery		T	0041	29.4467	$1,875.55		$375.11
29860	Hip arthroscopy, dx		T	0041	29.4467	$1,875.55		$375.11
29861	Hip arthroscopy/surgery		T	0041	29.4467	$1,875.55		$375.11
29862	Hip arthroscopy/surgery		T	0042	47.7765	$3,043.03	$804.70	$608.61
29863	Hip arthroscopy/surgery		T	0042	47.7765	$3,043.03	$804.70	$608.61
29866	Autgrft implnt, knee w/scope		T	0042	47.7765	$3,043.03	$804.70	$608.61
29867	Allgrft implnt, knee w/scope		T	0042	47.7765	$3,043.03	$804.70	$608.61
29868	Meniscal trnspl, knee w/scpe		T	0042	47.7765	$3,043.03	$804.70	$608.61
29870	Knee arthroscopy, dx		T	0041	29.4467	$1,875.55		$375.11
29871	Knee arthroscopy/drainage		T	0041	29.4467	$1,875.55		$375.11
29873	Knee arthroscopy/surgery		T	0041	29.4467	$1,875.55		$375.11
29874	Knee arthroscopy/surgery		T	0041	29.4467	$1,875.55		$375.11
29875	Knee arthroscopy/surgery		T	0041	29.4467	$1,875.55		$375.11
29876	Knee arthroscopy/surgery		T	0041	29.4467	$1,875.55		$375.11
29877	Knee arthroscopy/surgery		T	0041	29.4467	$1,875.55		$375.11
29879	Knee arthroscopy/surgery		T	0041	29.4467	$1,875.55		$375.11
29880	Knee arthroscopy/surgery		T	0041	29.4467	$1,875.55		$375.11
29881	Knee arthroscopy/surgery		T	0041	29.4467	$1,875.55		$375.11
29882	Knee arthroscopy/surgery		T	0041	29.4467	$1,875.55		$375.11
29883	Knee arthroscopy/surgery		T	0041	29.4467	$1,875.55		$375.11
29884	Knee arthroscopy/surgery		T	0041	29.4467	$1,875.55		$375.11
29885	Knee arthroscopy/surgery		T	0042	47.7765	$3,043.03	$804.70	$608.61
29886	Knee arthroscopy/surgery		T	0041	29.4467	$1,875.55		$375.11
29887	Knee arthroscopy/surgery		T	0041	29.4467	$1,875.55		$375.11
29888	Knee arthroscopy/surgery		T	0042	47.7765	$3,043.03	$804.70	$608.61
29889	Knee arthroscopy/surgery		T	0042	47.7765	$3,043.03	$804.70	$608.61
29891	Ankle arthroscopy/surgery		T	0041	29.4467	$1,875.55		$375.11
29892	Ankle arthroscopy/surgery		T	0041	29.4467	$1,875.55		$375.11
29893	Scope, plantar fasciotomy		T	0055	21.1762	$1,348.78	$355.30	$269.76
29894	Ankle arthroscopy/surgery		T	0041	29.4467	$1,875.55		$375.11
29895	Ankle arthroscopy/surgery		T	0041	29.4467	$1,875.55		$375.11
29897	Ankle arthroscopy/surgery		T	0041	29.4467	$1,875.55		$375.11
29898	Ankle arthroscopy/surgery		T	0041	29.4467	$1,875.55		$375.11
29899	Ankle arthroscopy/surgery		T	0042	47.7765	$3,043.03	$804.70	$608.61

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
29900	Mcp joint arthroscopy, dx		T	0053	16.822	$1,071.44	$253.40	$214.29
29901	Mcp joint arthroscopy, surg		T	0053	16.822	$1,071.44	$253.40	$214.29
29902	Mcp joint arthroscopy, surg		T	0053	16.822	$1,071.44	$253.40	$214.29
29999	Arthroscopy of joint		T	0041	29.4467	$1,875.55		$375.11
30000	Drainage of nose lesion		T	0251	2.5765	$164.11		$32.82
30020	Drainage of nose lesion		T	0251	2.5765	$164.11		$32.82
3006F	Cxr doc rev		M					
30100	Intranasal biopsy		T	0252	7.6539	$487.50	$109.10	$97.50
30110	Removal of nose polyp(s)		T	0253	16.6341	$1,059.48	$282.20	$211.90
30115	Removal of nose polyp(s)		T	0253	16.6341	$1,059.48	$282.20	$211.90
30117	Removal of intranasal lesion		T	0253	16.6341	$1,059.48	$282.20	$211.90
30118	Removal of intranasal lesion		T	0254	24.3535	$1,551.15	$321.30	$310.23
3011F	Lipid panel doc rev		M					
30120	Revision of nose		T	0253	16.6341	$1,059.48	$282.20	$211.90
30124	Removal of nose lesion		T	0252	7.6539	$487.50	$109.10	$97.50
30125	Removal of nose lesion		T	0256	40.5598	$2,583.38		$516.68
30130	Excise inferior turbinate		T	0253	16.6341	$1,059.48	$282.20	$211.90
30140	Resect inferior turbinate		T	0254	24.3535	$1,551.15	$321.30	$310.23
3014F	Screen mammo doc rev		M					
30150	Partial removal of nose		T	0256	40.5598	$2,583.38		$516.68
30160	Removal of nose		T	0256	40.5598	$2,583.38		$516.68
3017F	Colorectal ca screen doc rev		M					
30200	Injection treatment of nose		T	0252	7.6539	$487.50	$109.10	$97.50
3020F	Lvf assess		M					
30210	Nasal sinus therapy		T	0252	7.6539	$487.50	$109.10	$97.50
3021F	Lvef mod/sever deprs syst		M					
30220	Insert nasal septal button		T	0252	7.6539	$487.50	$109.10	$97.50
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					
30300	Remove nasal foreign body		X	0340	0.6416	$40.87		$8.17
30310	Remove nasal foreign body		T	0253	16.6341	$1,059.48	$282.20	$211.90
30320	Remove nasal foreign body		T	0253	16.6341	$1,059.48	$282.20	$211.90
3035F	O2 saturation =88% /pa0 =55		M					
3037F	O2 saturation> 88% /pao>55		M					
30400	Reconstruction of nose		T	0256	40.5598	$2,583.38		$516.68
3040F	Fev<40% predicted value		M					
30410	Reconstruction of nose		T	0256	40.5598	$2,583.38		$516.68
30420	Reconstruction of nose		T	0256	40.5598	$2,583.38		$516.68
3042F	Fev=40% predicted value		M					
30430	Revision of nose		T	0254	24.3535	$1,551.15	$321.30	$310.23
30435	Revision of nose		T	0256	40.5598	$2,583.38		$516.68
3044F	HG a1c level < 7.0%		M					
30450	Revision of nose		T	0256	40.5598	$2,583.38		$516.68
3045F	HG a1c level 7.0-9.0%		M					
30460	Revision of nose		T	0256	40.5598	$2,583.38		$516.68
30462	Revision of nose		T	0256	40.5598	$2,583.38		$516.68
30465	Repair nasal stenosis		T	0256	40.5598	$2,583.38		$516.68
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					
30520	Repair of nasal septum		T	0254	24.3535	$1,551.15	$321.30	$310.23
30540	Repair nasal defect		T	0256	40.5598	$2,583.38		$516.68
30545	Repair nasal defect		T	0256	40.5598	$2,583.38		$516.68
30560	Release of nasal adhesions		T	0251	2.5765	$164.11		$32.82
30580	Repair upper jaw fistula		T	0256	40.5598	$2,583.38		$516.68
30600	Repair mouth/nose fistula		T	0256	40.5598	$2,583.38		$516.68
3060F	Pos microalbuminuria rev		M					
3061F	Neg microalbuminuria rev		M					
30620	Intranasal reconstruction		T	0256	40.5598	$2,583.38		$516.68
3062F	Pos macroalbuminuria rev		M					
30630	Repair nasal septum defect		T	0254	24.3535	$1,551.15	$321.30	$310.23
3066F	Nephropathy doc tx		M					
3072F	Low risk for retinopathy		M					
3073F	Pre-surg eye measures doc'd		M					
3074F	Syst bp < 130 mm hg		M					
3075F	Syst bp ≧130-139 mm hg		M					
3077F	Syst bp = 140 mm hg		M					
3078F	Diast bp < 80 mm hg		M					
3079F	Diast bp 80-89 mm hg		M					
30801	Ablate inf turbinate, superf		T	0252	7.6539	$487.50	$109.10	$97.50
30802	Cauterization, inner nose		T	0252	7.6539	$487.50	$109.10	$97.50
3080F	Diast bp = 90 mm hg		M					
3082F	Kt/v <1.2		M					
3083F	Kt/v ≧ 1.2 and <1.7		M					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
3084F	Kt/v≧1.7		M					
3085F	Suicide risk assessed		M					
3088F	MDD, mild		M					
3089F	MDD, moderate		M					
30901	Control of nosebleed		T	0250	1.1708	$74.57	$25.30	$14.91
30903	Control of nosebleed		T	0250	1.1708	$74.57	$25.30	$14.91
30905	Control of nosebleed		T	0250	1.1708	$74.57	$25.30	$14.91
30906	Repeat control of nosebleed		T	0250	1.1708	$74.57	$25.30	$14.91
3090F	MDD, severe; w/o psych		M					
30915	Ligation, nasal sinus artery		T	0092	26.4396	$1,684.02		$336.80
3091F	MDD, severe; w/ psych		M					
30920	Ligation, upper jaw artery		T	0092	26.4396	$1,684.02		$336.80
3092F	MDD, in remission		M					
30930	Ther fx, nasal inf turbinate		T	0253	16.6341	$1,059.48	$282.20	$211.90
3093F	Doc new diag 1st/addl. mdd		M					
3095F	Central dexa results doc'd		M					
3096F	Central dexa ordered		M					
30999	Nasal surgery procedure		T	0251	2.5765	$164.11		$32.82
31000	Irrigation, maxillary sinus		T	0251	2.5765	$164.11		$32.82
31002	Irrigation, sphenoid sinus		T	0252	7.6539	$487.50	$109.10	$97.50
3100F	Carot blk doc'd w/ carot ref		M					
3101F	Intl carot blk 30-99% range		M					
31020	Exploration, maxillary sinus		T	0254	24.3535	$1,551.15	$321.30	$310.23
3102F	Int carot blk < 30%		M					
31030	Exploration, maxillary sinus		T	0256	40.5598	$2,583.38		$516.68
31032	Explore sinus, remove polyps		T	0256	40.5598	$2,583.38		$516.68
31040	Exploration behind upper jaw		T	0254	24.3535	$1,551.15	$321.30	$310.23
31050	Exploration, sphenoid sinus		T	0256	40.5598	$2,583.38		$516.68
31051	Sphenoid sinus surgery		T	0256	40.5598	$2,583.38		$516.68
31070	Exploration of frontal sinus		T	0254	24.3535	$1,551.15	$321.30	$310.23
31075	Exploration of frontal sinus		T	0256	40.5598	$2,583.38		$516.68
31080	Removal of frontal sinus		T	0256	40.5598	$2,583.38		$516.68
31081	Removal of frontal sinus		T	0256	40.5598	$2,583.38		$516.68
31084	Removal of frontal sinus		T	0256	40.5598	$2,583.38		$516.68
31085	Removal of frontal sinus		T	0256	40.5598	$2,583.38		$516.68
31086	Removal of frontal sinus		T	0256	40.5598	$2,583.38		$516.68
31087	Removal of frontal sinus		T	0256	40.5598	$2,583.38		$516.68
31090	Exploration of sinuses		T	0256	40.5598	$2,583.38		$516.68
3110F	Pres/absn hmrhg/lesion doc'd		M					
3111F	Ct/mri brain done w/in 24hrs		M					
3112F	Ct/mri brain done > 24 hrs		M					
31200	Removal of ethmoid sinus		T	0256	40.5598	$2,583.38		$516.68
31201	Removal of ethmoid sinus		T	0256	40.5598	$2,583.38		$516.68
31205	Removal of ethmoid sinus		T	0256	40.5598	$2,583.38		$516.68
3120F	12-lead ecg performed		M					
31225	Removal of upper jaw		C					
31230	Removal of upper jaw		C					
31231	Nasal endoscopy, dx		T	0072	1.573	$100.19	$21.20	$20.04
31233	Nasal/sinus endoscopy, dx		T	0072	1.573	$100.19	$21.20	$20.04
31235	Nasal/sinus endoscopy, dx		T	0074	17.4546	$1,111.74	$292.20	$222.35
31237	Nasal/sinus endoscopy, surg		T	0074	17.4546	$1,111.74	$292.20	$222.35
31238	Nasal/sinus endoscopy, surg		T	0074	17.4546	$1,111.74	$292.20	$222.35
31239	Nasal/sinus endoscopy, surg		T	0075	23.2819	$1,482.89	$445.90	$296.58
31240	Nasal/sinus endoscopy, surg		T	0074	17.4546	$1,111.74	$292.20	$222.35
31254	Revision of ethmoid sinus		T	0075	23.2819	$1,482.89	$445.90	$296.58
31255	Removal of ethmoid sinus		T	0075	23.2819	$1,482.89	$445.90	$296.58
31256	Exploration maxillary sinus		T	0075	23.2819	$1,482.89	$445.90	$296.58
31267	Endoscopy, maxillary sinus		T	0075	23.2819	$1,482.89	$445.90	$296.58
31276	Sinus endoscopy, surgical		T	0075	23.2819	$1,482.89	$445.90	$296.58
31287	Nasal/sinus endoscopy, surg		T	0075	23.2819	$1,482.89	$445.90	$296.58
31288	Nasal/sinus endoscopy, surg		T	0075	23.2819	$1,482.89	$445.90	$296.58
31290	Nasal/sinus endoscopy, surg		C					
31291	Nasal/sinus endoscopy, surg		C					
31292	Nasal/sinus endoscopy, surg		T	0075	23.2819	$1,482.89	$445.90	$296.58
31293	Nasal/sinus endoscopy, surg		T	0075	23.2819	$1,482.89	$445.90	$296.58
31294	Nasal/sinus endoscopy, surg		T	0075	23.2819	$1,482.89	$445.90	$296.58
31299	Sinus surgery procedure		T	0251	2.5765	$164.11		$32.82
31300	Removal of larynx lesion		T	0254	24.3535	$1,551.15	$321.30	$310.23
3130F	Upper gi endoscopy performed		M					
31320	Diagnostic incision, larynx		T	0256	40.5598	$2,583.38		$516.68
3132F	Doc ref. upper gi endoscopy		M					
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					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
31382	Partial removal of larynx		C					
31390	Removal of larynx & pharynx		C					
31395	Reconstruct larynx & pharynx		C					
31400	Revision of larynx		T	0256	40.5598	$2,583.38		$516.68
3140F	Forceps esoph biopsy done		M					
3141F	Upper gi endo shows barrtt's		M					
31420	Removal of epiglottis		T	0256	40.5598	$2,583.38		$516.68
3142F	Upper gi endo not barrtt's		M					
3143F	Doc order barium swallow tst		M					
31500	Insert emergency airway		S	0094	2.5547	$162.72	$46.20	$32.54
31502	Change of windpipe airway	CH	S	0078	1.3636	$86.85		$17.37
31505	Diagnostic laryngoscopy		T	0071	0.8256	$52.58	$11.20	$10.52
31510	Laryngoscopy with biopsy		T	0074	17.4546	$1,111.74	$292.20	$222.35
31511	Remove foreign body, larynx		T	0072	1.573	$100.19	$21.20	$20.04
31512	Removal of larynx lesion		T	0074	17.4546	$1,111.74	$292.20	$222.35
31513	Injection into vocal cord		T	0072	1.573	$100.19	$21.20	$20.04
31515	Laryngoscopy for aspiration		T	0074	17.4546	$1,111.74	$292.20	$222.35
31520	Dx laryngoscopy, newborn		T	0072	1.573	$100.19	$21.20	$20.04
31525	Dx laryngoscopy excl nb		T	0074	17.4546	$1,111.74	$292.20	$222.35
31526	Dx laryngoscopy w/oper scope		T	0075	23.2819	$1,482.89	$445.90	$296.58
31527	Laryngoscopy for treatment		T	0075	23.2819	$1,482.89	$445.90	$296.58
31528	Laryngoscopy and dilation		T	0074	17.4546	$1,111.74	$292.20	$222.35
31529	Laryngoscopy and dilation		T	0074	17.4546	$1,111.74	$292.20	$222.35
31530	Laryngoscopy w/fb removal		T	0075	23.2819	$1,482.89	$445.90	$296.58
31531	Laryngoscopy w/fb & op scope		T	0075	23.2819	$1,482.89	$445.90	$296.58
31535	Laryngoscopy w/biopsy		T	0075	23.2819	$1,482.89	$445.90	$296.58
31536	Laryngoscopy w/bx & op scope		T	0075	23.2819	$1,482.89	$445.90	$296.58
31540	Laryngoscopy w/exc of tumor		T	0075	23.2819	$1,482.89	$445.90	$296.58
31541	Larynscop w/tumr exc + scope		T	0075	23.2819	$1,482.89	$445.90	$296.58
31545	Remove vc lesion w/scope		T	0075	23.2819	$1,482.89	$445.90	$296.58
31546	Remove vc lesion scope/graft		T	0075	23.2819	$1,482.89	$445.90	$296.58
31560	Laryngoscop w/arytenoidectom		T	0075	23.2819	$1,482.89	$445.90	$296.58
31561	Larynscop, remve cart + scop		T	0075	23.2819	$1,482.89	$445.90	$296.58
31570	Laryngoscope w/vc inj		T	0074	17.4546	$1,111.74	$292.20	$222.35
31571	Laryngoscop w/vc inj + scope		T	0075	23.2819	$1,482.89	$445.90	$296.58
31575	Diagnostic laryngoscopy		T	0072	1.573	$100.19	$21.20	$20.04
31576	Laryngoscopy with biopsy		T	0075	23.2819	$1,482.89	$445.90	$296.58
31577	Remove foreign body, larynx		T	0073	4.206	$267.89	$69.10	$53.58
31578	Removal of larynx lesion		T	0075	23.2819	$1,482.89	$445.90	$296.58
31579	Diagnostic laryngoscopy		T	0073	4.206	$267.89	$69.10	$53.58
31580	Revision of larynx		T	0256	40.5598	$2,583.38		$516.68
31582	Revision of larynx		T	0256	40.5598	$2,583.38		$516.68
31584	Treat larynx fracture		C					
31587	Revision of larynx		C					
31588	Revision of larynx		T	0256	40.5598	$2,583.38		$516.68
31590	Reinnervate larynx		T	0256	40.5598	$2,583.38		$516.68
31595	Larynx nerve surgery		T	0256	40.5598	$2,583.38		$516.68
31599	Larynx surgery procedure		T	0251	2.5765	$164.11		$32.82
31600	Incision of windpipe		T	0254	24.3535	$1,551.15	$321.30	$310.23
31601	Incision of windpipe		T	0254	24.3535	$1,551.15	$321.30	$310.23
31603	Incision of windpipe		T	0252	7.6539	$487.50	$109.10	$97.50
31605	Incision of windpipe		T	0252	7.6539	$487.50	$109.10	$97.50
31610	Incision of windpipe		T	0254	24.3535	$1,551.15	$321.30	$310.23
31611	Surgery/speech prosthesis		T	0254	24.3535	$1,551.15	$321.30	$310.23
31612	Puncture/clear windpipe		T	0254	24.3535	$1,551.15	$321.30	$310.23
31613	Repair windpipe opening		T	0254	24.3535	$1,551.15	$321.30	$310.23
31614	Repair windpipe opening		T	0256	40.5598	$2,583.38		$516.68
31615	Visualization of windpipe		T	0076	10.1732	$647.96	$189.80	$129.59
31620	Endobronchial us add-on	CH	N					
31622	Dx bronchoscope/wash		T	0076	10.1732	$647.96	$189.80	$129.59
31623	Dx bronchoscope/brush		T	0076	10.1732	$647.96	$189.80	$129.59
31624	Dx bronchoscope/lavage		T	0076	10.1732	$647.96	$189.80	$129.59
31625	Bronchoscopy w/biopsy(s)		T	0076	10.1732	$647.96	$189.80	$129.59
31628	Bronchoscopy/lung bx, each		T	0076	10.1732	$647.96	$189.80	$129.59
31629	Bronchoscopy/needle bx, each		T	0076	10.1732	$647.96	$189.80	$129.59
31630	Bronchoscopy dilate/fx repr		T	0415	24.2882	$1,546.99	$459.90	$309.40
31631	Bronchoscopy, dilate w/stent		T	0415	24.2882	$1,546.99	$459.90	$309.40
31632	Bronchoscopy/lung bx, add'l		T	0076	10.1732	$647.96	$189.80	$129.59
31633	Bronchoscopy/needle bx add'l		T	0076	10.1732	$647.96	$189.80	$129.59
31635	Bronchoscopy w/fb removal		T	0076	10.1732	$647.96	$189.80	$129.59
31636	Bronchoscopy, bronch stents		T	0415	24.2882	$1,546.99	$459.90	$309.40
31637	Bronchoscopy, stent add-on		T	0076	10.1732	$647.96	$189.80	$129.59
31638	Bronchoscopy, revise stent		T	0415	24.2882	$1,546.99	$459.90	$309.40
31640	Bronchoscopy w/tumor excise		T	0415	24.2882	$1,546.99	$459.90	$309.40
31641	Bronchoscopy, treat blockage		T	0415	24.2882	$1,546.99	$459.90	$309.40
31643	Diag bronchoscope/catheter		T	0076	10.1732	$647.96	$189.80	$129.59
31645	Bronchoscopy, clear airways		T	0076	10.1732	$647.96	$189.80	$129.59
31646	Bronchoscopy, reclear airway		T	0076	10.1732	$647.96	$189.80	$129.59

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
31656	Bronchoscopy, inj for x-ray		T	0076	10.1732	$647.96	$189.80	$129.59
31715	Injection for bronchus x-ray		N					
31717	Bronchial brush biopsy		T	0073	4.206	$267.89	$69.10	$53.58
31720	Clearance of airways	CH	S	0077	0.3904	$24.87	$7.70	$4.97
31725	Clearance of airways		C					
31730	Intro, windpipe wire/tube		T	0073	4.206	$267.89	$69.10	$53.58
31750	Repair of windpipe		T	0256	40.5598	$2,583.38		$516.68
31755	Repair of windpipe		T	0256	40.5598	$2,583.38		$516.68
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	24.3535	$1,551.15	$321.30	$310.23
31786	Remove windpipe lesion		C					
31800	Repair of windpipe injury		C					
31805	Repair of windpipe injury		C					
31820	Closure of windpipe lesion		T	0253	16.6341	$1,059.48	$282.20	$211.90
31825	Repair of windpipe defect		T	0254	24.3535	$1,551.15	$321.30	$310.23
31830	Revise windpipe scar		T	0254	24.3535	$1,551.15	$321.30	$310.23
31899	Airways surgical procedure		T	0076	10.1732	$647.96	$189.80	$129.59
32000	Drainage of chest		T	0070	5.3095	$338.18		$67.64
32002	Treatment of collapsed lung		T	0070	5.3095	$338.18		$67.64
32005	Treat lung lining chemically		T	0070	5.3095	$338.18		$67.64
32019	Insert pleural catheter		T	0652	31.7598	$2,022.88		$404.58
32020	Insertion of chest tube		T	0070	5.3095	$338.18		$67.64
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	5.3095	$338.18		$67.64
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					
32400	Needle biopsy chest lining		T	0685	9.5741	$609.80		$121.96
32402	Open biopsy chest lining		C					
32405	Biopsy, lung or mediastinum		T	0685	9.5741	$609.80		$121.96
32420	Puncture/clear lung		T	0070	5.3095	$338.18		$67.64
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					
32601	Thoracoscopy, diagnostic		T	0069	33.1688	$2,112.62	$591.60	$422.52
32602	Thoracoscopy, diagnostic		T	0069	33.1688	$2,112.62	$591.60	$422.52
32603	Thoracoscopy, diagnostic		T	0069	33.1688	$2,112.62	$591.60	$422.52
32604	Thoracoscopy, diagnostic		T	0069	33.1688	$2,112.62	$591.60	$422.52
32605	Thoracoscopy, diagnostic		T	0069	33.1688	$2,112.62	$591.60	$422.52
32606	Thoracoscopy, diagnostic		T	0069	33.1688	$2,112.62	$591.60	$422.52
32650	Thoracoscopy, surgical		C					
32651	Thoracoscopy, surgical		C					
32652	Thoracoscopy, surgical		C					
32653	Thoracoscopy, surgical		C					
32654	Thoracoscopy, surgical		C					
32655	Thoracoscopy, surgical		C					
32656	Thoracoscopy, surgical		C					
32657	Thoracoscopy, surgical		C					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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	5.3095	$338.18		$67.64
32997	Total lung lavage		C					
32998	Perq rf ablate tx, pul tumor		T	0423	44.1192	$2,810.08		$562.02
32999	Chest surgery procedure		T	0070	5.3095	$338.18		$67.64
33010	Drainage of heart sac		T	0070	5.3095	$338.18		$67.64
33011	Repeat drainage of heart sac		T	0070	5.3095	$338.18		$67.64
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					
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	122.5662	$7,806.61	$1,682.20	$1,561.32
33207	Insertion of heart pacemaker		T	0089	122.5662	$7,806.61	$1,682.20	$1,561.32
33208	Insertion of heart pacemaker		T	0655	144.2764	$9,189.40		$1,837.88
33210	Insertion of heart electrode		T	0106	75.0068	$4,777.41		$955.48
33211	Insertion of heart electrode		T	0106	75.0068	$4,777.41		$955.48
33212	Insertion of pulse generator		T	0090	99.8268	$6,358.27	$1,612.80	$1,271.65
33213	Insertion of pulse generator		T	0654	106.9053	$6,809.12		$1,361.82
33214	Upgrade of pacemaker system		T	0655	144.2764	$9,189.40		$1,837.88
33215	Reposition pacing-defib lead		T	0105	24.7274	$1,574.96	$370.40	$314.99
33216	Insert lead pace-defib, one		T	0106	75.0068	$4,777.41		$955.48
33217	Insert lead pace-defib, dual		T	0106	75.0068	$4,777.41		$955.48
33218	Repair lead pace-defib, one		T	0105	24.7274	$1,574.96	$370.40	$314.99
33220	Repair lead pace-defib, dual		T	0105	24.7274	$1,574.96	$370.40	$314.99
33222	Revise pocket, pacemaker	CH	T	0136	15.4399	$983.41		$196.68
33223	Revise pocket, pacing-defib	CH	T	0136	15.4399	$983.41		$196.68
33224	Insert pacing lead & connect		T	0418	250.5383	$15,957.54		$3,191.51
33225	L ventric pacing lead add-on		T	0418	250.5383	$15,957.54		$3,191.51
33226	Reposition l ventric lead		T	0105	24.7274	$1,574.96	$370.40	$314.99
33233	Removal of pacemaker system		T	0105	24.7274	$1,574.96	$370.40	$314.99
33234	Removal of pacemaker system		T	0105	24.7274	$1,574.96	$370.40	$314.99
33235	Removal pacemaker electrode		T	0105	24.7274	$1,574.96	$370.40	$314.99
33236	Remove electrode/thoracotomy		C					
33237	Remove electrode/thoracotomy		C					
33238	Remove electrode/thoracotomy		C					
33240	Insert pulse generator	CH	T	0107	353.1242	$22,491.54		$4,498.31
33241	Remove pulse generator		T	0105	24.7274	$1,574.96	$370.40	$314.99
33243	Remove eltrd/thoracotomy		C					
33244	Remove eltrd, transven		T	0105	24.7274	$1,574.96	$370.40	$314.99
33249	Eltrd/insert pace-defib	CH	T	0108	403.0232	$25,669.76		$5,133.95
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					
33261	Ablate heart dysrhythm focus		C					
33265	Ablate atria w/bypass, endo		C					
33266	Ablate atria w/o bypass endo		C					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
33282	Implant pat-active ht record		S	0680	71.6463	$4,563.37		$912.67
33284	Remove pat-active ht record		T	0109	6.1077	$389.02		$77.80
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					
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					
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					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
33608	Repair anomaly w/conduit		C					
33610	Repair by enlargement		C					
33611	Repair double ventricle		C					
33612	Repair double ventricle		C					
33615	Repair, modified fontan		C					
33617	Repair single ventricle		C					
33619	Repair single ventricle		C					
33641	Repair heart septum defect		C					
33645	Revision of heart veins		C					
33647	Repair heart septum defects		C					
33660	Repair of heart defects		C					
33665	Repair of heart defects		C					
33670	Repair of heart chambers		C					
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					
33732	Repair heart-vein defect		C					
33735	Revision of heart chamber		C					
33736	Revision of heart chamber		C					
33737	Revision of heart chamber		C					
33750	Major vessel shunt		C					
33755	Major vessel shunt		C					
33762	Major vessel shunt		C					
33764	Major vessel shunt & graft		C					
33766	Major vessel shunt		C					
33767	Major vessel shunt		C					
33768	Cavopulmonary shunting		C					
33770	Repair great vessels defect		C					
33771	Repair great vessels defect		C					
33774	Repair great vessels defect		C					
33775	Repair great vessels defect		C					
33776	Repair great vessels defect		C					
33777	Repair great vessels defect		C					
33778	Repair great vessels defect		C					
33779	Repair great vessels defect		C					
33780	Repair great vessels defect		C					
33781	Repair great vessels defect		C					
33786	Repair arterial trunk		C					
33788	Revision of pulmonary artery		C					
33800	Aortic suspension		C					
33802	Repair vessel defect		C					
33803	Repair vessel defect		C					
33813	Repair septal defect		C					
33814	Repair septal defect		C					
33820	Revise major vessel		C					
33822	Revise major vessel		C					
33824	Revise major vessel		C					
33840	Remove aorta constriction		C					
33845	Remove aorta constriction		C					
33851	Remove aorta constriction		C					
33852	Repair septal defect		C					
33853	Repair septal defect		C					
33860	Ascending aortic graft		C					
33861	Ascending aortic graft		C					
33863	Ascending aortic graft		C					
33870	Transverse aortic arch graft		C					
33875	Thoracic aortic graft		C					
33877	Thoracoabdominal graft		C					
33880	Endovasc taa repr incl subcl		C					
33881	Endovasc taa repr w/o subcl		C					
33883	Insert endovasc prosth, taa		C					
33884	Endovasc prosth, taa, add-on		C					
33886	Endovasc prosth, delayed		C					
33889	Artery transpose/endovas taa		C					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
33999	Cardiac surgery procedure		T	0070	5.3095	$338.18		$67.64
34001	Removal of artery clot		C					
34051	Removal of artery clot		C					
34101	Removal of artery clot		T	0088	39.8001	$2,534.99	$655.20	$507.00
34111	Removal of arm artery clot		T	0088	39.8001	$2,534.99	$655.20	$507.00
34151	Removal of artery clot		C					
34201	Removal of artery clot		T	0088	39.8001	$2,534.99	$655.20	$507.00
34203	Removal of leg artery clot		T	0088	39.8001	$2,534.99	$655.20	$507.00
34401	Removal of vein clot		C					
34421	Removal of vein clot		T	0088	39.8001	$2,534.99	$655.20	$507.00
34451	Removal of vein clot		C					
34471	Removal of vein clot		T	0088	39.8001	$2,534.99	$655.20	$507.00
34490	Removal of vein clot		T	0088	39.8001	$2,534.99	$655.20	$507.00
34501	Repair valve, femoral vein		T	0088	39.8001	$2,534.99	$655.20	$507.00
34502	Reconstruct vena cava		C					
34510	Transposition of vein valve		T	0088	39.8001	$2,534.99	$655.20	$507.00
34520	Cross-over vein graft		T	0088	39.8001	$2,534.99	$655.20	$507.00
34530	Leg vein fusion		T	0088	39.8001	$2,534.99	$655.20	$507.00
34800	Endovas aaa repr w/sm tube		C					
34802	Endovas aaa repr w/2-p part		C					
34803	Endovas aaa repr w/3-p part		C					
34804	Endovas aaa repr w/1-p part		C					
34805	Endovas aaa repr w/long tube		C					
34808	Endovas iliac a device addon		C					
34812	Xpose for endoprosth, femorl		C					
34813	Femoral endovas graft add-on		C					
34820	Xpose for endoprosth, iliac		C					
34825	Endovasc extend prosth, init		C					
34826	Endovasc exten prosth, add'l		C					
34830	Open aortic tube prosth repr		C					
34831	Open aortoiliac prosth repr		C					
34832	Open aortofemor prosth repr		C					
34833	Xpose for endoprosth, iliac		C					
34834	Xpose, endoprosth, brachial		C					
34900	Endovasc iliac repr w/graft		C					
35001	Repair defect of artery		C					
35002	Repair artery rupture, neck		C					
35005	Repair defect of artery		C					
35011	Repair defect of artery		T	0653	41.0875	$2,616.99		$523.40
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					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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	30.8639	$1,965.81		$393.16
35182	Repair blood vessel lesion		C					
35184	Repair blood vessel lesion		T	0093	30.8639	$1,965.81		$393.16
35188	Repair blood vessel lesion		T	0088	39.8001	$2,534.99	$655.20	$507.00
35189	Repair blood vessel lesion		C					
35190	Repair blood vessel lesion		T	0093	30.8639	$1,965.81		$393.16
35201	Repair blood vessel lesion		T	0093	30.8639	$1,965.81		$393.16
35206	Repair blood vessel lesion		T	0093	30.8639	$1,965.81		$393.16
35207	Repair blood vessel lesion		T	0088	39.8001	$2,534.99	$655.20	$507.00
35211	Repair blood vessel lesion		C					
35216	Repair blood vessel lesion		C					
35221	Repair blood vessel lesion		C					
35226	Repair blood vessel lesion		T	0093	30.8639	$1,965.81		$393.16
35231	Repair blood vessel lesion		T	0093	30.8639	$1,965.81		$393.16
35236	Repair blood vessel lesion		T	0093	30.8639	$1,965.81		$393.16
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	30.8639	$1,965.81		$393.16
35261	Repair blood vessel lesion		T	0653	41.0875	$2,616.99		$523.40
35266	Repair blood vessel lesion		T	0653	41.0875	$2,616.99		$523.40
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	41.0875	$2,616.99		$523.40
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	30.8639	$1,965.81		$393.16
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		C					
35456	Repair arterial blockage		C					
35458	Repair arterial blockage	CH	T	0083	46.0685	$2,934.24		$586.85
35459	Repair arterial blockage	CH	T	0083	46.0685	$2,934.24		$586.85
35460	Repair venous blockage	CH	T	0083	46.0685	$2,934.24		$586.85
35470	Repair arterial blockage	CH	T	0083	46.0685	$2,934.24		$586.85
35471	Repair arterial blockage	CH	T	0083	46.0685	$2,934.24		$586.85
35472	Repair arterial blockage	CH	T	0083	46.0685	$2,934.24		$586.85
35473	Repair arterial blockage	CH	T	0083	46.0685	$2,934.24		$586.85
35474	Repair arterial blockage	CH	T	0083	46.0685	$2,934.24		$586.85
35475	Repair arterial blockage	CH	T	0083	46.0685	$2,934.24		$586.85
35476	Repair venous blockage	CH	T	0083	46.0685	$2,934.24		$586.85
35480	Atherectomy, open		C					
35481	Atherectomy, open		C					
35482	Atherectomy, open		C					
35483	Atherectomy, open		C					
35484	Atherectomy, open	CH	T	0082	88.7717	$5,654.14		$1,130.83
35485	Atherectomy, open	CH	T	0082	88.7717	$5,654.14		$1,130.83
35490	Atherectomy, percutaneous	CH	T	0082	88.7717	$5,654.14		$1,130.83
35491	Atherectomy, percutaneous	CH	T	0082	88.7717	$5,654.14		$1,130.83
35492	Atherectomy, percutaneous	CH	T	0082	88.7717	$5,654.14		$1,130.83
35493	Atherectomy, percutaneous	CH	T	0082	88.7717	$5,654.14		$1,130.83

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
35494	Atherectomy, percutaneous	CH	T	0082	88.7717	$5,654.14		$1,130.83
35495	Atherectomy, percutaneous	CH	T	0082	88.7717	$5,654.14		$1,130.83
35500	Harvest vein for bypass	CH	T	0103	15.2572	$971.78		$194.36
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					
35525	Artery bypass graft		C					
35526	Artery bypass graft		C					
35531	Artery bypass graft		C					
35533	Artery bypass graft		C					
35536	Artery bypass graft		C					
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					
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 artery for cabg		C					
35601	Artery bypass graft		C					
35606	Artery bypass graft		C					
35612	Artery bypass graft		C					
35616	Artery bypass graft		C					
35621	Artery bypass graft		C					
35623	Bypass graft, not vein		C					
35626	Artery bypass graft		C					
35631	Artery bypass graft		C					
35636	Artery bypass graft		C					
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					
35685	Bypass graft patency/patch		T	0093	30.8639	$1,965.81		$393.16
35686	Bypass graft/av fist patency		T	0093	30.8639	$1,965.81		$393.16
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	0115	30.5379	$1,945.05		$389.01

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
35800	Explore neck vessels		C					
35820	Explore chest vessels		C					
35840	Explore abdominal vessels		C					
35860	Explore limb vessels		T	0093	30.8639	$1,965.81		$393.16
35870	Repair vessel graft defect		C					
35875	Removal of clot in graft		T	0088	39.8001	$2,534.99	$655.20	$507.00
35876	Removal of clot in graft		T	0088	39.8001	$2,534.99	$655.20	$507.00
35879	Revise graft w/vein		T	0088	39.8001	$2,534.99	$655.20	$507.00
35881	Revise graft w/vein		T	0088	39.8001	$2,534.99	$655.20	$507.00
35883	Revise graft w/nonauto graft		T	0088	39.8001	$2,534.99	$655.20	$507.00
35884	Revise graft w/vein		T	0088	39.8001	$2,534.99	$655.20	$507.00
35901	Excision, graft, neck		C					
35903	Excision, graft, extremity		T	0115	30.5379	$1,945.05		$389.01
35905	Excision, graft, thorax		C					
35907	Excision, graft, abdomen		C					
36000	Place needle in vein		N					
36002	Pseudoaneurysm injection trt		S	0267	2.4859	$158.33	$60.50	$31.67
36005	Injection ext venography		N					
36010	Place catheter in vein		N					
36011	Place catheter in vein		N					
36012	Place catheter in vein		N					
36013	Place catheter in artery		N					
36014	Place catheter in artery		N					
36015	Place catheter in artery		N					
36100	Establish access to artery		N					
36120	Establish access to artery		N					
36140	Establish access to artery		N					
36145	Artery to vein shunt		N					
36160	Establish access to aorta		N					
36200	Place catheter in aorta		N					
36215	Place catheter in artery		N					
36216	Place catheter in artery		N					
36217	Place catheter in artery		N					
36218	Place catheter in artery		N					
36245	Place catheter in artery		N					
36246	Place catheter in artery		N					
36247	Place catheter in artery		N					
36248	Place catheter in artery		N					
36260	Insertion of infusion pump		T	0623	29.3210	$1,867.54		$373.51
36261	Revision of infusion pump		T	0623	29.3210	$1,867.54		$373.51
36262	Removal of infusion pump		T	0622	24.5273	$1,562.22		$312.44
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		T	0035	0.2091	$13.32		$2.66
36425	Vein access cutdown > 1 yr		T	0035	0.2091	$13.32		$2.66
36430	Blood transfusion service		S	0110	3.4924	$222.44		$44.49
36440	Bl push transfuse, 2 yr or <		S	0110	3.4924	$222.44		$44.49
36450	Bl exchange/transfuse, nb		S	0110	3.4924	$222.44		$44.49
36455	Bl exchange/transfuse non-nb		S	0110	3.4924	$222.44		$44.49
36460	Transfusion service, fetal		S	0110	3.4924	$222.44		$44.49
36468	Injection(s), spider veins	CH	T	0013	0.8046	$51.25		$10.25
36469	Injection(s), spider veins	CH	T	0013	0.8046	$51.25		$10.25
36470	Injection therapy of vein	CH	T	0013	0.8046	$51.25		$10.25
36471	Injection therapy of veins	CH	T	0013	0.8046	$51.25		$10.25
36475	Endovenous rf, 1st vein		T	0091	43.6609	$2,780.89		$556.18
36476	Endovenous rf, vein add-on	CH	T	0092	26.4396	$1,684.02		$336.80
36478	Endovenous laser, 1st vein		T	0092	26.4396	$1,684.02		$336.80
36479	Endovenous laser vein addon		T	0092	26.4396	$1,684.02		$336.80
36481	Insertion of catheter, vein		N					
36500	Insertion of catheter, vein		N					
36510	Insertion of catheter, vein		N					
36511	Apheresis wbc		S	0111	12.1982	$776.94	$198.40	$155.39
36512	Apheresis rbc		S	0111	12.1982	$776.94	$198.40	$155.39
36513	Apheresis platelets		S	0111	12.1982	$776.94	$198.40	$155.39
36514	Apheresis plasma		S	0111	12.1982	$776.94	$198.40	$155.39
36515	Apheresis, adsorp/reinfuse		S	0112	31.9648	$2,035.93	$433.20	$407.19
36516	Apheresis, selective		S	0112	31.9648	$2,035.93	$433.20	$407.19
36522	Photopheresis		S	0112	31.9648	$2,035.93	$433.20	$407.19
36540	Collect blood venous device		Q	0624	0.5763	$36.71	$12.60	$7.34
36550	Declot vascular device		T	0676	2.5179	$160.37		$32.07
36555	Insert non-tunnel cv cath		T	0621	11.0043	$700.90		$140.18
36556	Insert non-tunnel cv cath		T	0621	11.0043	$700.90		$140.18
36557	Insert tunneled cv cath		T	0622	24.5273	$1,562.22		$312.44

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
36558	Insert tunneled cv cath		T	0622	24.5273	$1,562.22		$312.44
36560	Insert tunneled cv cath		T	0623	29.3210	$1,867.54		$373.51
36561	Insert tunneled cv cath		T	0623	29.3210	$1,867.54		$373.51
36563	Insert tunneled cv cath		T	0623	29.3210	$1,867.54		$373.51
36565	Insert tunneled cv cath		T	0623	29.3210	$1,867.54		$373.51
36566	Insert tunneled cv cath		T	0625	87.32	$5,561.67		$1,112.33
36568	Insert picc cath		T	0621	11.0043	$700.90		$140.18
36569	Insert picc cath		T	0621	11.0043	$700.90		$140.18
36570	Insert picvad cath		T	0622	24.5273	$1,562.22		$312.44
36571	Insert picvad cath		T	0622	24.5273	$1,562.22		$312.44
36575	Repair tunneled cv cath	CH	T	0109	6.1077	$389.02		$77.80
36576	Repair tunneled cv cath		T	0621	11.0043	$700.90		$140.18
36578	Replace tunneled cv cath		T	0622	24.5273	$1,562.22		$312.44
36580	Replace cvad cath		T	0621	11.0043	$700.90		$140.18
36581	Replace tunneled cv cath		T	0622	24.5273	$1,562.22		$312.44
36582	Replace tunneled cv cath		T	0623	29.3210	$1,867.54		$373.51
36583	Replace tunneled cv cath		T	0623	29.3210	$1,867.54		$373.51
36584	Replace picc cath		T	0621	11.0043	$700.90		$140.18
36585	Replace picvad cath		T	0622	24.5273	$1,562.22		$312.44
36589	Removal tunneled cv cath	CH	T	0109	6.1077	$389.02		$77.80
36590	Removal tunneled cv cath		T	0621	11.0043	$700.90		$140.18
36595	Mech remov tunneled cv cath		T	0622	24.5273	$1,562.22		$312.44
36596	Mech remov tunneled cv cath		T	0621	11.0043	$700.90		$140.18
36597	Reposition venous catheter		T	0621	11.0043	$700.90		$140.18
36598	Inj w/fluor, eval cv device	CH	T	0676	2.5179	$160.37		$32.07
36600	Withdrawal of arterial blood		Q	0035	0.2091	$13.32		$2.66
36620	Insertion catheter, artery		N					
36625	Insertion catheter, artery		N					
36640	Insertion catheter, artery		T	0623	29.3210	$1,867.54		$373.51
36660	Insertion catheter, artery		C					
36680	Insert needle, bone cavity		T	0002	1.1915	$75.89		$15.18
36800	Insertion of cannula		T	0115	30.5379	$1,945.05		$389.01
36810	Insertion of cannula		T	0115	30.5379	$1,945.05		$389.01
36815	Insertion of cannula		T	0115	30.5379	$1,945.05		$389.01
36818	Av fuse, uppr arm, cephalic		T	0088	39.8001	$2,534.99	$655.20	$507.00
36819	Av fuse, uppr arm, basilic		T	0088	39.8001	$2,534.99	$655.20	$507.00
36820	Av fusion/forearm vein		T	0088	39.8001	$2,534.99	$655.20	$507.00
36821	Av fusion direct any site		T	0088	39.8001	$2,534.99	$655.20	$507.00
36822	Insertion of cannula(s)		C					
36823	Insertion of cannula(s)		C					
36825	Artery-vein autograft		T	0088	39.8001	$2,534.99	$655.20	$507.00
36830	Artery-vein nonautograft		T	0088	39.8001	$2,534.99	$655.20	$507.00
36831	Open thrombect av fistula		T	0088	39.8001	$2,534.99	$655.20	$507.00
36832	Av fistula revision, open		T	0088	39.8001	$2,534.99	$655.20	$507.00
36833	Av fistula revision		T	0088	39.8001	$2,534.99	$655.20	$507.00
36834	Repair A-V aneurysm		T	0088	39.8001	$2,534.99	$655.20	$507.00
36835	Artery to vein shunt		T	0115	30.5379	$1,945.05		$389.01
36838	Dist revas ligation, hemo		T	0088	39.8001	$2,534.99	$655.20	$507.00
36860	External cannula declotting		T	0676	2.5179	$160.37		$32.07
36861	Cannula declotting		T	0115	30.5379	$1,945.05		$389.01
36870	Percut thrombect av fistula		T	0653	41.0875	$2,616.99		$523.40
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					
37183	Remove hepatic shunt (tips)		T	0229	89.7027	$5,713.43		$1,142.69
37184	Prim art mech thrombectomy		T	0088	39.8001	$2,534.99	$655.20	$507.00
37185	Prim art m-thrombect add-on		T	0088	39.8001	$2,534.99	$655.20	$507.00
37186	Sec art m-thrombect add-on		T	0088	39.8001	$2,534.99	$655.20	$507.00
37187	Venous mech thrombectomy		T	0088	39.8001	$2,534.99	$655.20	$507.00
37188	Venous m-thrombectomy add-on		T	0088	39.8001	$2,534.99	$655.20	$507.00
37195	Thrombolytic therapy, stroke		T	0676	2.5179	$160.37		$32.07
37200	Transcatheter biopsy	CH	T	0623	29.3210	$1,867.54		$373.51
37201	Transcatheter therapy infuse	CH	T	0103	15.2572	$971.78		$194.36
37202	Transcatheter therapy infuse	CH	T	0103	15.2572	$971.78		$194.36
37203	Transcatheter retrieval	CH	T	0623	29.3210	$1,867.54		$373.51
37204	Transcatheter occlusion	CH	T	0082	88.7717	$5,654.14		$1,130.83
37205	Transcath iv stent, percut		T	0229	89.7027	$5,713.43		$1,142.69
37206	Transcath iv stent/perc addl		T	0229	89.7027	$5,713.43		$1,142.69
37207	Transcath iv stent, open		T	0229	89.7027	$5,713.43		$1,142.69
37208	Transcath iv stent/open addl		T	0229	89.7027	$5,713.43		$1,142.69
37209	Change iv cath at thromb tx	CH	T	0623	29.3210	$1,867.54		$373.51
37210	Embolization uterine fibroid		T	0202	43.2255	$2,753.16	$981.50	$550.63
37215	Transcath stent, cca w/eps		C					
37216	Transcath stent, cca w/o eps		E					
37250	Iv us first vessel add-on	CH	N					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
37251	lv us each add vessel add-on	CH	N					
37500	Endoscopy ligate perf veins		T	0091	43.6609	$2,780.89		$556.18
37501	Vascular endoscopy procedure		T	0092	26.4396	$1,684.02		$336.80
37565	Ligation of neck vein		T	0093	30.8639	$1,965.81		$393.16
37600	Ligation of neck artery		T	0093	30.8639	$1,965.81		$393.16
37605	Ligation of neck artery		T	0091	43.6609	$2,780.89		$556.18
37606	Ligation of neck artery		T	0092	26.4396	$1,684.02		$336.80
37607	Ligation of a-v fistula		T	0092	26.4396	$1,684.02		$336.80
37609	Temporal artery procedure		T	0021	16.5832	$1,056.23	$219.40	$211.25
37615	Ligation of neck artery		T	0092	26.4396	$1,684.02		$336.80
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	43.6609	$2,780.89		$556.18
37650	Revision of major vein		T	0092	26.4396	$1,684.02		$336.80
37660	Revision of major vein		C					
37700	Revise leg vein	CH	T	0092	26.4396	$1,684.02		$336.80
37718	Ligate/strip short leg vein	CH	T	0092	26.4396	$1,684.02		$336.80
37722	Ligate/strip long leg vein		T	0091	43.6609	$2,780.89		$556.18
37735	Removal of leg veins/lesion		T	0091	43.6609	$2,780.89		$556.18
37760	Ligation, leg veins, open		T	0092	26.4396	$1,684.02		$336.80
37765	Phleb veins - extrem - to 20		T	0092	26.4396	$1,684.02		$336.80
37766	Phleb veins - extrem 20+		T	0092	26.4396	$1,684.02		$336.80
37780	Revision of leg vein		T	0092	26.4396	$1,684.02		$336.80
37785	Ligate/divide/excise vein		T	0092	26.4396	$1,684.02		$336.80
37788	Revascularization, penis		C					
37790	Penile venous occlusion		T	0181	35.1574	$2,239.28	$621.80	$447.86
37799	Vascular surgery procedure		T	0103	15.2572	$971.78		$194.36
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	46.1201	$2,937.53	$1,001.80	$587.51
38129	Laparoscope proc, spleen		T	0130	34.8153	$2,217.49	$659.50	$443.50
38200	Injection for spleen x-ray		N					
38204	Bl donor search management		N					
38205	Harvest allogenic stem cells		S	0111	12.1982	$776.94	$198.40	$155.39
38206	Harvest auto stem cells		S	0111	12.1982	$776.94	$198.40	$155.39
38207	Cryopreserve stem cells	CH	X	0344	0.8586	$54.69	$15.60	$10.94
38208	Thaw preserved stem cells	CH	X	0344	0.8586	$54.69	$15.60	$10.94
38209	Wash harvest stem cells	CH	X	0344	0.8586	$54.69	$15.60	$10.94
38210	T-cell depletion of harvest	CH	S	0110	3.4924	$222.44		$44.49
38211	Tumor cell deplete of harvst	CH	S	0110	3.4924	$222.44		$44.49
38212	Rbc depletion of harvest	CH	S	0110	3.4924	$222.44		$44.49
38213	Platelet deplete of harvest	CH	S	0110	3.4924	$222.44		$44.49
38214	Volume deplete of harvest	CH	S	0110	3.4924	$222.44		$44.49
38215	Harvest stem cell concentrte	CH	S	0110	3.4924	$222.44		$44.49
38220	Bone marrow aspiration		T	0003	3.239	$206.30		$41.26
38221	Bone marrow biopsy		T	0003	3.239	$206.30		$41.26
38230	Bone marrow collection	CH	S	0112	31.9648	$2,035.93	$433.20	$407.19
38240	Bone marrow/stem transplant	CH	S	0112	31.9648	$2,035.93	$433.20	$407.19
38241	Bone marrow/stem transplant	CH	S	0112	31.9648	$2,035.93	$433.20	$407.19
38242	Lymphocyte infuse transplant		S	0111	12.1982	$776.94	$198.40	$155.39
38300	Drainage, lymph node lesion		T	0007	12.5792	$801.21		$160.24
38305	Drainage, lymph node lesion		T	0008	19.0457	$1,213.08		$242.62
38308	Incision of lymph channels		T	0113	23.5105	$1,497.45		$299.49
38380	Thoracic duct procedure		C					
38381	Thoracic duct procedure		C					
38382	Thoracic duct procedure		C					
38500	Biopsy/removal, lymph nodes		T	0113	23.5105	$1,497.45		$299.49
38505	Needle biopsy, lymph nodes		T	0005	7.3012	$465.04		$93.01
38510	Biopsy/removal, lymph nodes		T	0113	23.5105	$1,497.45		$299.49
38520	Biopsy/removal, lymph nodes		T	0113	23.5105	$1,497.45		$299.49
38525	Biopsy/removal, lymph nodes		T	0113	23.5105	$1,497.45		$299.49
38530	Biopsy/removal, lymph nodes		T	0113	23.5105	$1,497.45		$299.49
38542	Explore deep node(s), neck		T	0114	45.1729	$2,877.20		$575.44
38550	Removal, neck/armpit lesion		T	0113	23.5105	$1,497.45		$299.49
38555	Removal, neck/armpit lesion		T	0113	23.5105	$1,497.45		$299.49
38562	Removal, pelvic lymph nodes		C					
38564	Removal, abdomen lymph nodes		C					
38570	Laparoscopy, lymph node biop		T	0131	46.1201	$2,937.53	$1,001.80	$587.51
38571	Laparoscopy, lymphadenectomy		T	0132	71.0022	$4,522.34	$1,239.20	$904.47
38572	Laparoscopy, lymphadenectomy		T	0131	46.1201	$2,937.53	$1,001.80	$587.51
38589	Laparoscope proc, lymphatic		T	0130	34.8153	$2,217.49	$659.50	$443.50
38700	Removal of lymph nodes, neck		T	0113	23.5105	$1,497.45		$299.49
38720	Removal of lymph nodes, neck		T	0113	23.5105	$1,497.45		$299.49
38724	Removal of lymph nodes, neck		C					
38740	Remove armpit lymph nodes		T	0114	45.1729	$2,877.20		$575.44

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
38745	Remove armpit lymph nodes		T	0114	45.1729	$2,877.20		$575.44
38746	Remove thoracic lymph nodes		C					
38747	Remove abdominal lymph nodes		C					
38760	Remove groin lymph nodes		T	0113	23.5105	$1,497.45		$299.49
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		Q	0389	1.5806	$100.67	$33.80	$20.13
38794	Access thoracic lymph duct		N					
38999	Blood/lymph system procedure		S	0110	3.4924	$222.44		$44.49
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	33.1688	$2,112.62	$591.60	$422.52
39499	Chest procedure		C					
39501	Repair diaphragm laceration		C					
39502	Repair paraesophageal hernia		C					
39503	Repair of diaphragm hernia		C					
39520	Repair of diaphragm hernia		C					
39530	Repair of diaphragm hernia		C					
39531	Repair of diaphragm hernia		C					
39540	Repair of diaphragm hernia		C					
39541	Repair of diaphragm hernia		C					
39545	Revision of diaphragm		C					
39560	Resect diaphragm, simple		C					
39561	Resect diaphragm, complex		C					
39599	Diaphragm surgery procedure		C					
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					
4005F	Pharm thx for op rx'd		M					
4006F	Beta-blocker therapy rx		M					
4007F	Antiox vit/min supp rx'd		M					
4009F	Ace/arb inhibitor therapy rx		M					
4011F	Oral antiplatelet therapy rx		M					
4012F	Warfarin therapy rx		M					
4014F	Written discharge instr prvd		M					
4015F	Persist asthma medicine ctrl		M					
4016F	Anti-inflm/anlgsc agent rx		M					
4017F	Gi prophylaxis for nsaid rx		M					
4018F	Therapy exercise joint rx		M					
4019F	Doc recpt counsl vit d/calc+		M					
4025F	Inhaled broncholidator rx		M					
4030F	Oxygen therapy rx		M					
4033F	Pulmonary rehab rec		M					
4035F	Influenza imm rec		M					
4037F	Influenza imm order/admin		M					
4040F	pneumoc imm order/admin		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					
40490	Biopsy of lip		T	0251	2.5765	$164.11		$32.82
4049F	Doc order given stop antibio		M					
40500	Partial excision of lip		T	0253	16.6341	$1,059.48	$282.20	$211.90
4050F	Ht care plan doc		M					
40510	Partial excision of lip		T	0254	24.3535	$1,551.15	$321.30	$310.23
4051F	Referred for an av fistula		M					
40520	Partial excision of lip		T	0253	16.6341	$1,059.48	$282.20	$211.90
40525	Reconstruct lip with flap		T	0254	24.3535	$1,551.15	$321.30	$310.23
40527	Reconstruct lip with flap		T	0254	24.3535	$1,551.15	$321.30	$310.23
4052F	Hemodialysis via av fistula		M					
40530	Partial removal of lip		T	0254	24.3535	$1,551.15	$321.30	$310.23
4053F	Hemodialysis via av graft		M					
4054F	Hemodialysis via catheter		M					
4055F	Pt. rcvng periton dialysis		M					
4056F	Approp. oral rehyd. recomm'd		M					
4058F	Ped gastro ed given, caregvr		M					
4060F	Psych svcs provided		M					
4062F	Pt referral psych doc'd		M					
4064F	Antidepressant rx		M					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
40650	Repair lip		T	0252	7.6539	$487.50	$109.10	$97.50
40652	Repair lip		T	0252	7.6539	$487.50	$109.10	$97.50
40654	Repair lip		T	0252	7.6539	$487.50	$109.10	$97.50
4065F	Antipsychotic rx		M					
4066F	Ect provided		M					
4067F	Pt referral for ect doc'd		M					
40700	Repair cleft lip/nasal		T	0256	40.5598	$2,583.38		$516.68
40701	Repair cleft lip/nasal		T	0256	40.5598	$2,583.38		$516.68
40702	Repair cleft lip/nasal		T	0256	40.5598	$2,583.38		$516.68
4070F	Dvt prophylx recv'd day 2		M					
40720	Repair cleft lip/nasal		T	0256	40.5598	$2,583.38		$516.68
4073F	Oral antiplat thx rx dischrg		M					
4075F	Anticoag thx rx at dischrg		M					
40761	Repair cleft lip/nasal		T	0256	40.5598	$2,583.38		$516.68
4077F	Doc t-pa admin considered		M					
40799	Lip surgery procedure		T	0251	2.5765	$164.11		$32.82
4079F	Doc rehab svcs considered		M					
40800	Drainage of mouth lesion		T	0006	1.463	$93.18		$18.64
40801	Drainage of mouth lesion		T	0252	7.6539	$487.50	$109.10	$97.50
40804	Removal, foreign body, mouth		X	0340	0.6416	$40.87		$8.17
40805	Removal, foreign body, mouth		T	0252	7.6539	$487.50	$109.10	$97.50
40806	Incision of lip fold		T	0251	2.5765	$164.11		$32.82
40808	Biopsy of mouth lesion		T	0251	2.5765	$164.11		$32.82
40810	Excision of mouth lesion		T	0253	16.6341	$1,059.48	$282.20	$211.90
40812	Excise/repair mouth lesion		T	0253	16.6341	$1,059.48	$282.20	$211.90
40814	Excise/repair mouth lesion		T	0253	16.6341	$1,059.48	$282.20	$211.90
40816	Excision of mouth lesion		T	0254	24.3535	$1,551.15	$321.30	$310.23
40818	Excise oral mucosa for graft		T	0251	2.5765	$164.11		$32.82
40819	Excise lip or cheek fold		T	0252	7.6539	$487.50	$109.10	$97.50
40820	Treatment of mouth lesion		T	0253	16.6341	$1,059.48	$282.20	$211.90
40830	Repair mouth laceration		T	0251	2.5765	$164.11		$32.82
40831	Repair mouth laceration		T	0252	7.6539	$487.50	$109.10	$97.50
40840	Reconstruction of mouth		T	0254	24.3535	$1,551.15	$321.30	$310.23
40842	Reconstruction of mouth		T	0254	24.3535	$1,551.15	$321.30	$310.23
40843	Reconstruction of mouth		T	0254	24.3535	$1,551.15	$321.30	$310.23
40844	Reconstruction of mouth		T	0256	40.5598	$2,583.38		$516.68
40845	Reconstruction of mouth		T	0256	40.5598	$2,583.38		$516.68
4084F	Aspirin recv'd w/in 24 hrs		M					
40899	Mouth surgery procedure		T	0251	2.5765	$164.11		$32.82
41000	Drainage of mouth lesion		T	0253	16.6341	$1,059.48	$282.20	$211.90
41005	Drainage of mouth lesion		T	0251	2.5765	$164.11		$32.82
41006	Drainage of mouth lesion		T	0254	24.3535	$1,551.15	$321.30	$310.23
41007	Drainage of mouth lesion		T	0253	16.6341	$1,059.48	$282.20	$211.90
41008	Drainage of mouth lesion		T	0253	16.6341	$1,059.48	$282.20	$211.90
41009	Drainage of mouth lesion		T	0251	2.5765	$164.11		$32.82
41010	Incision of tongue fold		T	0252	7.6539	$487.50	$109.10	$97.50
41015	Drainage of mouth lesion		T	0251	2.5765	$164.11		$32.82
41016	Drainage of mouth lesion		T	0252	7.6539	$487.50	$109.10	$97.50
41017	Drainage of mouth lesion		T	0252	7.6539	$487.50	$109.10	$97.50
41018	Drainage of mouth lesion		T	0252	7.6539	$487.50	$109.10	$97.50
41100	Biopsy of tongue		T	0252	7.6539	$487.50	$109.10	$97.50
41105	Biopsy of tongue		T	0253	16.6341	$1,059.48	$282.20	$211.90
41108	Biopsy of floor of mouth		T	0252	7.6539	$487.50	$109.10	$97.50
41110	Excision of tongue lesion		T	0253	16.6341	$1,059.48	$282.20	$211.90
41112	Excision of tongue lesion		T	0253	16.6341	$1,059.48	$282.20	$211.90
41113	Excision of tongue lesion		T	0253	16.6341	$1,059.48	$282.20	$211.90
41114	Excision of tongue lesion		T	0254	24.3535	$1,551.15	$321.30	$310.23
41115	Excision of tongue fold		T	0252	7.6539	$487.50	$109.10	$97.50
41116	Excision of mouth lesion		T	0253	16.6341	$1,059.48	$282.20	$211.90
41120	Partial removal of tongue		T	0254	24.3535	$1,551.15	$321.30	$310.23
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	0251	2.5765	$164.11		$32.82
41251	Repair tongue laceration		T	0251	2.5765	$164.11		$32.82
41252	Repair tongue laceration		T	0252	7.6539	$487.50	$109.10	$97.50
41500	Fixation of tongue		T	0254	24.3535	$1,551.15	$321.30	$310.23
41510	Tongue to lip surgery		T	0253	16.6341	$1,059.48	$282.20	$211.90
41520	Reconstruction, tongue fold		T	0252	7.6539	$487.50	$109.10	$97.50
41599	Tongue and mouth surgery		T	0251	2.5765	$164.11		$32.82
41800	Drainage of gum lesion		T	0006	1.463	$93.18		$18.64
41805	Removal foreign body, gum		T	0254	24.3535	$1,551.15	$321.30	$310.23
41806	Removal foreign body,jawbone		T	0253	16.6341	$1,059.48	$282.20	$211.90
41820	Excision, gum, each quadrant		T	0252	7.6539	$487.50	$109.10	$97.50

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
41821	Excision of gum flap		T	0252	7.6539	$487.50	$109.10	$97.50
41822	Excision of gum lesion		T	0253	16.6341	$1,059.48	$282.20	$211.90
41823	Excision of gum lesion		T	0254	24.3535	$1,551.15	$321.30	$310.23
41825	Excision of gum lesion		T	0253	16.6341	$1,059.48	$282.20	$211.90
41826	Excision of gum lesion		T	0253	16.6341	$1,059.48	$282.20	$211.90
41827	Excision of gum lesion		T	0254	24.3535	$1,551.15	$321.30	$310.23
41828	Excision of gum lesion		T	0253	16.6341	$1,059.48	$282.20	$211.90
41830	Removal of gum tissue		T	0253	16.6341	$1,059.48	$282.20	$211.90
41850	Treatment of gum lesion		T	0253	16.6341	$1,059.48	$282.20	$211.90
41870	Gum graft		T	0254	24.3535	$1,551.15	$321.30	$310.23
41872	Repair gum		T	0253	16.6341	$1,059.48	$282.20	$211.90
41874	Repair tooth socket		T	0254	24.3535	$1,551.15	$321.30	$310.23
41899	Dental surgery procedure		T	0251	2.5765	$164.11		$32.82
42000	Drainage mouth roof lesion		T	0251	2.5765	$164.11		$32.82
42100	Biopsy roof of mouth		T	0252	7.6539	$487.50	$109.10	$97.50
42104	Excision lesion, mouth roof		T	0253	16.6341	$1,059.48	$282.20	$211.90
42106	Excision lesion, mouth roof		T	0253	16.6341	$1,059.48	$282.20	$211.90
42107	Excision lesion, mouth roof		T	0254	24.3535	$1,551.15	$321.30	$310.23
42120	Remove palate/lesion		T	0256	40.5598	$2,583.38		$516.68
42140	Excision of uvula		T	0252	7.6539	$487.50	$109.10	$97.50
42145	Repair palate, pharynx/uvula		T	0254	24.3535	$1,551.15	$321.30	$310.23
42160	Treatment mouth roof lesion		T	0253	16.6341	$1,059.48	$282.20	$211.90
42180	Repair palate		T	0251	2.5765	$164.11		$32.82
42182	Repair palate		T	0256	40.5598	$2,583.38		$516.68
42200	Reconstruct cleft palate		T	0256	40.5598	$2,583.38		$516.68
42205	Reconstruct cleft palate		T	0256	40.5598	$2,583.38		$516.68
42210	Reconstruct cleft palate		T	0256	40.5598	$2,583.38		$516.68
42215	Reconstruct cleft palate		T	0256	40.5598	$2,583.38		$516.68
42220	Reconstruct cleft palate		T	0256	40.5598	$2,583.38		$516.68
42225	Reconstruct cleft palate		T	0256	40.5598	$2,583.38		$516.68
42226	Lengthening of palate		T	0256	40.5598	$2,583.38		$516.68
42227	Lengthening of palate		T	0256	40.5598	$2,583.38		$516.68
42235	Repair palate		T	0253	16.6341	$1,059.48	$282.20	$211.90
42260	Repair nose to lip fistula		T	0254	24.3535	$1,551.15	$321.30	$310.23
42280	Preparation, palate mold		T	0251	2.5765	$164.11		$32.82
42281	Insertion, palate prosthesis		T	0253	16.6341	$1,059.48	$282.20	$211.90
42299	Palate/uvula surgery		T	0251	2.5765	$164.11		$32.82
42300	Drainage of salivary gland		T	0253	16.6341	$1,059.48	$282.20	$211.90
42305	Drainage of salivary gland		T	0253	16.6341	$1,059.48	$282.20	$211.90
42310	Drainage of salivary gland		T	0251	2.5765	$164.11		$32.82
42320	Drainage of salivary gland		T	0251	2.5765	$164.11		$32.82
42330	Removal of salivary stone		T	0253	16.6341	$1,059.48	$282.20	$211.90
42335	Removal of salivary stone		T	0253	16.6341	$1,059.48	$282.20	$211.90
42340	Removal of salivary stone		T	0253	16.6341	$1,059.48	$282.20	$211.90
42400	Biopsy of salivary gland		T	0005	7.3012	$465.04		$93.01
42405	Biopsy of salivary gland		T	0253	16.6341	$1,059.48	$282.20	$211.90
42408	Excision of salivary cyst		T	0253	16.6341	$1,059.48	$282.20	$211.90
42409	Drainage of salivary cyst		T	0253	16.6341	$1,059.48	$282.20	$211.90
42410	Excise parotid gland/lesion		T	0256	40.5598	$2,583.38		$516.68
42415	Excise parotid gland/lesion		T	0256	40.5598	$2,583.38		$516.68
42420	Excise parotid gland/lesion		T	0256	40.5598	$2,583.38		$516.68
42425	Excise parotid gland/lesion		T	0256	40.5598	$2,583.38		$516.68
42426	Excise parotid gland/lesion		C					
42440	Excise submaxillary gland		T	0256	40.5598	$2,583.38		$516.68
42450	Excise sublingual gland		T	0254	24.3535	$1,551.15	$321.30	$310.23
42500	Repair salivary duct		T	0254	24.3535	$1,551.15	$321.30	$310.23
42505	Repair salivary duct		T	0256	40.5598	$2,583.38		$516.68
42507	Parotid duct diversion		T	0256	40.5598	$2,583.38		$516.68
42508	Parotid duct diversion		T	0256	40.5598	$2,583.38		$516.68
42509	Parotid duct diversion		T	0256	40.5598	$2,583.38		$516.68
42510	Parotid duct diversion		T	0256	40.5598	$2,583.38		$516.68
42550	Injection for salivary x-ray		N					
42600	Closure of salivary fistula		T	0253	16.6341	$1,059.48	$282.20	$211.90
42650	Dilation of salivary duct		T	0252	7.6539	$487.50	$109.10	$97.50
42660	Dilation of salivary duct		T	0251	2.5765	$164.11		$32.82
42665	Ligation of salivary duct		T	0254	24.3535	$1,551.15	$321.30	$310.23
42699	Salivary surgery procedure		T	0251	2.5765	$164.11		$32.82
42700	Drainage of tonsil abscess		T	0251	2.5765	$164.11		$32.82
42720	Drainage of throat abscess		T	0253	16.6341	$1,059.48	$282.20	$211.90
42725	Drainage of throat abscess		T	0256	40.5598	$2,583.38		$516.68
42800	Biopsy of throat		T	0252	7.6539	$487.50	$109.10	$97.50
42802	Biopsy of throat		T	0253	16.6341	$1,059.48	$282.20	$211.90
42804	Biopsy of upper nose/throat		T	0253	16.6341	$1,059.48	$282.20	$211.90
42806	Biopsy of upper nose/throat		T	0254	24.3535	$1,551.15	$321.30	$310.23
42808	Excise pharynx lesion		T	0253	16.6341	$1,059.48	$282.20	$211.90
42809	Remove pharynx foreign body		X	0340	0.6416	$40.87		$8.17
42810	Excision of neck cyst		T	0254	24.3535	$1,551.15	$321.30	$310.23
42815	Excision of neck cyst		T	0256	40.5598	$2,583.38		$516.68

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
42820	Remove tonsils and adenoids		T	0258	22.9075	$1,459.05	$437.20	$291.81
42821	Remove tonsils and adenoids		T	0258	22.9075	$1,459.05	$437.20	$291.81
42825	Removal of tonsils		T	0258	22.9075	$1,459.05	$437.20	$291.81
42826	Removal of tonsils		T	0258	22.9075	$1,459.05	$437.20	$291.81
42830	Removal of adenoids		T	0258	22.9075	$1,459.05	$437.20	$291.81
42831	Removal of adenoids		T	0258	22.9075	$1,459.05	$437.20	$291.81
42835	Removal of adenoids		T	0258	22.9075	$1,459.05	$437.20	$291.81
42836	Removal of adenoids		T	0258	22.9075	$1,459.05	$437.20	$291.81
42842	Extensive surgery of throat		T	0254	24.3535	$1,551.15	$321.30	$310.23
42844	Extensive surgery of throat		T	0256	40.5598	$2,583.38		$516.68
42845	Extensive surgery of throat		C					
42860	Excision of tonsil tags		T	0258	22.9075	$1,459.05	$437.20	$291.81
42870	Excision of lingual tonsil		T	0258	22.9075	$1,459.05	$437.20	$291.81
42890	Partial removal of pharynx		T	0256	40.5598	$2,583.38		$516.68
42892	Revision of pharyngeal walls		T	0256	40.5598	$2,583.38		$516.68
42894	Revision of pharyngeal walls		C					
42900	Repair throat wound		T	0252	7.6539	$487.50	$109.10	$97.50
42950	Reconstruction of throat		T	0254	24.3535	$1,551.15	$321.30	$310.23
42953	Repair throat, esophagus		C					
42955	Surgical opening of throat		T	0254	24.3535	$1,551.15	$321.30	$310.23
42960	Control throat bleeding		T	0250	1.1708	$74.57	$25.30	$14.91
42961	Control throat bleeding		C					
42962	Control throat bleeding		T	0256	40.5598	$2,583.38		$516.68
42970	Control nose/throat bleeding		T	0250	1.1708	$74.57	$25.30	$14.91
42971	Control nose/throat bleeding		C					
42972	Control nose/throat bleeding		T	0253	16.6341	$1,059.48	$282.20	$211.90
42999	Throat surgery procedure		T	0251	2.5765	$164.11		$32.82
43020	Incision of esophagus		T	0252	7.6539	$487.50	$109.10	$97.50
43030	Throat muscle surgery		T	0253	16.6341	$1,059.48	$282.20	$211.90
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					
43130	Removal of esophagus pouch		T	0256	40.5598	$2,583.38		$516.68
43135	Removal of esophagus pouch		C					
43200	Esophagus endoscopy		T	0141	8.673	$552.41	$143.30	$110.48
43201	Esoph scope w/submucous inj		T	0141	8.673	$552.41	$143.30	$110.48
43202	Esophagus endoscopy, biopsy		T	0141	8.673	$552.41	$143.30	$110.48
43204	Esoph scope w/sclerosis inj		T	0141	8.673	$552.41	$143.30	$110.48
43205	Esophagus endoscopy/ligation		T	0141	8.673	$552.41	$143.30	$110.48
43215	Esophagus endoscopy		T	0141	8.673	$552.41	$143.30	$110.48
43216	Esophagus endoscopy/lesion		T	0141	8.673	$552.41	$143.30	$110.48
43217	Esophagus endoscopy		T	0141	8.673	$552.41	$143.30	$110.48
43219	Esophagus endoscopy		T	0384	25.2289	$1,606.90		$321.38
43220	Esoph endoscopy, dilation		T	0141	8.673	$552.41	$143.30	$110.48
43226	Esoph endoscopy, dilation		T	0141	8.673	$552.41	$143.30	$110.48
43227	Esoph endoscopy, repair		T	0141	8.673	$552.41	$143.30	$110.48
43228	Esoph endoscopy, ablation		T	0422	24.648	$1,569.91	$445.06	$313.98
43231	Esoph endoscopy w/us exam		T	0141	8.673	$552.41	$143.30	$110.48
43232	Esoph endoscopy w/us fn bx		T	0141	8.673	$552.41	$143.30	$110.48
43234	Upper GI endoscopy, exam		T	0141	8.673	$552.41	$143.30	$110.48
43235	Uppr gi endoscopy, diagnosis		T	0141	8.673	$552.41	$143.30	$110.48
43236	Uppr gi scope w/submuc inj		T	0141	8.673	$552.41	$143.30	$110.48
43237	Endoscopic us exam, esoph		T	0141	8.673	$552.41	$143.30	$110.48
43238	Uppr gi endoscopy w/us fn bx		T	0141	8.673	$552.41	$143.30	$110.48
43239	Upper GI endoscopy, biopsy		T	0141	8.673	$552.41	$143.30	$110.48
43240	Esoph endoscope w/drain cyst		T	0141	8.673	$552.41	$143.30	$110.48
43241	Upper GI endoscopy with tube		T	0141	8.673	$552.41	$143.30	$110.48
43242	Uppr gi endoscopy w/us fn bx		T	0141	8.673	$552.41	$143.30	$110.48
43243	Upper gi endoscopy & inject		T	0141	8.673	$552.41	$143.30	$110.48
43244	Upper GI endoscopy/ligation		T	0141	8.673	$552.41	$143.30	$110.48
43245	Uppr gi scope dilate strictr		T	0141	8.673	$552.41	$143.30	$110.48
43246	Place gastrostomy tube		T	0141	8.673	$552.41	$143.30	$110.48
43247	Operative upper GI endoscopy		T	0141	8.673	$552.41	$143.30	$110.48
43248	Uppr gi endoscopy/guide wire		T	0141	8.673	$552.41	$143.30	$110.48
43249	Esoph endoscopy, dilation		T	0141	8.673	$552.41	$143.30	$110.48
43250	Upper GI endoscopy/tumor		T	0141	8.673	$552.41	$143.30	$110.48
43251	Operative upper GI endoscopy		T	0141	8.673	$552.41	$143.30	$110.48

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
43255	Operative upper GI endoscopy		T	0141	8.673	$552.41	$143.30	$110.48
43256	Uppr gi endoscopy w/stent		T	0384	25.2289	$1,606.90		$321.38
43257	Uppr gi scope w/thrml txmnt		T	0422	24.648	$1,569.91	$445.06	$313.98
43258	Operative upper GI endoscopy		T	0141	8.673	$552.41	$143.30	$110.48
43259	Endoscopic ultrasound exam		T	0141	8.673	$552.41	$143.30	$110.48
43260	Endo cholangiopancreatograph		T	0151	21.282	$1,355.51		$271.10
43261	Endo cholangiopancreatograph		T	0151	21.282	$1,355.51		$271.10
43262	Endo cholangiopancreatograph		T	0151	21.282	$1,355.51		$271.10
43263	Endo cholangiopancreatograph		T	0151	21.282	$1,355.51		$271.10
43264	Endo cholangiopancreatograph		T	0151	21.282	$1,355.51		$271.10
43265	Endo cholangiopancreatograph		T	0151	21.282	$1,355.51		$271.10
43267	Endo cholangiopancreatograph		T	0151	21.282	$1,355.51		$271.10
43268	Endo cholangiopancreatograph		T	0384	25.2289	$1,606.90		$321.38
43269	Endo cholangiopancreatograph		T	0384	25.2289	$1,606.90		$321.38
43271	Endo cholangiopancreatograph		T	0151	21.282	$1,355.51		$271.10
43272	Endo cholangiopancreatograph		T	0151	21.282	$1,355.51		$271.10
43280	Laparoscopy, fundoplasty		T	0132	71.0022	$4,522.34	$1,239.20	$904.47
43289	Laparoscope proc, esoph		T	0130	34.8153	$2,217.49	$659.50	$443.50
43300	Repair of esophagus		C					
43305	Repair esophagus and fistula		C					
43310	Repair of esophagus		C					
43312	Repair esophagus and fistula		C					
43313	Esophagoplasty congenital		C					
43314	Tracheo-esophagoplasty cong		C					
43320	Fuse esophagus & stomach		C					
43324	Revise esophagus & stomach		C					
43325	Revise esophagus & stomach		C					
43326	Revise esophagus & stomach		C					
43330	Repair of esophagus		C					
43331	Repair of esophagus		C					
43340	Fuse esophagus & intestine		C					
43341	Fuse esophagus & intestine		C					
43350	Surgical opening, esophagus		C					
43351	Surgical opening, esophagus		C					
43352	Surgical opening, esophagus		C					
43360	Gastrointestinal repair		C					
43361	Gastrointestinal repair		C					
43400	Ligate esophagus veins		C					
43401	Esophagus surgery for veins		C					
43405	Ligate/staple esophagus		C					
43410	Repair esophagus wound		C					
43415	Repair esophagus wound		C					
43420	Repair esophagus opening		C					
43425	Repair esophagus opening		C					
43450	Dilate esophagus		T	0140	6.0867	$387.68	$91.40	$77.54
43453	Dilate esophagus		T	0140	6.0867	$387.68	$91.40	$77.54
43456	Dilate esophagus		T	0140	6.0867	$387.68	$91.40	$77.54
43458	Dilate esophagus	CH	T	0141	8.673	$552.41	$143.30	$110.48
43460	Pressure treatment esophagus		C					
43496	Free jejunum flap, microvasc		C					
43499	Esophagus surgery procedure		T	0141	8.673	$552.41	$143.30	$110.48
43500	Surgical opening of stomach		C					
43501	Surgical repair of stomach		C					
43502	Surgical repair of stomach		C					
43510	Surgical opening of stomach		T	0141	8.673	$552.41	$143.30	$110.48
43520	Incision of pyloric muscle		C					
43600	Biopsy of stomach		T	0141	8.673	$552.41	$143.30	$110.48
43605	Biopsy of stomach		C					
43610	Excision of stomach lesion		C					
43611	Excision of stomach lesion		C					
43620	Removal of stomach		C					
43621	Removal of stomach		C					
43622	Removal of stomach		C					
43631	Removal of stomach, partial		C					
43632	Removal of stomach, partial		C					
43633	Removal of stomach, partial		C					
43634	Removal of stomach, partial		C					
43635	Removal of stomach, partial		C					
43640	Vagotomy & pylorus repair		C					
43641	Vagotomy & pylorus repair		C					
43644	Lap gastric bypass/roux-en-y		C					
43645	Lap gastr bypass incl smll i		C					
43647	Lap impl electrode, antrum		T	0130	34.8153	$2,217.49	$659.50	$443.50
43648	Lap revise/remv eltrd antrum		T	0130	34.8153	$2,217.49	$659.50	$443.50
43651	Laparoscopy, vagus nerve		T	0132	71.0022	$4,522.34	$1,239.20	$904.47
43652	Laparoscopy, vagus nerve		T	0132	71.0022	$4,522.34	$1,239.20	$904.47
43653	Laparoscopy, gastrostomy		T	0131	46.1201	$2,937.53	$1,001.80	$587.51
43659	Laparoscope proc, stom		T	0130	34.8153	$2,217.49	$659.50	$443.50

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
43750	Place gastrostomy tube		T	0141	8.673	$552.41	$143.30	$110.48
43752	Nasal/orogastric w/stent		X	0272	1.327	$84.52	$31.60	$16.90
43760	Change gastrostomy tube		T	0121	3.2914	$209.64	$43.80	$41.93
43761	Reposition gastrostomy tube	CH	T	0141	8.673	$552.41	$143.30	$110.48
43770	Lap, place gastr adjust band		C					
43771	Lap, revise adjust gast band		C					
43772	Lap, remove adjust gast band		C					
43773	Lap, change adjust gast band		C					
43774	Lap remov adj gast band/port		C					
43800	Reconstruction of pylorus		C					
43810	Fusion of stomach and bowel		C					
43820	Fusion of stomach and bowel		C					
43825	Fusion of stomach and bowel		C					
43830	Place gastrostomy tube		T	0422	24.648	$1,569.91	$445.06	$313.98
43831	Place gastrostomy tube		T	0141	8.673	$552.41	$143.30	$110.48
43832	Place gastrostomy tube		C					
43840	Repair of stomach lesion		C					
43842	V-band gastroplasty		E					
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					
43870	Repair stomach opening		T	0141	8.673	$552.41	$143.30	$110.48
43880	Repair stomach-bowel fistula		C					
43881	Impl/redo electrd, antrum		C					
43882	Revise/remove electrd antrum		C					
43886	Revise gastric port, open	CH	T	0137	20.9338	$1,333.34		$266.67
43887	Remove gastric port, open	CH	T	0135	4.6816	$298.19		$59.64
43888	Change gastric port, open	CH	T	0137	20.9338	$1,333.34		$266.67
43999	Stomach surgery procedure		T	0141	8.673	$552.41	$143.30	$110.48
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	8.673	$552.41	$143.30	$110.48
44110	Excise intestine lesion(s)		C					
44111	Excision of bowel lesion(s)		C					
44120	Removal of small intestine		C					
44121	Removal of small intestine		C					
44125	Removal of small intestine		C					
44126	Enterectomy w/o taper, cong		C					
44127	Enterectomy w/taper, cong		C					
44128	Enterectomy cong, add-on		C					
44130	Bowel to bowel fusion		C					
44132	Enterectomy, cadaver donor		C					
44133	Enterectomy, live donor		C					
44135	Intestine transplnt, cadaver		C					
44136	Intestine transplant, live		C					
44137	Remove intestinal allograft		C					
44139	Mobilization of colon		C					
44140	Partial removal of colon		C					
44141	Partial removal of colon		C					
44143	Partial removal of colon		C					
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	46.1201	$2,937.53	$1,001.80	$587.51
44186	Lap, jejunostomy		T	0131	46.1201	$2,937.53	$1,001.80	$587.51
44187	Lap, ileo/jejuno-stomy		C					
44188	Lap, colostomy		C					
44202	Lap, enterectomy		C					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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	71.0022	$4,522.34	$1,239.20	$904.47
44207	L colectomy/coloproctostomy		T	0132	71.0022	$4,522.34	$1,239.20	$904.47
44208	L colectomy/coloproctostomy		T	0132	71.0022	$4,522.34	$1,239.20	$904.47
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	34.8153	$2,217.49	$659.50	$443.50
44227	Lap, close enterostomy		C					
44238	Laparoscope proc, intestine		T	0130	34.8153	$2,217.49	$659.50	$443.50
44300	Open bowel to skin		C					
44310	Ileostomy/jejunostomy		C					
44312	Revision of ileostomy	CH	T	0137	20.9338	$1,333.34		$266.67
44314	Revision of ileostomy		C					
44316	Devise bowel pouch		C					
44320	Colostomy		C					
44322	Colostomy with biopsies		C					
44340	Revision of colostomy	CH	T	0137	20.9338	$1,333.34		$266.67
44345	Revision of colostomy		C					
44346	Revision of colostomy		C					
44360	Small bowel endoscopy		T	0142	9.6264	$613.13	$152.70	$122.63
44361	Small bowel endoscopy/biopsy		T	0142	9.6264	$613.13	$152.70	$122.63
44363	Small bowel endoscopy		T	0142	9.6264	$613.13	$152.70	$122.63
44364	Small bowel endoscopy		T	0142	9.6264	$613.13	$152.70	$122.63
44365	Small bowel endoscopy		T	0142	9.6264	$613.13	$152.70	$122.63
44366	Small bowel endoscopy		T	0142	9.6264	$613.13	$152.70	$122.63
44369	Small bowel endoscopy		T	0142	9.6264	$613.13	$152.70	$122.63
44370	Small bowel endoscopy/stent		T	0384	25.2289	$1,606.90		$321.38
44372	Small bowel endoscopy		T	0142	9.6264	$613.13	$152.70	$122.63
44373	Small bowel endoscopy		T	0142	9.6264	$613.13	$152.70	$122.63
44376	Small bowel endoscopy		T	0142	9.6264	$613.13	$152.70	$122.63
44377	Small bowel endoscopy/biopsy		T	0142	9.6264	$613.13	$152.70	$122.63
44378	Small bowel endoscopy		T	0142	9.6264	$613.13	$152.70	$122.63
44379	S bowel endoscope w/stent		T	0384	25.2289	$1,606.90		$321.38
44380	Small bowel endoscopy		T	0142	9.6264	$613.13	$152.70	$122.63
44382	Small bowel endoscopy		T	0142	9.6264	$613.13	$152.70	$122.63
44383	Ileoscopy w/stent		T	0384	25.2289	$1,606.90		$321.38
44385	Endoscopy of bowel pouch		T	0143	9.036	$575.53	$186.00	$115.11
44386	Endoscopy, bowel pouch/biop		T	0143	9.036	$575.53	$186.00	$115.11
44388	Colonoscopy		T	0143	9.036	$575.53	$186.00	$115.11
44389	Colonoscopy with biopsy		T	0143	9.036	$575.53	$186.00	$115.11
44390	Colonoscopy for foreign body		T	0143	9.036	$575.53	$186.00	$115.11
44391	Colonoscopy for bleeding		T	0143	9.036	$575.53	$186.00	$115.11
44392	Colonoscopy & polypectomy		T	0143	9.036	$575.53	$186.00	$115.11
44393	Colonoscopy, lesion removal		T	0143	9.036	$575.53	$186.00	$115.11
44394	Colonoscopy w/snare		T	0143	9.036	$575.53	$186.00	$115.11
44397	Colonoscopy w/stent		T	0384	25.2289	$1,606.90		$321.38
44500	Intro, gastrointestinal tube		T	0121	3.2914	$209.64	$43.80	$41.93
44602	Suture, small intestine		C					
44603	Suture, small intestine		C					
44604	Suture, large intestine		C					
44605	Repair of bowel lesion		C					
44615	Intestinal stricturoplasty		C					
44620	Repair bowel opening		C					
44625	Repair bowel opening		C					
44626	Repair bowel opening		C					
44640	Repair bowel-skin fistula		C					
44650	Repair bowel fistula		C					
44660	Repair bowel-bladder fistula		C					
44661	Repair bowel-bladder fistula		C					
44680	Surgical revision, intestine		C					
44700	Suspend bowel w/prosthesis		C					
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	25.4636	$1,621.85	$397.90	$324.37
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	13.9599	$889.15	$228.70	$177.83
44950	Appendectomy		C					
44955	Appendectomy add-on		C					
44960	Appendectomy		C					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
44970	Laparoscopy, appendectomy		T	0131	46.1201	$2,937.53	$1,001.80	$587.51
44979	Laparoscope proc, app		T	0130	34.8153	$2,217.49	$659.50	$443.50
45000	Drainage of pelvic abscess	CH	T	0155	11.6524	$742.18		$148.44
45005	Drainage of rectal abscess		T	0155	11.6524	$742.18		$148.44
45020	Drainage of rectal abscess		T	0155	11.6524	$742.18		$148.44
45100	Biopsy of rectum		T	0149	23.2282	$1,479.47		$295.89
45108	Removal of anorectal lesion		T	0149	23.2282	$1,479.47		$295.89
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					
45150	Excision of rectal stricture		T	0149	23.2282	$1,479.47		$295.89
45160	Excision of rectal lesion		T	0149	23.2282	$1,479.47		$295.89
45170	Excision of rectal lesion		T	0149	23.2282	$1,479.47		$295.89
45190	Destruction, rectal tumor		T	0149	23.2282	$1,479.47		$295.89
45300	Proctosigmoidoscopy dx		T	0146	5.1441	$327.64		$65.53
45303	Proctosigmoidoscopy dilate		T	0147	8.8611	$564.39		$112.88
45305	Proctosigmoidoscopy w/bx		T	0147	8.8611	$564.39		$112.88
45307	Proctosigmoidoscopy fb		T	0428	21.8923	$1,394.39		$278.88
45308	Proctosigmoidoscopy removal		T	0147	8.8611	$564.39		$112.88
45309	Proctosigmoidoscopy removal		T	0147	8.8611	$564.39		$112.88
45315	Proctosigmoidoscopy removal		T	0147	8.8611	$564.39		$112.88
45317	Proctosigmoidoscopy bleed		T	0147	8.8611	$564.39		$112.88
45320	Proctosigmoidoscopy ablate		T	0428	21.8923	$1,394.39		$278.88
45321	Proctosigmoidoscopy volvul		T	0428	21.8923	$1,394.39		$278.88
45327	Proctosigmoidoscopy w/stent		T	0384	25.2289	$1,606.90		$321.38
45330	Diagnostic sigmoidoscopy		T	0146	5.1441	$327.64		$65.53
45331	Sigmoidoscopy and biopsy		T	0146	5.1441	$327.64		$65.53
45332	Sigmoidoscopy w/fb removal		T	0146	5.1441	$327.64		$65.53
45333	Sigmoidoscopy & polypectomy		T	0147	8.8611	$564.39		$112.88
45334	Sigmoidoscopy for bleeding		T	0147	8.8611	$564.39		$112.88
45335	Sigmoidoscopy w/submuc inj		T	0146	5.1441	$327.64		$65.53
45337	Sigmoidoscopy & decompress		T	0146	5.1441	$327.64		$65.53
45338	Sigmoidoscopy w/tumr remove		T	0147	8.8611	$564.39		$112.88
45339	Sigmoidoscopy w/ablate tumr		T	0147	8.8611	$564.39		$112.88
45340	Sig w/balloon dilation		T	0147	8.8611	$564.39		$112.88
45341	Sigmoidoscopy w/ultrasound		T	0147	8.8611	$564.39		$112.88
45342	Sigmoidoscopy w/us guide bx		T	0147	8.8611	$564.39		$112.88
45345	Sigmoidoscopy w/stent		T	0384	25.2289	$1,606.90		$321.38
45355	Surgical colonoscopy		T	0143	9.036	$575.53	$186.00	$115.11
45378	Diagnostic colonoscopy		T	0143	9.036	$575.53	$186.00	$115.11
45379	Colonoscopy w/fb removal		T	0143	9.036	$575.53	$186.00	$115.11
45380	Colonoscopy and biopsy		T	0143	9.036	$575.53	$186.00	$115.11
45381	Colonoscopy, submucous inj		T	0143	9.036	$575.53	$186.00	$115.11
45382	Colonoscopy/control bleeding		T	0143	9.036	$575.53	$186.00	$115.11
45383	Lesion removal colonoscopy		T	0143	9.036	$575.53	$186.00	$115.11
45384	Lesion remove colonoscopy		T	0143	9.036	$575.53	$186.00	$115.11
45385	Lesion removal colonoscopy		T	0143	9.036	$575.53	$186.00	$115.11
45386	Colonoscopy dilate stricture		T	0143	9.036	$575.53	$186.00	$115.11
45387	Colonoscopy w/stent		T	0384	25.2289	$1,606.90		$321.38
45391	Colonoscopy w/endoscope us		T	0143	9.036	$575.53	$186.00	$115.11
45392	Colonoscopy w/endoscopic fnb		T	0143	9.036	$575.53	$186.00	$115.11
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	34.8153	$2,217.49	$659.50	$443.50
45500	Repair of rectum		T	0149	23.2282	$1,479.47		$295.89
45505	Repair of rectum		T	0150	30.5544	$1,946.10	$437.10	$389.22
45520	Treatment of rectal prolapse	CH	T	0013	0.8046	$51.25		$10.25
45540	Correct rectal prolapse		C					
45541	Correct rectal prolapse		T	0150	30.5544	$1,946.10	$437.10	$389.22
45550	Repair rectum/remove sigmoid		C					
45560	Repair of rectocele		T	0150	30.5544	$1,946.10	$437.10	$389.22
45562	Exploration/repair of rectum		C					
45563	Exploration/repair of rectum		C					
45800	Repair rect/bladder fistula		C					
45805	Repair fistula w/colostomy		C					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
45820	Repair rectourethral fistula		C					
45825	Repair fistula w/colostomy		C					
45900	Reduction of rectal prolapse		T	0148	4.5189	$287.82		$57.56
45905	Dilation of anal sphincter		T	0149	23.2282	$1,479.47		$295.89
45910	Dilation of rectal narrowing		T	0149	23.2282	$1,479.47		$295.89
45915	Remove rectal obstruction	CH	T	0155	11.6524	$742.18		$148.44
45990	Surg dx exam, anorectal	CH	T	0149	23.2282	$1,479.47		$295.89
45999	Rectum surgery procedure		T	0148	4.5189	$287.82		$57.56
46020	Placement of seton		T	0149	23.2282	$1,479.47		$295.89
46030	Removal of rectal marker		T	0148	4.5189	$287.82		$57.56
46040	Incision of rectal abscess		T	0149	23.2282	$1,479.47		$295.89
46045	Incision of rectal abscess		T	0149	23.2282	$1,479.47		$295.89
46050	Incision of anal abscess	CH	T	0155	11.6524	$742.18		$148.44
46060	Incision of rectal abscess		T	0149	23.2282	$1,479.47		$295.89
46070	Incision of anal septum		T	0155	11.6524	$742.18		$148.44
46080	Incision of anal sphincter		T	0149	23.2282	$1,479.47		$295.89
46083	Incise external hemorrhoid		T	0164	2.1659	$137.95		$27.59
46200	Removal of anal fissure		T	0149	23.2282	$1,479.47		$295.89
46210	Removal of anal crypt		T	0149	23.2282	$1,479.47		$295.89
46211	Removal of anal crypts		T	0149	23.2282	$1,479.47		$295.89
46220	Removal of anal tag		T	0149	23.2282	$1,479.47		$295.89
46221	Ligation of hemorrhoid(s)		T	0148	4.5189	$287.82		$57.56
46230	Removal of anal tags		T	0149	23.2282	$1,479.47		$295.89
46250	Hemorrhoidectomy		T	0149	23.2282	$1,479.47		$295.89
46255	Hemorrhoidectomy		T	0149	23.2282	$1,479.47		$295.89
46257	Remove hemorrhoids & fissure		T	0149	23.2282	$1,479.47		$295.89
46258	Remove hemorrhoids & fistula		T	0149	23.2282	$1,479.47		$295.89
46260	Hemorrhoidectomy		T	0149	23.2282	$1,479.47		$295.89
46261	Remove hemorrhoids & fissure		T	0149	23.2282	$1,479.47		$295.89
46262	Remove hemorrhoids & fistula		T	0149	23.2282	$1,479.47		$295.89
46270	Removal of anal fistula		T	0149	23.2282	$1,479.47		$295.89
46275	Removal of anal fistula		T	0149	23.2282	$1,479.47		$295.89
46280	Removal of anal fistula		T	0149	23.2282	$1,479.47		$295.89
46285	Removal of anal fistula		T	0149	23.2282	$1,479.47		$295.89
46288	Repair anal fistula		T	0149	23.2282	$1,479.47		$295.89
46320	Removal of hemorrhoid clot	CH	T	0149	23.2282	$1,479.47		$295.89
46500	Injection into hemorrhoid(s)		T	0155	11.6524	$742.18		$148.44
46505	Chemodenervation anal musc		T	0148	4.5189	$287.82		$57.56
46600	Diagnostic anoscopy		X	0340	0.6416	$40.87		$8.17
46604	Anoscopy and dilation		T	0147	8.8611	$564.39		$112.88
46606	Anoscopy and biopsy		T	0146	5.1441	$327.64		$65.53
46608	Anoscopy, remove for body		T	0147	8.8611	$564.39		$112.88
46610	Anoscopy, remove lesion		T	0428	21.8923	$1,394.39		$278.88
46611	Anoscopy		T	0147	8.8611	$564.39		$112.88
46612	Anoscopy, remove lesions		T	0428	21.8923	$1,394.39		$278.88
46614	Anoscopy, control bleeding		T	0146	5.1441	$327.64		$65.53
46615	Anoscopy		T	0428	21.8923	$1,394.39		$278.88
46700	Repair of anal stricture		T	0149	23.2282	$1,479.47		$295.89
46705	Repair of anal stricture		C					
46706	Repr of anal fistula w/glue		T	0150	30.5544	$1,946.10	$437.10	$389.22
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					
46750	Repair of anal sphincter	CH	T	0150	30.5544	$1,946.10	$437.10	$389.22
46751	Repair of anal sphincter		C					
46753	Reconstruction of anus		T	0149	23.2282	$1,479.47		$295.89
46754	Removal of suture from anus		T	0149	23.2282	$1,479.47		$295.89
46760	Repair of anal sphincter	CH	T	0150	30.5544	$1,946.10	$437.10	$389.22
46761	Repair of anal sphincter	CH	T	0150	30.5544	$1,946.10	$437.10	$389.22
46762	Implant artificial sphincter	CH	T	0150	30.5544	$1,946.10	$437.10	$389.22
46900	Destruction, anal lesion(s)		T	0016	2.7493	$175.11		$35.02
46910	Destruction, anal lesion(s)		T	0017	20.0977	$1,280.08		$256.02
46916	Cryosurgery, anal lesion(s)	CH	T	0015	1.5119	$96.30		$19.26
46917	Laser surgery, anal lesions	CH	T	0017	20.0977	$1,280.08		$256.02
46922	Excision of anal lesion(s)	CH	T	0017	20.0977	$1,280.08		$256.02
46924	Destruction, anal lesion(s)	CH	T	0017	20.0977	$1,280.08		$256.02
46934	Destruction of hemorrhoids		T	0155	11.6524	$742.18		$148.44
46935	Destruction of hemorrhoids		T	0155	11.6524	$742.18		$148.44
46936	Destruction of hemorrhoids		T	0149	23.2282	$1,479.47		$295.89
46937	Cryotherapy of rectal lesion		T	0149	23.2282	$1,479.47		$295.89

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
46938	Cryotherapy of rectal lesion		T	0150	30.5544	$1,946.10	$437.10	$389.22
46940	Treatment of anal fissure		T	0149	23.2282	$1,479.47		$295.89
46942	Treatment of anal fissure		T	0148	4.5189	$287.82		$57.56
46945	Ligation of hemorrhoids		T	0155	11.6524	$742.18		$148.44
46946	Ligation of hemorrhoids		T	0155	11.6524	$742.18		$148.44
46947	Hemorrhoidopexy by stapling		T	0150	30.5544	$1,946.10	$437.10	$389.22
46999	Anus surgery procedure		T	0148	4.5189	$287.82		$57.56
47000	Needle biopsy of liver		T	0685	9.5741	$609.80		$121.96
47001	Needle biopsy, liver add-on		N					
47010	Open drainage, liver lesion		C					
47011	Percut drain, liver lesion		T	0037	13.9599	$889.15	$228.70	$177.83
47015	Inject/aspirate liver cyst		C					
47100	Wedge biopsy of liver		C					
47120	Partial removal of liver		C					
47122	Extensive removal of liver		C					
47125	Partial removal of liver		C					
47130	Partial removal of liver		C					
47133	Removal of donor liver		C					
47135	Transplantation of liver		C					
47136	Transplantation of liver		C					
47140	Partial removal, donor liver		C					
47141	Partial removal, donor liver		C					
47142	Partial removal, donor liver		C					
47143	Prep donor liver, whole		C					
47144	Prep donor liver, 3-segment		C					
47145	Prep donor liver, lobe split		C					
47146	Prep donor liver/venous		C					
47147	Prep donor liver/arterial		C					
47300	Surgery for liver lesion		C					
47350	Repair liver wound		C					
47360	Repair liver wound		C					
47361	Repair liver wound		C					
47362	Repair liver wound		C					
47370	Laparo ablate liver tumor rf		T	0132	71.0022	$4,522.34	$1,239.20	$904.47
47371	Laparo ablate liver cryosurg		T	0131	46.1201	$2,937.53	$1,001.80	$587.51
47379	Laparoscope procedure, liver		T	0130	34.8153	$2,217.49	$659.50	$443.50
47380	Open ablate liver tumor rf		C					
47381	Open ablate liver tumor cryo		C					
47382	Percut ablate liver rf		T	0423	44.1192	$2,810.08		$562.02
47399	Liver surgery procedure		T	0004	4.5062	$287.01		$57.40
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	28.7304	$1,829.93		$365.99
47500	Injection for liver x-rays		N					
47505	Injection for liver x-rays		N					
47510	Insert catheter, bile duct		T	0152	28.7304	$1,829.93		$365.99
47511	Insert bile duct drain		T	0152	28.7304	$1,829.93		$365.99
47525	Change bile duct catheter		T	0427	14.8912	$948.47		$189.69
47530	Revise/reinsert bile tube		T	0427	14.8912	$948.47		$189.69
47550	Bile duct endoscopy add-on		C					
47552	Biliary endoscopy thru skin		T	0152	28.7304	$1,829.93		$365.99
47553	Biliary endoscopy thru skin		T	0152	28.7304	$1,829.93		$365.99
47554	Biliary endoscopy thru skin		T	0152	28.7304	$1,829.93		$365.99
47555	Biliary endoscopy thru skin		T	0152	28.7304	$1,829.93		$365.99
47556	Biliary endoscopy thru skin		T	0152	28.7304	$1,829.93		$365.99
47560	Laparoscopy w/cholangio		T	0130	34.8153	$2,217.49	$659.50	$443.50
47561	Laparo w/cholangio/biopsy		T	0130	34.8153	$2,217.49	$659.50	$443.50
47562	Laparoscopic cholecystectomy		T	0131	46.1201	$2,937.53	$1,001.80	$587.51
47563	Laparo cholecystectomy/graph		T	0131	46.1201	$2,937.53	$1,001.80	$587.51
47564	Laparo cholecystectomy/explr		T	0131	46.1201	$2,937.53	$1,001.80	$587.51
47570	Laparo cholecystoenterostomy		C					
47579	Laparoscope proc, biliary		T	0130	34.8153	$2,217.49	$659.50	$443.50
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	28.7304	$1,829.93		$365.99
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					
47719	Fusion of bile duct cyst		C					
47720	Fuse gallbladder & bowel		C					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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	28.7304	$1,829.93		$365.99
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	9.5741	$609.80		$121.96
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					
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	13.9599	$889.15	$228.70	$177.83
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	4.5062	$287.01		$57.40
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	13.9599	$889.15	$228.70	$177.83
49040	Drain, open, abdom abscess		C					
49041	Drain, percut, abdom abscess		T	0037	13.9599	$889.15	$228.70	$177.83
49060	Drain, open, retrop abscess		C					
49061	Drain, percut, retroper absc		T	0037	13.9599	$889.15	$228.70	$177.83
49062	Drain to peritoneal cavity		C					
49080	Puncture, peritoneal cavity		T	0070	5.3095	$338.18		$67.64
49081	Removal of abdominal fluid		T	0070	5.3095	$338.18		$67.64
49180	Biopsy, abdominal mass		T	0685	9.5741	$609.80		$121.96
49200	Removal of abdominal lesion		T	0130	34.8153	$2,217.49	$659.50	$443.50
49201	Remove abdom lesion, complex		C					
49215	Excise sacral spine tumor		C					
49220	Multiple surgery, abdomen		C					
49250	Excision of umbilicus		T	0153	25.4636	$1,621.85	$397.90	$324.37
49255	Removal of omentum		C					
49320	Diag laparo separate proc		T	0130	34.8153	$2,217.49	$659.50	$443.50
49321	Laparoscopy, biopsy		T	0130	34.8153	$2,217.49	$659.50	$443.50
49322	Laparoscopy, aspiration		T	0130	34.8153	$2,217.49	$659.50	$443.50
49323	Laparo drain lymphocele		T	0130	34.8153	$2,217.49	$659.50	$443.50
49324	Lap insertion perm ip cath		T	0130	34.8153	$2,217.49	$659.50	$443.50
49325	Lap revision perm ip cath		T	0130	34.8153	$2,217.49	$659.50	$443.50
49326	Lap w/omentopexy add-on		T	0130	34.8153	$2,217.49	$659.50	$443.50
49329	Laparo proc, abdm/per/oment		T	0130	34.8153	$2,217.49	$659.50	$443.50
49400	Air injection into abdomen		N					
49402	Remove foreign body, adbomen		T	0153	25.4636	$1,621.85	$397.90	$324.37
49419	Insrt abdom cath for chemotx		T	0115	30.5379	$1,945.05		$389.01
49420	Insert abdom drain, temp		T	0652	31.7598	$2,022.88		$404.58
49421	Insert abdom drain, perm		T	0652	31.7598	$2,022.88		$404.58
49422	Remove perm cannula/catheter		T	0105	24.7274	$1,574.96	$370.40	$314.99
49423	Exchange drainage catheter		T	0427	14.8912	$948.47		$189.69

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
49424	Assess cyst, contrast inject		N					
49425	Insert abdomen-venous drain		C					
49426	Revise abdomen-venous shunt		T	0153	25.4636	$1,621.85	$397.90	$324.37
49427	Injection, abdominal shunt		N					
49428	Ligation of shunt		C					
49429	Removal of shunt		T	0105	24.7274	$1,574.96	$370.40	$314.99
49435	Insert subq exten to ip cath		T	0427	14.8912	$948.47		$189.69
49436	Embedded ip cath exit-site		T	0427	14.8912	$948.47		$189.69
49491	Rpr hern preemie reduc		T	0154	31.1722	$1,985.45	$464.80	$397.09
49492	Rpr ing hern premie, blocked		T	0154	31.1722	$1,985.45	$464.80	$397.09
49495	Rpr ing hernia baby, reduc		T	0154	31.1722	$1,985.45	$464.80	$397.09
49496	Rpr ing hernia baby, blocked		T	0154	31.1722	$1,985.45	$464.80	$397.09
49500	Rpr ing hernia, init, reduce		T	0154	31.1722	$1,985.45	$464.80	$397.09
49501	Rpr ing hernia, init blocked		T	0154	31.1722	$1,985.45	$464.80	$397.09
49505	Prp i/hern init reduc >5 yr		T	0154	31.1722	$1,985.45	$464.80	$397.09
49507	Prp i/hern init block >5 yr		T	0154	31.1722	$1,985.45	$464.80	$397.09
49520	Rerepair ing hernia, reduce		T	0154	31.1722	$1,985.45	$464.80	$397.09
49521	Rerepair ing hernia, blocked		T	0154	31.1722	$1,985.45	$464.80	$397.09
49525	Repair ing hernia, sliding		T	0154	31.1722	$1,985.45	$464.80	$397.09
49540	Repair lumbar hernia		T	0154	31.1722	$1,985.45	$464.80	$397.09
49550	Rpr rem hernia, init, reduce		T	0154	31.1722	$1,985.45	$464.80	$397.09
49553	Rpr fem hernia, init blocked		T	0154	31.1722	$1,985.45	$464.80	$397.09
49555	Rerepair fem hernia, reduce		T	0154	31.1722	$1,985.45	$464.80	$397.09
49557	Rerepair fem hernia, blocked		T	0154	31.1722	$1,985.45	$464.80	$397.09
49560	Rpr ventral hern init, reduc		T	0154	31.1722	$1,985.45	$464.80	$397.09
49561	Rpr ventral hern init, block		T	0154	31.1722	$1,985.45	$464.80	$397.09
49565	Rerepair ventrl hern, reduce		T	0154	31.1722	$1,985.45	$464.80	$397.09
49566	Rerepair ventrl hern, block		T	0154	31.1722	$1,985.45	$464.80	$397.09
49568	Hernia repair w/mesh		T	0154	31.1722	$1,985.45	$464.80	$397.09
49570	Rpr epigastric hern, reduce		T	0154	31.1722	$1,985.45	$464.80	$397.09
49572	Rpr epigastric hern, blocked		T	0154	31.1722	$1,985.45	$464.80	$397.09
49580	Rpr umbil hern, reduc < 5 yr		T	0154	31.1722	$1,985.45	$464.80	$397.09
49582	Rpr umbil hern, block < 5 yr		T	0154	31.1722	$1,985.45	$464.80	$397.09
49585	Rpr umbil hern, reduc > 5 yr		T	0154	31.1722	$1,985.45	$464.80	$397.09
49587	Rpr umbil hern, block > 5 yr		T	0154	31.1722	$1,985.45	$464.80	$397.09
49590	Repair spigelian hernia		T	0154	31.1722	$1,985.45	$464.80	$397.09
49600	Repair umbilical lesion		T	0154	31.1722	$1,985.45	$464.80	$397.09
49605	Repair umbilical lesion		C					
49606	Repair umbilical lesion		C					
49610	Repair umbilical lesion		C					
49611	Repair umbilical lesion		C					
49650	Laparo hernia repair initial		T	0131	46.1201	$2,937.53	$1,001.80	$587.51
49651	Laparo hernia repair recur		T	0131	46.1201	$2,937.53	$1,001.80	$587.51
49659	Laparo proc, hernia repair		T	0130	34.8153	$2,217.49	$659.50	$443.50
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	25.4636	$1,621.85	$397.90	$324.37
50010	Exploration of kidney		C					
50020	Renal abscess, open drain		T	0162	25.2775	$1,610.00		$322.00
50021	Renal abscess, percut drain		T	0037	13.9599	$889.15	$228.70	$177.83
50040	Drainage of kidney		C					
50045	Exploration of kidney		C					
5005F	Pt counsld on exam for moles		M					
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	45.9021	$2,923.64		$584.73
50081	Removal of kidney stone		T	0429	45.9021	$2,923.64		$584.73
50100	Revise kidney blood vessels		C					
5010F	Macul+fndngs to dr mng dm		M					
50120	Exploration of kidney		C					
50125	Explore and drain kidney		C					
50130	Removal of kidney stone		C					
50135	Exploration of kidney		C					
5015F	Doc fx & test/txmnt for op		M					
50200	Biopsy of kidney		T	0685	9.5741	$609.80		$121.96
50205	Biopsy of kidney		C					
50220	Remove kidney, open		C					
50225	Removal kidney open, complex		C					
50230	Removal kidney open, radical		C					
50234	Removal of kidney & ureter		C					
50236	Removal of kidney & ureter		C					
50240	Partial removal of kidney		C					
50250	Cryoablate renal mass open		C					
50280	Removal of kidney lesion		C					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
50382	Change ureter stent, percut	CH	T	0162	25.2775	$1,610.00		$322.00
50384	Remove ureter stent, percut		T	0161	18.1376	$1,155.24	$243.72	$231.05
50387	Change ext/int ureter stent	CH	T	0427	14.8912	$948.47		$189.69
50389	Remove renal tube w/fluoro	CH	T	0160	6.1077	$389.02		$77.80
50390	Drainage of kidney lesion		T	0685	9.5741	$609.80		$121.96
50391	Instll rx agnt into rnal tub		T	0126	1.085	$69.11	$16.40	$13.82
50392	Insert kidney drain		T	0161	18.1376	$1,155.24	$243.72	$231.05
50393	Insert ureteral tube	CH	T	0162	25.2775	$1,610.00		$322.00
50394	Injection for kidney x-ray		N					
50395	Create passage to kidney		T	0161	18.1376	$1,155.24	$243.72	$231.05
50396	Measure kidney pressure		T	0164	2.1659	$137.95		$27.59
50398	Change kidney tube	CH	T	0427	14.8912	$948.47		$189.69
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	34.8153	$2,217.49	$659.50	$443.50
50542	Laparo ablate renal mass		T	0132	71.0022	$4,522.34	$1,239.20	$904.47
50543	Laparo partial nephrectomy		T	0131	46.1201	$2,937.53	$1,001.80	$587.51
50544	Laparoscopy, pyeloplasty		T	0130	34.8153	$2,217.49	$659.50	$443.50
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	34.8153	$2,217.49	$659.50	$443.50
50551	Kidney endoscopy		T	0160	6.1077	$389.02		$77.80
50553	Kidney endoscopy	CH	T	0162	25.2775	$1,610.00		$322.00
50555	Kidney endoscopy & biopsy		T	0160	6.1077	$389.02		$77.80
50557	Kidney endoscopy & treatment		T	0162	25.2775	$1,610.00		$322.00
50561	Kidney endoscopy & treatment	CH	T	0162	25.2775	$1,610.00		$322.00
50562	Renal scope w/tumor resect		T	0160	6.1077	$389.02		$77.80
50570	Kidney endoscopy		T	0160	6.1077	$389.02		$77.80
50572	Kidney endoscopy		T	0160	6.1077	$389.02		$77.80
50574	Kidney endoscopy & biopsy		T	0160	6.1077	$389.02		$77.80
50575	Kidney endoscopy		T	0163	36.9175	$2,351.39		$470.28
50576	Kidney endoscopy & treatment		T	0161	18.1376	$1,155.24	$243.72	$231.05
50580	Kidney endoscopy & treatment	CH	T	0161	18.1376	$1,155.24	$243.72	$231.05
50590	Fragmenting of kidney stone		T	0169	43.0352	$2,741.04	$1,009.40	$548.21
50592	Perc rf ablate renal tumor		T	0423	44.1192	$2,810.08		$562.02
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	1.085	$69.11	$16.40	$13.82
50688	Change of ureter tube/stent	CH	T	0427	14.8912	$948.47		$189.69
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		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					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
50945	Laparoscopy ureterolithotomy		T	0131	46.1201	$2,937.53	$1,001.80	$587.51
50947	Laparo new ureter/bladder		T	0131	46.1201	$2,937.53	$1,001.80	$587.51
50948	Laparo new ureter/bladder		T	0131	46.1201	$2,937.53	$1,001.80	$587.51
50949	Laparoscope proc, ureter		T	0130	34.8153	$2,217.49	$659.50	$443.50
50951	Endoscopy of ureter		T	0160	6.1077	$389.02		$77.80
50953	Endoscopy of ureter		T	0160	6.1077	$389.02		$77.80
50955	Ureter endoscopy & biopsy	CH	T	0162	25.2775	$1,610.00		$322.00
50957	Ureter endoscopy & treatment	CH	T	0162	25.2775	$1,610.00		$322.00
50961	Ureter endoscopy & treatment	CH	T	0162	25.2775	$1,610.00		$322.00
50970	Ureter endoscopy		T	0160	6.1077	$389.02		$77.80
50972	Ureter endoscopy & catheter		T	0160	6.1077	$389.02		$77.80
50974	Ureter endoscopy & biopsy		T	0161	18.1376	$1,155.24	$243.72	$231.05
50976	Ureter endoscopy & treatment		T	0161	18.1376	$1,155.24	$243.72	$231.05
50980	Ureter endoscopy & treatment	CH	T	0162	25.2775	$1,610.00		$322.00
51000	Drainage of bladder		T	0164	2.1659	$137.95		$27.59
51005	Drainage of bladder		T	0126	1.085	$69.11	$16.40	$13.82
51010	Drainage of bladder		T	0165	19.6126	$1,249.19		$249.84
51020	Incise & treat bladder		T	0162	25.2775	$1,610.00		$322.00
51030	Incise & treat bladder		T	0162	25.2775	$1,610.00		$322.00
51040	Incise & drain bladder		T	0162	25.2775	$1,610.00		$322.00
51045	Incise bladder/drain ureter		T	0160	6.1077	$389.02		$77.80
51050	Removal of bladder stone		T	0162	25.2775	$1,610.00		$322.00
51060	Removal of ureter stone		C					
51065	Remove ureter calculus		T	0162	25.2775	$1,610.00		$322.00
51080	Drainage of bladder abscess		T	0008	19.0457	$1,213.08		$242.62
51500	Removal of bladder cyst		T	0154	31.1722	$1,985.45	$464.80	$397.09
51520	Removal of bladder lesion		T	0162	25.2775	$1,610.00		$322.00
51525	Removal of bladder lesion		C					
51530	Removal of bladder lesion		C					
51535	Repair of ureter lesion	CH	T	0162	25.2775	$1,610.00		$322.00
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	2.1659	$137.95		$27.59
51701	Insert bladder catheter		X	0340	0.6416	$40.87		$8.17
51702	Insert temp bladder cath		X	0340	0.6416	$40.87		$8.17
51703	Insert bladder cath, complex		T	0126	1.085	$69.11	$16.40	$13.82
51705	Change of bladder tube	CH	T	0164	2.1659	$137.95		$27.59
51710	Change of bladder tube	CH	T	0427	14.8912	$948.47		$189.69
51715	Endoscopic injection/implant		T	0168	30.1994	$1,923.49	$388.10	$384.70
51720	Treatment of bladder lesion		T	0164	2.1659	$137.95		$27.59
51725	Simple cystometrogram	CH	T	0156	3.0601	$194.91		$38.98
51726	Complex cystometrogram		T	0156	3.0601	$194.91		$38.98
51736	Urine flow measurement		T	0126	1.085	$69.11	$16.40	$13.82
51741	Electro-uroflowmetry, first		T	0126	1.085	$69.11	$16.40	$13.82
51772	Urethra pressure profile		T	0164	2.1659	$137.95		$27.59
51784	Anal/urinary muscle study		T	0126	1.085	$69.11	$16.40	$13.82
51785	Anal/urinary muscle study		T	0126	1.085	$69.11	$16.40	$13.82
51792	Urinary reflex study		T	0126	1.085	$69.11	$16.40	$13.82
51795	Urine voiding pressure study		T	0164	2.1659	$137.95		$27.59
51797	Intraabdominal pressure test		T	0164	2.1659	$137.95		$27.59
51798	Us urine capacity measure		X	0340	0.6416	$40.87		$8.17

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
51800	Revision of bladder/urethra		C					
51820	Revision of urinary tract		C					
51840	Attach bladder/urethra		C					
51841	Attach bladder/urethra		C					
51845	Repair bladder neck		C					
51860	Repair of bladder wound		C					
51865	Repair of bladder wound		C					
51880	Repair of bladder opening		T	0162	25.2775	$1,610.00		$322.00
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	46.1201	$2,937.53	$1,001.80	$587.51
51992	Laparo sling operation		T	0131	46.1201	$2,937.53	$1,001.80	$587.51
51999	Laparoscope proc, bla		T	0130	34.8153	$2,217.49	$659.50	$443.50
52000	Cystoscopy		T	0160	6.1077	$389.02		$77.80
52001	Cystoscopy, removal of clots	CH	T	0161	18.1376	$1,155.24	$243.72	$231.05
52005	Cystoscopy & ureter catheter		T	0161	18.1376	$1,155.24	$243.72	$231.05
52007	Cystoscopy and biopsy	CH	T	0162	25.2775	$1,610.00		$322.00
52010	Cystoscopy & duct catheter		T	0160	6.1077	$389.02		$77.80
52204	Cystoscopy w/biopsy(s)		T	0161	18.1376	$1,155.24	$243.72	$231.05
52214	Cystoscopy and treatment		T	0162	25.2775	$1,610.00		$322.00
52224	Cystoscopy and treatment		T	0162	25.2775	$1,610.00		$322.00
52234	Cystoscopy and treatment		T	0162	25.2775	$1,610.00		$322.00
52235	Cystoscopy and treatment		T	0162	25.2775	$1,610.00		$322.00
52240	Cystoscopy and treatment		T	0162	25.2775	$1,610.00		$322.00
52250	Cystoscopy and radiotracer		T	0162	25.2775	$1,610.00		$322.00
52260	Cystoscopy and treatment		T	0161	18.1376	$1,155.24	$243.72	$231.05
52265	Cystoscopy and treatment		T	0160	6.1077	$389.02		$77.80
52270	Cystoscopy & revise urethra		T	0161	18.1376	$1,155.24	$243.72	$231.05
52275	Cystoscopy & revise urethra	CH	T	0162	25.2775	$1,610.00		$322.00
52276	Cystoscopy and treatment	CH	T	0162	25.2775	$1,610.00		$322.00
52277	Cystoscopy and treatment		T	0162	25.2775	$1,610.00		$322.00
52281	Cystoscopy and treatment		T	0161	18.1376	$1,155.24	$243.72	$231.05
52282	Cystoscopy, implant stent		T	0163	36.9175	$2,351.39		$470.28
52283	Cystoscopy and treatment	CH	T	0162	25.2775	$1,610.00		$322.00
52285	Cystoscopy and treatment		T	0161	18.1376	$1,155.24	$243.72	$231.05
52290	Cystoscopy and treatment		T	0161	18.1376	$1,155.24	$243.72	$231.05
52300	Cystoscopy and treatment	CH	T	0162	25.2775	$1,610.00		$322.00
52301	Cystoscopy and treatment	CH	T	0162	25.2775	$1,610.00		$322.00
52305	Cystoscopy and treatment	CH	T	0162	25.2775	$1,610.00		$322.00
52310	Cystoscopy and treatment	CH	T	0161	18.1376	$1,155.24	$243.72	$231.05
52315	Cystoscopy and treatment	CH	T	0162	25.2775	$1,610.00		$322.00
52317	Remove bladder stone		T	0162	25.2775	$1,610.00		$322.00
52318	Remove bladder stone		T	0162	25.2775	$1,610.00		$322.00
52320	Cystoscopy and treatment		T	0162	25.2775	$1,610.00		$322.00
52325	Cystoscopy, stone removal		T	0162	25.2775	$1,610.00		$322.00
52327	Cystoscopy, inject material		T	0162	25.2775	$1,610.00		$322.00
52330	Cystoscopy and treatment		T	0162	25.2775	$1,610.00		$322.00
52332	Cystoscopy and treatment		T	0162	25.2775	$1,610.00		$322.00
52334	Create passage to kidney		T	0162	25.2775	$1,610.00		$322.00
52341	Cysto w/ureter stricture tx		T	0162	25.2775	$1,610.00		$322.00
52342	Cysto w/up stricture tx		T	0162	25.2775	$1,610.00		$322.00
52343	Cysto w/renal stricture tx		T	0162	25.2775	$1,610.00		$322.00
52344	Cysto/uretero, stricture tx		T	0162	25.2775	$1,610.00		$322.00
52345	Cysto/uretero w/up stricture		T	0162	25.2775	$1,610.00		$322.00
52346	Cystouretero w/renal strict		T	0162	25.2775	$1,610.00		$322.00
52351	Cystouretero & or pyeloscope	CH	T	0162	25.2775	$1,610.00		$322.00
52352	Cystouretero w/stone remove		T	0162	25.2775	$1,610.00		$322.00
52353	Cystouretero w/lithotripsy		T	0163	36.9175	$2,351.39		$470.28
52354	Cystouretero w/biopsy		T	0162	25.2775	$1,610.00		$322.00
52355	Cystouretero w/excise tumor		T	0162	25.2775	$1,610.00		$322.00
52400	Cystouretero w/congen repr		T	0162	25.2775	$1,610.00		$322.00
52402	Cystourethro cut ejacul duct		T	0162	25.2775	$1,610.00		$322.00
52450	Incision of prostate		T	0162	25.2775	$1,610.00		$322.00
52500	Revision of bladder neck		T	0162	25.2775	$1,610.00		$322.00
52510	Dilation prostatic urethra	CH	T	0162	25.2775	$1,610.00		$322.00
52601	Prostatectomy (TURP)		T	0163	36.9175	$2,351.39		$470.28
52606	Control postop bleeding		T	0162	25.2775	$1,610.00		$322.00
52612	Prostatectomy, first stage		T	0163	36.9175	$2,351.39		$470.28
52614	Prostatectomy, second stage		T	0163	36.9175	$2,351.39		$470.28
52620	Remove residual prostate		T	0163	36.9175	$2,351.39		$470.28
52630	Remove prostate regrowth		T	0163	36.9175	$2,351.39		$470.28
52640	Relieve bladder contracture		T	0162	25.2775	$1,610.00		$322.00
52647	Laser surgery of prostate		T	0429	45.9021	$2,923.64		$584.73
52648	Laser surgery of prostate		T	0429	45.9021	$2,923.64		$584.73

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
52700	Drainage of prostate abscess		T	0162	25.2775	$1,610.00		$322.00
53000	Incision of urethra		T	0166	19.657	$1,252.01		$250.40
53010	Incision of urethra		T	0166	19.657	$1,252.01		$250.40
53020	Incision of urethra		T	0166	19.657	$1,252.01		$250.40
53025	Incision of urethra		T	0166	19.657	$1,252.01		$250.40
53040	Drainage of urethra abscess		T	0166	19.657	$1,252.01		$250.40
53060	Drainage of urethra abscess		T	0166	19.657	$1,252.01		$250.40
53080	Drainage of urinary leakage		T	0166	19.657	$1,252.01		$250.40
53085	Drainage of urinary leakage		T	0166	19.657	$1,252.01		$250.40
53200	Biopsy of urethra		T	0166	19.657	$1,252.01		$250.40
53210	Removal of urethra		T	0168	30.1994	$1,923.49	$388.10	$384.70
53215	Removal of urethra		T	0166	19.657	$1,252.01		$250.40
53220	Treatment of urethra lesion		T	0168	30.1994	$1,923.49	$388.10	$384.70
53230	Removal of urethra lesion		T	0168	30.1994	$1,923.49	$388.10	$384.70
53235	Removal of urethra lesion		T	0166	19.657	$1,252.01		$250.40
53240	Surgery for urethra pouch		T	0168	30.1994	$1,923.49	$388.10	$384.70
53250	Removal of urethra gland		T	0166	19.657	$1,252.01		$250.40
53260	Treatment of urethra lesion		T	0166	19.657	$1,252.01		$250.40
53265	Treatment of urethra lesion		T	0166	19.657	$1,252.01		$250.40
53270	Removal of urethra gland		T	0166	19.657	$1,252.01		$250.40
53275	Repair of urethra defect		T	0166	19.657	$1,252.01		$250.40
53400	Revise urethra, stage 1		T	0168	30.1994	$1,923.49	$388.10	$384.70
53405	Revise urethra, stage 2		T	0168	30.1994	$1,923.49	$388.10	$384.70
53410	Reconstruction of urethra		T	0168	30.1994	$1,923.49	$388.10	$384.70
53415	Reconstruction of urethra		C					
53420	Reconstruct urethra, stage 1		T	0168	30.1994	$1,923.49	$388.10	$384.70
53425	Reconstruct urethra, stage 2		T	0168	30.1994	$1,923.49	$388.10	$384.70
53430	Reconstruction of urethra		T	0168	30.1994	$1,923.49	$388.10	$384.70
53431	Reconstruct urethra/bladder		T	0168	30.1994	$1,923.49	$388.10	$384.70
53440	Male sling procedure		S	0385	85.3372	$5,435.38		$1,087.08
53442	Remove/revise male sling		T	0168	30.1994	$1,923.49	$388.10	$384.70
53444	Insert tandem cuff		S	0385	85.3372	$5,435.38		$1,087.08
53445	Insert uro/ves nck sphincter		S	0386	143.8001	$9,159.06		$1,831.81
53446	Remove uro sphincter		T	0168	30.1994	$1,923.49	$388.10	$384.70
53447	Remove/replace ur sphincter		S	0386	143.8001	$9,159.06		$1,831.81
53448	Remov/replc ur sphinctr comp		C					
53449	Repair uro sphincter		T	0168	30.1994	$1,923.49	$388.10	$384.70
53450	Revision of urethra		T	0168	30.1994	$1,923.49	$388.10	$384.70
53460	Revision of urethra		T	0166	19.657	$1,252.01		$250.40
53500	Urethrlys, transvag w/ scope		T	0168	30.1994	$1,923.49	$388.10	$384.70
53502	Repair of urethra injury		T	0166	19.657	$1,252.01		$250.40
53505	Repair of urethra injury		T	0168	30.1994	$1,923.49	$388.10	$384.70
53510	Repair of urethra injury		T	0166	19.657	$1,252.01		$250.40
53515	Repair of urethra injury		T	0168	30.1994	$1,923.49	$388.10	$384.70
53520	Repair of urethra defect		T	0168	30.1994	$1,923.49	$388.10	$384.70
53600	Dilate urethra stricture		T	0156	3.0601	$194.91		$38.98
53601	Dilate urethra stricture		T	0126	1.085	$69.11	$16.40	$13.82
53605	Dilate urethra stricture		T	0161	18.1376	$1,155.24	$243.72	$231.05
53620	Dilate urethra stricture		T	0165	19.6126	$1,249.19		$249.84
53621	Dilate urethra stricture		T	0164	2.1659	$137.95		$27.59
53660	Dilation of urethra		T	0126	1.085	$69.11	$16.40	$13.82
53661	Dilation of urethra		T	0126	1.085	$69.11	$16.40	$13.82
53665	Dilation of urethra		T	0166	19.657	$1,252.01		$250.40
53850	Prostatic microwave thermotx	CH	T	0163	36.9175	$2,351.39		$470.28
53852	Prostatic rf thermotx	CH	T	0163	36.9175	$2,351.39		$470.28
53853	Prostatic water thermother		T	0162	25.2775	$1,610.00		$322.00
53899	Urology surgery procedure		T	0126	1.085	$69.11	$16.40	$13.82
54000	Slitting of prepuce		T	0166	19.657	$1,252.01		$250.40
54001	Slitting of prepuce		T	0166	19.657	$1,252.01		$250.40
54015	Drain penis lesion		T	0008	19.0457	$1,213.08		$242.62
54050	Destruction, penis lesion(s)	CH	T	0015	1.5119	$96.30		$19.26
54055	Destruction, penis lesion(s)		T	0017	20.0977	$1,280.08		$256.02
54056	Cryosurgery, penis lesion(s)	CH	T	0013	0.8046	$51.25		$10.25
54057	Laser surg, penis lesion(s)		T	0017	20.0977	$1,280.08		$256.02
54060	Excision of penis lesion(s)		T	0017	20.0977	$1,280.08		$256.02
54065	Destruction, penis lesion(s)	CH	T	0017	20.0977	$1,280.08		$256.02
54100	Biopsy of penis		T	0021	16.5832	$1,056.23	$219.40	$211.25
54105	Biopsy of penis		T	0022	21.4534	$1,366.43	$354.40	$273.29
54110	Treatment of penis lesion		T	0181	35.1574	$2,239.28	$621.80	$447.86
54111	Treat penis lesion, graft		T	0181	35.1574	$2,239.28	$621.80	$447.86
54112	Treat penis lesion, graft		T	0181	35.1574	$2,239.28	$621.80	$447.86
54115	Treatment of penis lesion		T	0008	19.0457	$1,213.08		$242.62
54120	Partial removal of penis		T	0181	35.1574	$2,239.28	$621.80	$447.86
54125	Removal of penis		C					
54130	Remove penis & nodes		C					
54135	Remove penis & nodes		C					
54150	Circumcision w/regionl block	CH	T	0183	22.7802	$1,450.94		$290.19
54160	Circumcision, neonate	CH	T	0183	22.7802	$1,450.94		$290.19

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
54161	Circum 28 days or older	CH	T	0183	22.7802	$1,450.94		$290.19
54162	Lysis penil circumic lesion	CH	T	0183	22.7802	$1,450.94		$290.19
54163	Repair of circumcision	CH	T	0183	22.7802	$1,450.94		$290.19
54164	Frenulotomy of penis	CH	T	0183	22.7802	$1,450.94		$290.19
54200	Treatment of penis lesion		T	0164	2.1659	$137.95		$27.59
54205	Treatment of penis lesion		T	0181	35.1574	$2,239.28	$621.80	$447.86
54220	Treatment of penis lesion		T	0164	2.1659	$137.95		$27.59
54230	Prepare penis study		N					
54231	Dynamic cavernosometry		T	0165	19.6126	$1,249.19		$249.84
54235	Penile injection		T	0164	2.1659	$137.95		$27.59
54240	Penis study		T	0126	1.085	$69.11	$16.40	$13.82
54250	Penis study		T	0164	2.1659	$137.95		$27.59
54300	Revision of penis		T	0181	35.1574	$2,239.28	$621.80	$447.86
54304	Revision of penis		T	0181	35.1574	$2,239.28	$621.80	$447.86
54308	Reconstruction of urethra		T	0181	35.1574	$2,239.28	$621.80	$447.86
54312	Reconstruction of urethra		T	0181	35.1574	$2,239.28	$621.80	$447.86
54316	Reconstruction of urethra		T	0181	35.1574	$2,239.28	$621.80	$447.86
54318	Reconstruction of urethra		T	0181	35.1574	$2,239.28	$621.80	$447.86
54322	Reconstruction of urethra		T	0181	35.1574	$2,239.28	$621.80	$447.86
54324	Reconstruction of urethra		T	0181	35.1574	$2,239.28	$621.80	$447.86
54326	Reconstruction of urethra		T	0181	35.1574	$2,239.28	$621.80	$447.86
54328	Revise penis/urethra		T	0181	35.1574	$2,239.28	$621.80	$447.86
54332	Revise penis/urethra		C					
54336	Revise penis/urethra		C					
54340	Secondary urethral surgery		T	0181	35.1574	$2,239.28	$621.80	$447.86
54344	Secondary urethral surgery		T	0181	35.1574	$2,239.28	$621.80	$447.86
54348	Secondary urethral surgery		T	0181	35.1574	$2,239.28	$621.80	$447.86
54352	Reconstruct urethra/penis		T	0181	35.1574	$2,239.28	$621.80	$447.86
54360	Penis plastic surgery		T	0181	35.1574	$2,239.28	$621.80	$447.86
54380	Repair penis		T	0181	35.1574	$2,239.28	$621.80	$447.86
54385	Repair penis		T	0181	35.1574	$2,239.28	$621.80	$447.86
54390	Repair penis and bladder		C					
54400	Insert semi-rigid prosthesis		S	0385	85.3372	$5,435.38		$1,087.08
54401	Insert self-contd prosthesis		S	0386	143.8001	$9,159.06		$1,831.81
54405	Insert multi-comp penis pros		S	0386	143.8001	$9,159.06		$1,831.81
54406	Remove muti-comp penis pros		T	0181	35.1574	$2,239.28	$621.80	$447.86
54408	Repair multi-comp penis pros		T	0181	35.1574	$2,239.28	$621.80	$447.86
54410	Remove/replace penis prosth		S	0386	143.8001	$9,159.06		$1,831.81
54411	Remov/replc penis pros, comp		C					
54415	Remove self-contd penis pros		T	0181	35.1574	$2,239.28	$621.80	$447.86
54416	Remv/repl penis contain pros		S	0386	143.8001	$9,159.06		$1,831.81
54417	Remv/replc penis pros, compl		C					
54420	Revision of penis		T	0181	35.1574	$2,239.28	$621.80	$447.86
54430	Revision of penis		C					
54435	Revision of penis		T	0181	35.1574	$2,239.28	$621.80	$447.86
54440	Repair of penis		T	0181	35.1574	$2,239.28	$621.80	$447.86
54450	Preputial stretching		T	0156	3.0601	$194.91		$38.98
54500	Biopsy of testis		T	0037	13.9599	$889.15	$228.70	$177.83
54505	Biopsy of testis		T	0183	22.7802	$1,450.94		$290.19
54512	Excise lesion testis		T	0183	22.7802	$1,450.94		$290.19
54520	Removal of testis		T	0183	22.7802	$1,450.94		$290.19
54522	Orchiectomy, partial		T	0183	22.7802	$1,450.94		$290.19
54530	Removal of testis		T	0154	31.1722	$1,985.45	$464.80	$397.09
54535	Extensive testis surgery		C					
54550	Exploration for testis		T	0154	31.1722	$1,985.45	$464.80	$397.09
54560	Exploration for testis		T	0183	22.7802	$1,450.94		$290.19
54600	Reduce testis torsion		T	0183	22.7802	$1,450.94		$290.19
54620	Suspension of testis		T	0183	22.7802	$1,450.94		$290.19
54640	Suspension of testis		T	0154	31.1722	$1,985.45	$464.80	$397.09
54650	Orchiopexy (Fowler-Stephens)		C					
54660	Revision of testis		T	0183	22.7802	$1,450.94		$290.19
54670	Repair testis injury		T	0183	22.7802	$1,450.94		$290.19
54680	Relocation of testis(es)		T	0183	22.7802	$1,450.94		$290.19
54690	Laparoscopy, orchiectomy		T	0131	46.1201	$2,937.53	$1,001.80	$587.51
54692	Laparoscopy, orchiopexy		T	0132	71.0022	$4,522.34	$1,239.20	$904.47
54699	Laparoscope proc, testis		T	0130	34.8153	$2,217.49	$659.50	$443.50
54700	Drainage of scrotum		T	0183	22.7802	$1,450.94		$290.19
54800	Biopsy of epididymis		T	0004	4.5062	$287.01		$57.40
54830	Remove epididymis lesion		T	0183	22.7802	$1,450.94		$290.19
54840	Remove epididymis lesion		T	0183	22.7802	$1,450.94		$290.19
54860	Removal of epididymis		T	0183	22.7802	$1,450.94		$290.19
54861	Removal of epididymis		T	0183	22.7802	$1,450.94		$290.19
54865	Explore epididymis		T	0183	22.7802	$1,450.94		$290.19
54900	Fusion of spermatic ducts		T	0183	22.7802	$1,450.94		$290.19
54901	Fusion of spermatic ducts		T	0183	22.7802	$1,450.94		$290.19
55000	Drainage of hydrocele		T	0004	4.5062	$287.01		$57.40
55040	Removal of hydrocele		T	0154	31.1722	$1,985.45	$464.80	$397.09
55041	Removal of hydroceles		T	0154	31.1722	$1,985.45	$464.80	$397.09

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
55060	Repair of hydrocele		T	0183	22.7802	$1,450.94		$290.19
55100	Drainage of scrotum abscess		T	0007	12.5792	$801.21		$160.24
55110	Explore scrotum		T	0183	22.7802	$1,450.94		$290.19
55120	Removal of scrotum lesion		T	0183	22.7802	$1,450.94		$290.19
55150	Removal of scrotum		T	0183	22.7802	$1,450.94		$290.19
55175	Revision of scrotum		T	0183	22.7802	$1,450.94		$290.19
55180	Revision of scrotum		T	0183	22.7802	$1,450.94		$290.19
55200	Incision of sperm duct		T	0183	22.7802	$1,450.94		$290.19
55250	Removal of sperm duct(s)		T	0183	22.7802	$1,450.94		$290.19
55300	Prepare, sperm duct x-ray		N					
55400	Repair of sperm duct		T	0183	22.7802	$1,450.94		$290.19
55450	Ligation of sperm duct		T	0183	22.7802	$1,450.94		$290.19
55500	Removal of hydrocele		T	0183	22.7802	$1,450.94		$290.19
55520	Removal of sperm cord lesion		T	0183	22.7802	$1,450.94		$290.19
55530	Revise spermatic cord veins		T	0183	22.7802	$1,450.94		$290.19
55535	Revise spermatic cord veins		T	0154	31.1722	$1,985.45	$464.80	$397.09
55540	Revise hernia & sperm veins		T	0154	31.1722	$1,985.45	$464.80	$397.09
55550	Laparo ligate spermatic vein		T	0131	46.1201	$2,937.53	$1,001.80	$587.51
55559	Laparo proc, spermatic cord		T	0130	34.8153	$2,217.49	$659.50	$443.50
55600	Incise sperm duct pouch		T	0183	22.7802	$1,450.94		$290.19
55605	Incise sperm duct pouch		C					
55650	Remove sperm duct pouch		C					
55680	Remove sperm pouch lesion		T	0183	22.7802	$1,450.94		$290.19
55700	Biopsy of prostate		T	0184	11.3168	$720.80		$144.16
55705	Biopsy of prostate		T	0184	11.3168	$720.80		$144.16
55720	Drainage of prostate abscess		T	0162	25.2775	$1,610.00		$322.00
55725	Drainage of prostate abscess		T	0162	25.2775	$1,610.00		$322.00
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	19.6126	$1,249.19		$249.84
55862	Extensive prostate surgery		C					
55865	Extensive prostate surgery		C					
55866	Laparo radical prostatectomy		C					
55870	Electroejaculation	CH	T	0189	3.0466	$194.05		$38.81
55873	Cryoablate prostate		T	0674	123.7218	$7,880.21		$1,576.04
55875	Transperi needle place, pros	CH	Q	0163	36.9175	$2,351.39		$470.28
55876	Place rt device/marker, pros		T	0156	3.0601	$194.91		$38.98
55899	Genital surgery procedure		T	0126	1.085	$69.11	$16.40	$13.82
55970	Sex transformation, M to F		E					
55980	Sex transformation, F to M		E					
56405	I & D of vulva/perineum		T	0189	3.0466	$194.05		$38.81
56420	Drainage of gland abscess		T	0188	1.4138	$90.05		$18.01
56440	Surgery for vulva lesion	CH	T	0193	19.2052	$1,223.24		$244.65
56441	Lysis of labial lesion(s)		T	0193	19.2052	$1,223.24		$244.65
56442	Hymenotomy		T	0193	19.2052	$1,223.24		$244.65
56501	Destroy, vulva lesions, sim		T	0017	20.0977	$1,280.08		$256.02
56515	Destroy vulva lesion/s compl	CH	T	0017	20.0977	$1,280.08		$256.02
56605	Biopsy of vulva/perineum	CH	T	0189	3.0466	$194.05		$38.81
56606	Biopsy of vulva/perineum	CH	T	0188	1.4138	$90.05		$18.01
56620	Partial removal of vulva	CH	T	0193	19.2052	$1,223.24		$244.65
56625	Complete removal of vulva	CH	T	0193	19.2052	$1,223.24		$244.65
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	CH	T	0193	19.2052	$1,223.24		$244.65
56740	Remove vagina gland lesion	CH	T	0193	19.2052	$1,223.24		$244.65
56800	Repair of vagina	CH	T	0193	19.2052	$1,223.24		$244.65
56805	Repair clitoris		T	0193	19.2052	$1,223.24		$244.65
56810	Repair of perineum	CH	T	0193	19.2052	$1,223.24		$244.65
56820	Exam of vulva w/scope		T	0188	1.4138	$90.05		$18.01
56821	Exam/biopsy of vulva w/scope	CH	T	0188	1.4138	$90.05		$18.01
57000	Exploration of vagina		T	0193	19.2052	$1,223.24		$244.65
57010	Drainage of pelvic abscess		T	0193	19.2052	$1,223.24		$244.65
57020	Drainage of pelvic fluid		T	0192	7.4497	$474.49		$94.90
57022	I & d vaginal hematoma, pp		T	0007	12.5792	$801.21		$160.24
57023	I & d vag hematoma, non-ob		T	0008	19.0457	$1,213.08		$242.62
57061	Destroy vag lesions, simple	CH	T	0193	19.2052	$1,223.24		$244.65

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
57065	Destroy vag lesions, complex	CH	T	0193	19.2052	$1,223.24		$244.65
57100	Biopsy of vagina		T	0192	7.4497	$474.49		$94.90
57105	Biopsy of vagina	CH	T	0193	19.2052	$1,223.24		$244.65
57106	Remove vagina wall, partial	CH	T	0193	19.2052	$1,223.24		$244.65
57107	Remove vagina tissue, part		T	0195	32.9713	$2,100.04	$483.80	$420.01
57109	Vaginectomy partial w/nodes		T	0195	32.9713	$2,100.04	$483.80	$420.01
57110	Remove vagina wall, complete		C					
57111	Remove vagina tissue, compl		C					
57112	Vaginectomy w/nodes, compl		C					
57120	Closure of vagina		T	0195	32.9713	$2,100.04	$483.80	$420.01
57130	Remove vagina lesion	CH	T	0193	19.2052	$1,223.24		$244.65
57135	Remove vagina lesion	CH	T	0193	19.2052	$1,223.24		$244.65
57150	Treat vagina infection	CH	T	0188	1.4138	$90.05		$18.01
57155	Insert uteri tandems/ovoids		T	0192	7.4497	$474.49		$94.90
57160	Insert pessary/other device		T	0188	1.4138	$90.05		$18.01
57170	Fitting of diaphragm/cap		T	0191	0.1414	$9.01	$2.50	$1.80
57180	Treat vaginal bleeding	CH	T	0188	1.4138	$90.05		$18.01
57200	Repair of vagina	CH	T	0193	19.2052	$1,223.24		$244.65
57210	Repair vagina/perineum	CH	T	0193	19.2052	$1,223.24		$244.65
57220	Revision of urethra		T	0202	43.2255	$2,753.16	$981.50	$550.63
57230	Repair of urethral lesion		T	0195	32.9713	$2,100.04	$483.80	$420.01
57240	Repair bladder & vagina		T	0195	32.9713	$2,100.04	$483.80	$420.01
57250	Repair rectum & vagina		T	0195	32.9713	$2,100.04	$483.80	$420.01
57260	Repair of vagina		T	0195	32.9713	$2,100.04	$483.80	$420.01
57265	Extensive repair of vagina		T	0202	43.2255	$2,753.16	$981.50	$550.63
57267	Insert mesh/pelvic flr addon		T	0195	32.9713	$2,100.04	$483.80	$420.01
57268	Repair of bowel bulge		T	0195	32.9713	$2,100.04	$483.80	$420.01
57270	Repair of bowel pouch		C					
57280	Suspension of vagina		C					
57282	Colpopexy, extraperitoneal		T	0202	43.2255	$2,753.16	$981.50	$550.63
57283	Colpopexy, intraperitoneal		T	0202	43.2255	$2,753.16	$981.50	$550.63
57284	Repair paravaginal defect		T	0202	43.2255	$2,753.16	$981.50	$550.63
57287	Revise/remove sling repair		T	0195	32.9713	$2,100.04	$483.80	$420.01
57288	Repair bladder defect		T	0202	43.2255	$2,753.16	$981.50	$550.63
57289	Repair bladder & vagina		T	0195	32.9713	$2,100.04	$483.80	$420.01
57291	Construction of vagina		T	0195	32.9713	$2,100.04	$483.80	$420.01
57292	Construct vagina with graft		T	0195	32.9713	$2,100.04	$483.80	$420.01
57295	Revise vag graft via vagina	CH	T	0193	19.2052	$1,223.24		$244.65
57296	Revise vag graft, open abd		C					
57300	Repair rectum-vagina fistula		T	0195	32.9713	$2,100.04	$483.80	$420.01
57305	Repair rectum-vagina fistula		C					
57307	Fistula repair & colostomy		C					
57308	Fistula repair, transperine		C					
57310	Repair urethrovaginal lesion		T	0202	43.2255	$2,753.16	$981.50	$550.63
57311	Repair urethrovaginal lesion		C					
57320	Repair bladder-vagina lesion		T	0195	32.9713	$2,100.04	$483.80	$420.01
57330	Repair bladder-vagina lesion		T	0195	32.9713	$2,100.04	$483.80	$420.01
57335	Repair vagina		T	0195	32.9713	$2,100.04	$483.80	$420.01
57400	Dilation of vagina	CH	T	0193	19.2052	$1,223.24		$244.65
57410	Pelvic examination		T	0193	19.2052	$1,223.24		$244.65
57415	Remove vaginal foreign body	CH	T	0193	19.2052	$1,223.24		$244.65
57420	Exam of vagina w/scope		T	0189	3.0466	$194.05		$38.81
57421	Exam/biopsy of vag w/scope		T	0189	3.0466	$194.05		$38.81
57425	Laparoscopy, surg, colpopexy		T	0130	34.8153	$2,217.49	$659.50	$443.50
57452	Exam of cervix w/scope		T	0188	1.4138	$90.05		$18.01
57454	Bx/curett of cervix w/scope		T	0189	3.0466	$194.05		$38.81
57455	Biopsy of cervix w/scope		T	0189	3.0466	$194.05		$38.81
57456	Endocerv curettage w/scope		T	0189	3.0466	$194.05		$38.81
57460	Bx of cervix w/scope, leep		T	0193	19.2052	$1,223.24		$244.65
57461	Conz of cervix w/scope, leep	CH	T	0193	19.2052	$1,223.24		$244.65
57500	Biopsy of cervix		T	0189	3.0466	$194.05		$38.81
57505	Endocervical curettage		T	0189	3.0466	$194.05		$38.81
57510	Cauterization of cervix		T	0193	19.2052	$1,223.24		$244.65
57511	Cryocautery of cervix		T	0188	1.4138	$90.05		$18.01
57513	Laser surgery of cervix		T	0193	19.2052	$1,223.24		$244.65
57520	Conization of cervix	CH	T	0193	19.2052	$1,223.24		$244.65
57522	Conization of cervix	CH	T	0193	19.2052	$1,223.24		$244.65
57530	Removal of cervix		T	0195	32.9713	$2,100.04	$483.80	$420.01
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	32.9713	$2,100.04	$483.80	$420.01
57555	Remove cervix/repair vagina		T	0195	32.9713	$2,100.04	$483.80	$420.01
57556	Remove cervix, repair bowel		T	0202	43.2255	$2,753.16	$981.50	$550.63
57558	D&c of cervical stump	CH	T	0193	19.2052	$1,223.24		$244.65
57700	Revision of cervix	CH	T	0193	19.2052	$1,223.24		$244.65
57720	Revision of cervix	CH	T	0193	19.2052	$1,223.24		$244.65
57800	Dilation of cervical canal		T	0193	19.2052	$1,223.24		$244.65

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
58100	Biopsy of uterus lining		T	0188	1.4138	$90.05		$18.01
58110	Bx done w/colposcopy add-on	CH	N					
58120	Dilation and curettage	CH	T	0193	19.2052	$1,223.24		$244.65
58140	Myomectomy abdom method		C					
58145	Myomectomy vag method		T	0195	32.9713	$2,100.04	$483.80	$420.01
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	32.9713	$2,100.04	$483.80	$420.01
58262	Vag hyst including t/o		T	0195	32.9713	$2,100.04	$483.80	$420.01
58263	Vag hyst w/t/o & vag repair		T	0195	32.9713	$2,100.04	$483.80	$420.01
58267	Vag hyst w/urinary repair		C					
58270	Vag hyst w/enterocele repair		T	0195	32.9713	$2,100.04	$483.80	$420.01
58275	Hysterectomy/revise vagina		C					
58280	Hysterectomy/revise vagina		C					
58285	Extensive hysterectomy		C					
58290	Vag hyst complex		T	0202	43.2255	$2,753.16	$981.50	$550.63
58291	Vag hyst incl t/o, complex		T	0202	43.2255	$2,753.16	$981.50	$550.63
58292	Vag hyst t/o & repair, compl		T	0202	43.2255	$2,753.16	$981.50	$550.63
58293	Vag hyst w/uro repair, compl		C					
58294	Vag hyst w/enterocele, compl		T	0202	43.2255	$2,753.16	$981.50	$550.63
58300	Insert intrauterine device		E					
58301	Remove intrauterine device		T	0188	1.4138	$90.05		$18.01
58321	Artificial insemination	CH	T	0189	3.0466	$194.05		$38.81
58322	Artificial insemination	CH	T	0189	3.0466	$194.05		$38.81
58323	Sperm washing	CH	T	0189	3.0466	$194.05		$38.81
58340	Catheter for hysterography		N					
58345	Reopen fallopian tube		T	0193	19.2052	$1,223.24		$244.65
58346	Insert heyman uteri capsule		T	0193	19.2052	$1,223.24		$244.65
58350	Reopen fallopian tube		T	0195	32.9713	$2,100.04	$483.80	$420.01
58353	Endometr ablate, thermal		T	0195	32.9713	$2,100.04	$483.80	$420.01
58356	Endometrial cryoablation		T	0202	43.2255	$2,753.16	$981.50	$550.63
58400	Suspension of uterus		C					
58410	Suspension of uterus		C					
58520	Repair of ruptured uterus		C					
58540	Revision of uterus		C					
58541	Lsh, uterus 250 g or less		T	0131	46.1201	$2,937.53	$1,001.80	$587.51
58542	Lsh w/t/o ut 250 g or less		T	0131	46.1201	$2,937.53	$1,001.80	$587.51
58543	Lsh uterus above 250 g		T	0131	46.1201	$2,937.53	$1,001.80	$587.51
58544	Lsh w/t/o uterus above 250 g		T	0131	46.1201	$2,937.53	$1,001.80	$587.51
58545	Laparoscopic myomectomy		T	0130	34.8153	$2,217.49	$659.50	$443.50
58546	Laparo-myomectomy, complex		T	0131	46.1201	$2,937.53	$1,001.80	$587.51
58548	Lap radical hyst		C					
58550	Laparo-asst vag hysterectomy		T	0132	71.0022	$4,522.34	$1,239.20	$904.47
58552	Laparo-vag hyst incl t/o		T	0131	46.1201	$2,937.53	$1,001.80	$587.51
58553	Laparo-vag hyst, complex		T	0131	46.1201	$2,937.53	$1,001.80	$587.51
58554	Laparo-vag hyst w/t/o, compl		T	0131	46.1201	$2,937.53	$1,001.80	$587.51
58555	Hysteroscopy, dx, sep proc		T	0190	22.1171	$1,408.70	$424.20	$281.74
58558	Hysteroscopy, biopsy		T	0190	22.1171	$1,408.70	$424.20	$281.74
58559	Hysteroscopy, lysis		T	0190	22.1171	$1,408.70	$424.20	$281.74
58560	Hysteroscopy, resect septum		T	0387	34.8162	$2,217.55	$655.50	$443.51
58561	Hysteroscopy, remove myoma		T	0387	34.8162	$2,217.55	$655.50	$443.51
58562	Hysteroscopy, remove fb		T	0190	22.1171	$1,408.70	$424.20	$281.74
58563	Hysteroscopy, ablation		T	0387	34.8162	$2,217.55	$655.50	$443.51
58565	Hysteroscopy, sterilization		T	0202	43.2255	$2,753.16	$981.50	$550.63
58578	Laparo proc, uterus		T	0130	34.8153	$2,217.49	$659.50	$443.50
58579	Hysteroscope procedure		T	0190	22.1171	$1,408.70	$424.20	$281.74
58600	Division of fallopian tube		T	0195	32.9713	$2,100.04	$483.80	$420.01
58605	Division of fallopian tube		C					
58611	Ligate oviduct(s) add-on		C					
58615	Occlude fallopian tube(s)	CH	T	0193	19.2052	$1,223.24		$244.65
58660	Laparoscopy, lysis		T	0131	46.1201	$2,937.53	$1,001.80	$587.51
58661	Laparoscopy, remove adnexa		T	0131	46.1201	$2,937.53	$1,001.80	$587.51
58662	Laparoscopy, excise lesions		T	0131	46.1201	$2,937.53	$1,001.80	$587.51
58670	Laparoscopy, tubal cautery		T	0131	46.1201	$2,937.53	$1,001.80	$587.51
58671	Laparoscopy, tubal block		T	0131	46.1201	$2,937.53	$1,001.80	$587.51
58672	Laparoscopy, fimbrioplasty		T	0131	46.1201	$2,937.53	$1,001.80	$587.51
58673	Laparoscopy, salpingostomy		T	0131	46.1201	$2,937.53	$1,001.80	$587.51
58679	Laparo proc, oviduct-ovary		T	0130	34.8153	$2,217.49	$659.50	$443.50
58700	Removal of fallopian tube		C					
58720	Removal of ovary/tube(s)		C					
58740	Revise fallopian tube(s)		C					
58750	Repair oviduct		C					
58752	Revise ovarian tube(s)		C					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
58760	Remove tubal obstruction		C					
58770	Create new tubal opening		T	0195	32.9713	$2,100.04	$483.80	$420.01
58800	Drainage of ovarian cyst(s)		T	0193	19.2052	$1,223.24		$244.65
58805	Drainage of ovarian cyst(s)	CH	T	0195	32.9713	$2,100.04	$483.80	$420.01
58820	Drain ovary abscess, open		T	0195	32.9713	$2,100.04	$483.80	$420.01
58822	Drain ovary abscess, percut		C					
58823	Drain pelvic abscess, percut		T	0193	19.2052	$1,223.24		$244.65
58825	Transposition, ovary(s)		C					
58900	Biopsy of ovary(s)		T	0193	19.2052	$1,223.24		$244.65
58920	Partial removal of ovary(s)		T	0195	32.9713	$2,100.04	$483.80	$420.01
58925	Removal of ovarian cyst(s)		T	0195	32.9713	$2,100.04	$483.80	$420.01
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	CH	T	0189	3.0466	$194.05		$38.81
58974	Transfer of embryo	CH	T	0189	3.0466	$194.05		$38.81
58976	Transfer of embryo	CH	T	0189	3.0466	$194.05		$38.81
58999	Genital surgery procedure		T	0191	0.1414	$9.01	$2.50	$1.80
59000	Amniocentesis, diagnostic	CH	T	0189	3.0466	$194.05		$38.81
59001	Amniocentesis, therapeutic		T	0192	7.4497	$474.49		$94.90
59012	Fetal cord puncture,prenatal	CH	T	0189	3.0466	$194.05		$38.81
59015	Chorion biopsy	CH	T	0189	3.0466	$194.05		$38.81
59020	Fetal contract stress test	CH	T	0188	1.4138	$90.05		$18.01
59025	Fetal non-stress test	CH	T	0188	1.4138	$90.05		$18.01
59030	Fetal scalp blood sample	CH	T	0189	3.0466	$194.05		$38.81
59050	Fetal monitor w/report		M					
59051	Fetal monitor/interpret only		B					
59070	Transabdom amnioinfus w/us	CH	T	0189	3.0466	$194.05		$38.81
59072	Umbilical cord occlud w/us	CH	T	0189	3.0466	$194.05		$38.81
59074	Fetal fluid drainage w/us	CH	T	0189	3.0466	$194.05		$38.81
59076	Fetal shunt placement, w/us	CH	T	0189	3.0466	$194.05		$38.81
59100	Remove uterus lesion		T	0195	32.9713	$2,100.04	$483.80	$420.01
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	46.1201	$2,937.53	$1,001.80	$587.51
59151	Treat ectopic pregnancy		T	0131	46.1201	$2,937.53	$1,001.80	$587.51
59160	D & c after delivery	CH	T	0193	19.2052	$1,223.24		$244.65
59200	Insert cervical dilator		T	0189	3.0466	$194.05		$38.81
59300	Episiotomy or vaginal repair		T	0193	19.2052	$1,223.24		$244.65
59320	Revision of cervix	CH	T	0193	19.2052	$1,223.24		$244.65
59325	Revision of cervix		C					
59350	Repair of uterus		C					
59400	Obstetrical care		B					
59409	Obstetrical care	CH	T	0193	19.2052	$1,223.24		$244.65
59410	Obstetrical care		B					
59412	Antepartum manipulation	CH	T	0193	19.2052	$1,223.24		$244.65
59414	Deliver placenta		T	0193	19.2052	$1,223.24		$244.65
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	CH	T	0193	19.2052	$1,223.24		$244.65
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	CH	T	0193	19.2052	$1,223.24		$244.65
59820	Care of miscarriage	CH	T	0193	19.2052	$1,223.24		$244.65
59821	Treatment of miscarriage	CH	T	0193	19.2052	$1,223.24		$244.65
59830	Treat uterus infection		C					
59840	Abortion	CH	T	0193	19.2052	$1,223.24		$244.65
59841	Abortion	CH	T	0193	19.2052	$1,223.24		$244.65

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
59850	Abortion		C					
59851	Abortion		C					
59852	Abortion		C					
59855	Abortion		C					
59856	Abortion		C					
59857	Abortion		C					
59866	Abortion (mpr)	CH	T	0189	3.0466	$194.05		$38.81
59870	Evacuate mole of uterus	CH	T	0193	19.2052	$1,223.24		$244.65
59871	Remove cerclage suture	CH	T	0193	19.2052	$1,223.24		$244.65
59897	Fetal invas px w/us	CH	T	0189	3.0466	$194.05		$38.81
59898	Laparo proc, ob care/deliver		T	0130	34.8153	$2,217.49	$659.50	$443.50
59899	Maternity care procedure	CH	T	0191	0.1414	$9.01	$2.50	$1.80
60000	Drain thyroid/tongue cyst		T	0252	7.6539	$487.50	$109.10	$97.50
60001	Aspirate/inject thyriod cyst		T	0004	4.5062	$287.01		$57.40
6005F	Care level rationale doc		M					
60100	Biopsy of thyroid		T	0004	4.5062	$287.01		$57.40
6010F	Dysphag test done b/4 eating		M					
6015F	Pt recvng/OK for eating/swal		M					
60200	Remove thyroid lesion		T	0114	45.1729	$2,877.20		$575.44
6020F	NPO (nothing-mouth) ordered		M					
60210	Partial thyroid excision		T	0114	45.1729	$2,877.20		$575.44
60212	Partial thyroid excision		T	0114	45.1729	$2,877.20		$575.44
60220	Partial removal of thyroid		T	0114	45.1729	$2,877.20		$575.44
60225	Partial removal of thyroid		T	0114	45.1729	$2,877.20		$575.44
60240	Removal of thyroid		T	0114	45.1729	$2,877.20		$575.44
60252	Removal of thyroid		T	0256	40.5598	$2,583.38		$516.68
60254	Extensive thyroid surgery		C					
60260	Repeat thyroid surgery		T	0256	40.5598	$2,583.38		$516.68
60270	Removal of thyroid		C					
60271	Removal of thyroid	CH	T	0256	40.5598	$2,583.38		$516.68
60280	Remove thyroid duct lesion		T	0114	45.1729	$2,877.20		$575.44
60281	Remove thyroid duct lesion		T	0114	45.1729	$2,877.20		$575.44
60500	Explore parathyroid glands		T	0256	40.5598	$2,583.38		$516.68
60502	Re-explore parathyroids		T	0256	40.5598	$2,583.38		$516.68
60505	Explore parathyroid glands		C					
60512	Autotransplant parathyroid		T	0022	21.4534	$1,366.43	$354.40	$273.29
60520	Removal of thymus gland		T	0256	40.5598	$2,583.38		$516.68
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					
60659	Laparo proc, endocrine		T	0130	34.8153	$2,217.49	$659.50	$443.50
60699	Endocrine surgery procedure		T	0114	45.1729	$2,877.20		$575.44
61000	Remove cranial cavity fluid		T	0212	8.6797	$552.84		$110.57
61001	Remove cranial cavity fluid		T	0212	8.6797	$552.84		$110.57
61020	Remove brain cavity fluid		T	0212	8.6797	$552.84		$110.57
61026	Injection into brain canal		T	0212	8.6797	$552.84		$110.57
61050	Remove brain canal fluid		T	0212	8.6797	$552.84		$110.57
61055	Injection into brain canal		T	0212	8.6797	$552.84		$110.57
61070	Brain canal shunt procedure	CH	T	0121	3.2914	$209.64	$43.80	$41.93
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	37.1117	$2,363.76		$472.75
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					
61330	Decompress eye socket		T	0256	40.5598	$2,583.38		$516.68

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
61332	Explore/biopsy eye socket		C					
61333	Explore orbit/remove lesion		C					
61334	Explore orbit/remove object		T	0256	40.5598	$2,583.38		$516.68
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					
61542	Removal of brain tissue		C					
61543	Removal of brain tissue		C					
61544	Remove & treat brain lesion		C					
61545	Excision of brain tumor		C					
61546	Removal of pituitary gland		C					
61548	Removal of pituitary gland		C					
61550	Release of skull seams		C					
61552	Release of skull seams		C					
61556	Incise skull/sutures		C					
61557	Incise skull/sutures		C					
61558	Excision of skull/sutures		C					
61559	Excision of skull/sutures		C					
61563	Excision of skull tumor		C					
61564	Excision of skull tumor		C					
61566	Removal of brain tissue		C					
61567	Incision of brain tissue		C					
61570	Remove foreign body, brain		C					
61571	Incise skull for brain wound		C					
61575	Skull base/brainstem surgery		C					
61576	Skull base/brainstem surgery		C					
61580	Craniofacial approach, skull		C					
61581	Craniofacial approach, skull		C					
61582	Craniofacial approach, skull		C					
61583	Craniofacial approach, skull		C					
61584	Orbitocranial approach/skull		C					
61585	Orbitocranial approach/skull		C					
61586	Resect nasopharynx, skull		C					
61590	Infratemporal approach/skull		C					
61591	Infratemporal approach/skull		C					
61592	Orbitocranial approach/skull		C					
61595	Transtemporal approach/skull		C					
61596	Transcochlear approach/skull		C					
61597	Transcondylar approach/skull		C					
61598	Transpetrosal approach/skull		C					
61600	Resect/excise cranial lesion		C					
61601	Resect/excise cranial lesion		C					
61605	Resect/excise cranial lesion		C					
61606	Resect/excise cranial lesion		C					
61607	Resect/excise cranial lesion		C					
61608	Resect/excise cranial lesion		C					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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	CH	T	0082	88.7717	$5,654.14		$1,130.83
61624	Transcath occlusion, cns		C					
61626	Transcath occlusion, non-cns	CH	T	0082	88.7717	$5,654.14		$1,130.83
61630	Intracranial angioplasty		E					
61635	Intracran angioplsty w/stent		E					
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	32.0518	$2,041.48	$463.60	$408.30
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	CH	T	0221	32.0518	$2,041.48	$463.60	$408.30
61790	Treat trigeminal nerve		T	0220	18.5069	$1,178.76		$235.75
61791	Treat trigeminal tract	CH	T	0203	15.5687	$991.62	$240.30	$198.32
61793	Focus radiation beam		B					
61795	Brain surgery using computer	CH	N					
61850	Implant neuroelectrodes		C					
61860	Implant neuroelectrodes		C					
61863	Implant neuroelectrode		C					
61864	Implant neuroelectrde, addl		C					
61867	Implant neuroelectrode		C					
61868	Implant neuroelectrde, add'l		C					
61870	Implant neuroelectrodes		C					
61875	Implant neuroelectrodes		C					
61880	Revise/remove neuroelectrode		T	0687	24.1752	$1,539.79	$438.40	$307.96
61885	Insrt/redo neurostim 1 array		S	0039	197.4688	$12,577.38		$2,515.48
61886	Implant neurostim arrays		T	0315	262.8116	$16,739.26		$3,347.85
61888	Revise/remove neuroreceiver		T	0688	35.7248	$2,275.42	$874.50	$455.08
62000	Treat skull fracture		T	0254	24.3535	$1,551.15	$321.30	$310.23
62005	Treat skull fracture		C					
62010	Treatment of head injury		C					
62100	Repair brain fluid leakage		C					
62115	Reduction of skull defect		C					
62116	Reduction of skull defect		C					
62117	Reduction of skull defect		C					
62120	Repair skull cavity lesion		C					
62121	Incise skull repair		C					
62140	Repair of skull defect		C					
62141	Repair of skull defect		C					
62142	Remove skull plate/flap		C					
62143	Replace skull plate/flap		C					
62145	Repair of skull & brain		C					
62146	Repair of skull with graft		C					
62147	Repair of skull with graft		C					
62148	Retr bone flap to fix skull		C					
62160	Neuroendoscopy add-on	CH	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					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
62190	Establish brain cavity shunt		C					
62192	Establish brain cavity shunt		C					
62194	Replace/irrigate catheter	CH	T	0212	8.6797	$552.84		$110.57
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	14.8912	$948.47		$189.69
62230	Replace/revise brain shunt		T	0224	37.1117	$2,363.76		$472.75
62252	Csf shunt reprogram		S	0691	2.5849	$164.64	$56.08	$32.93
62256	Remove brain cavity shunt		C					
62258	Replace brain cavity shunt		C					
62263	Epidural lysis mult sessions		T	0203	15.5687	$991.62	$240.30	$198.32
62264	Epidural lysis on single day		T	0203	15.5687	$991.62	$240.30	$198.32
62268	Drain spinal cord cyst		T	0212	8.6797	$552.84		$110.57
62269	Needle biopsy, spinal cord		T	0685	9.5741	$609.80		$121.96
62270	Spinal fluid tap, diagnostic	CH	T	0206	4.1589	$264.89	$56.83	$52.98
62272	Drain cerebro spinal fluid	CH	T	0206	4.1589	$264.89	$56.83	$52.98
62273	Inject epidural patch		T	0206	4.1589	$264.89	$56.83	$52.98
62280	Treat spinal cord lesion		T	0207	7.137	$454.58		$90.92
62281	Treat spinal cord lesion		T	0207	7.137	$454.58		$90.92
62282	Treat spinal canal lesion		T	0207	7.137	$454.58		$90.92
62284	Injection for myelogram		N					
62287	Percutaneous diskectomy		T	0221	32.0518	$2,041.48	$463.60	$408.30
62290	Inject for spine disk x-ray		N					
62291	Inject for spine disk x-ray		N					
62292	Injection into disk lesion		T	0212	8.6797	$552.84		$110.57
62294	Injection into spinal artery		T	0212	8.6797	$552.84		$110.57
62310	Inject spine c/t		T	0207	7.137	$454.58		$90.92
62311	Inject spine l/s (cd)		T	0207	7.137	$454.58		$90.92
62318	Inject spine w/cath, c/t		T	0207	7.137	$454.58		$90.92
62319	Inject spine w/cath l/s (cd)		T	0207	7.137	$454.58		$90.92
62350	Implant spinal canal cath	CH	T	0224	37.1117	$2,363.76		$472.75
62351	Implant spinal canal cath		T	0208	47.6714	$3,036.33		$607.27
62355	Remove spinal canal catheter		T	0203	15.5687	$991.62	$240.30	$198.32
62360	Insert spine infusion device	CH	T	0224	37.1117	$2,363.76		$472.75
62361	Implant spine infusion pump		T	0227	178.7228	$11,383.39		$2,276.68
62362	Implant spine infusion pump		T	0227	178.7228	$11,383.39		$2,276.68
62365	Remove spine infusion device		T	0221	32.0518	$2,041.48	$463.60	$408.30
62367	Analyze spine infusion pump		S	0691	2.5849	$164.64	$56.08	$32.93
62368	Analyze spine infusion pump		S	0691	2.5849	$164.64	$56.08	$32.93
63001	Removal of spinal lamina		T	0208	47.6714	$3,036.33		$607.27
63003	Removal of spinal lamina		T	0208	47.6714	$3,036.33		$607.27
63005	Removal of spinal lamina		T	0208	47.6714	$3,036.33		$607.27
63011	Removal of spinal lamina		T	0208	47.6714	$3,036.33		$607.27
63012	Removal of spinal lamina		T	0208	47.6714	$3,036.33		$607.27
63015	Removal of spinal lamina		T	0208	47.6714	$3,036.33		$607.27
63016	Removal of spinal lamina		T	0208	47.6714	$3,036.33		$607.27
63017	Removal of spinal lamina		T	0208	47.6714	$3,036.33		$607.27
63020	Neck spine disk surgery		T	0208	47.6714	$3,036.33		$607.27
63030	Low back disk surgery		T	0208	47.6714	$3,036.33		$607.27
63035	Spinal disk surgery add-on		T	0208	47.6714	$3,036.33		$607.27
63040	Laminotomy, single cervical		T	0208	47.6714	$3,036.33		$607.27
63042	Laminotomy, single lumbar		T	0208	47.6714	$3,036.33		$607.27
63043	Laminotomy, add'l cervical		C					
63044	Laminotomy, add'l lumbar		C					
63045	Removal of spinal lamina		T	0208	47.6714	$3,036.33		$607.27
63046	Removal of spinal lamina		T	0208	47.6714	$3,036.33		$607.27
63047	Removal of spinal lamina		T	0208	47.6714	$3,036.33		$607.27
63048	Remove spinal lamina add-on		T	0208	47.6714	$3,036.33		$607.27
63050	Cervical laminoplasty		C					
63051	C-laminoplasty w/graft/plate		C					
63055	Decompress spinal cord		T	0208	47.6714	$3,036.33		$607.27
63056	Decompress spinal cord		T	0208	47.6714	$3,036.33		$607.27
63057	Decompress spine cord add-on		T	0208	47.6714	$3,036.33		$607.27
63064	Decompress spinal cord		T	0208	47.6714	$3,036.33		$607.27
63066	Decompress spine cord add-on		T	0208	47.6714	$3,036.33		$607.27
63075	Neck spine disk surgery		T	0208	47.6714	$3,036.33		$607.27
63076	Neck spine disk surgery		C					
63077	Spine disk surgery, thorax		C					
63078	Spine disk surgery, thorax		C					
63081	Removal of vertebral body		C					
63082	Remove vertebral body add-on		C					
63085	Removal of vertebral body		C					
63086	Remove vertebral body add-on		C					
63087	Removal of vertebral body		C					
63088	Remove vertebral body add-on		C					
63090	Removal of vertebral body		C					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
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	18.5069	$1,178.76		$235.75
63610	Stimulation of spinal cord		T	0220	18.5069	$1,178.76		$235.75
63615	Remove lesion of spinal cord		T	0220	18.5069	$1,178.76		$235.75
63650	Implant neuroelectrodes		S	0040	63.7536	$4,060.66		$812.13
63655	Implant neuroelectrodes		S	0061	81.3252	$5,179.85		$1,035.97
63660	Revise/remove neuroelectrode		T	0687	24.1752	$1,539.79	$438.40	$307.96
63685	Insrt/redo spine n generator		T	0222	193.3327	$12,313.94		$2,462.79
63688	Revise/remove neuroreceiver		T	0688	35.7248	$2,275.42	$874.50	$455.08
63700	Repair of spinal herniation		C					
63702	Repair of spinal herniation		C					
63704	Repair of spinal herniation		C					
63706	Repair of spinal herniation		C					
63707	Repair spinal fluid leakage		C					
63709	Repair spinal fluid leakage		C					
63710	Graft repair of spine defect		C					
63740	Install spinal shunt		C					
63741	Install spinal shunt	CH	T	0224	37.1117	$2,363.76		$472.75
63744	Revision of spinal shunt	CH	T	0224	37.1117	$2,363.76		$472.75
63746	Removal of spinal shunt		T	0109	6.1077	$389.02		$77.80
64400	N block inj, trigeminal		T	0204	2.3254	$148.11	$40.10	$29.62
64402	N block inj, facial		T	0204	2.3254	$148.11	$40.10	$29.62
64405	N block inj, occipital	CH	T	0206	4.1589	$264.89	$56.83	$52.98
64408	N block inj, vagus	CH	T	0206	4.1589	$264.89	$56.83	$52.98
64410	N block inj, phrenic	CH	T	0207	7.137	$454.58		$90.92
64412	N block inj, spinal accessor	CH	T	0207	7.137	$454.58		$90.92
64413	N block inj, cervical plexus	CH	T	0206	4.1589	$264.89	$56.83	$52.98

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
64415	N block inj, brachial plexus	CH	T	0206	4.1589	$264.89	$56.83	$52.98
64416	N block cont infuse, b plex	CH	T	0207	7.137	$454.58		$90.92
64417	N block inj, axillary	CH	T	0206	4.1589	$264.89	$56.83	$52.98
64418	N block inj, suprascapular	CH	T	0206	4.1589	$264.89	$56.83	$52.98
64420	N block inj, intercost, sng	CH	T	0206	4.1589	$264.89	$56.83	$52.98
64421	N block inj, intercost, mlt		T	0206	4.1589	$264.89	$56.83	$52.98
64425	N block inj, ilio-ing/hypogi	CH	T	0206	4.1589	$264.89	$56.83	$52.98
64430	N block inj, pudendal	CH	T	0207	7.137	$454.58		$90.92
64435	N block inj, paracervical	CH	T	0206	4.1589	$264.89	$56.83	$52.98
64445	N block inj, sciatic, sng	CH	T	0206	4.1589	$264.89	$56.83	$52.98
64446	N blk inj, sciatic, cont inf	CH	T	0203	15.5687	$991.62	$240.30	$198.32
64447	N block inj fem, single	CH	T	0206	4.1589	$264.89	$56.83	$52.98
64448	N block inj fem, cont inf	CH	T	0206	4.1589	$264.89	$56.83	$52.98
64449	N block inj, lumbar plexus	CH	T	0207	7.137	$454.58		$90.92
64450	N block, other peripheral	CH	T	0206	4.1589	$264.89	$56.83	$52.98
64470	Inj paravertebral c/t		T	0207	7.137	$454.58		$90.92
64472	Inj paravertebral c/t add-on		T	0206	4.1589	$264.89	$56.83	$52.98
64475	Inj paravertebral l/s		T	0207	7.137	$454.58		$90.92
64476	Inj paravertebral l/s add-on		T	0206	4.1589	$264.89	$56.83	$52.98
64479	Inj foramen epidural c/t		T	0207	7.137	$454.58		$90.92
64480	Inj foramen epidural add-on	CH	T	0206	4.1589	$264.89	$56.83	$52.98
64483	Inj foramen epidural l/s		T	0207	7.137	$454.58		$90.92
64484	Inj foramen epidural add-on		T	0207	7.137	$454.58		$90.92
64505	N block, spenopalatine gangl		T	0204	2.3254	$148.11	$40.10	$29.62
64508	N block, carotid sinus s/p		T	0204	2.3254	$148.11	$40.10	$29.62
64510	N block, stellate ganglion		T	0207	7.137	$454.58		$90.92
64517	N block inj, hypogas plxs	CH	T	0207	7.137	$454.58		$90.92
64520	N block, lumbar/thoracic		T	0207	7.137	$454.58		$90.92
64530	N block inj, celiac pelus		T	0207	7.137	$454.58		$90.92
64550	Apply neurostimulator		A					
64553	Implant neuroelectrodes		S	0225	221.4181	$14,102.78		$2,820.56
64555	Implant neuroelectrodes		S	0040	63.7536	$4,060.66		$812.13
64560	Implant neuroelectrodes		S	0040	63.7536	$4,060.66		$812.13
64561	Implant neuroelectrodes		S	0040	63.7536	$4,060.66		$812.13
64565	Implant neuroelectrodes		S	0040	63.7536	$4,060.66		$812.13
64573	Implant neuroelectrodes		S	0225	221.4181	$14,102.78		$2,820.56
64575	Implant neuroelectrodes		S	0061	81.3252	$5,179.85		$1,035.97
64577	Implant neuroelectrodes		S	0061	81.3252	$5,179.85		$1,035.97
64580	Implant neuroelectrodes		S	0061	81.3252	$5,179.85		$1,035.97
64581	Implant neuroelectrodes		S	0061	81.3252	$5,179.85		$1,035.97
64585	Revise/remove neuroelectrode		T	0687	24.1752	$1,539.79	$438.40	$307.96
64590	Insrt/redo pn/gastr stimul		T	0222	193.3327	$12,313.94		$2,462.79
64595	Revise/rmv pn/gastr stimul		T	0688	35.7248	$2,275.42	$874.50	$455.08
64600	Injection treatment of nerve		T	0203	15.5687	$991.62	$240.30	$198.32
64605	Injection treatment of nerve		T	0203	15.5687	$991.62	$240.30	$198.32
64610	Injection treatment of nerve		T	0203	15.5687	$991.62	$240.30	$198.32
64612	Destroy nerve, face muscle		T	0204	2.3254	$148.11	$40.10	$29.62
64613	Destroy nerve, neck muscle		T	0204	2.3254	$148.11	$40.10	$29.62
64614	Destroy nerve, extrem musc		T	0204	2.3254	$148.11	$40.10	$29.62
64620	Injection treatment of nerve	CH	T	0207	7.137	$454.58		$90.92
64622	Destr paravertebrl nerve l/s	CH	T	0207	7.137	$454.58		$90.92
64623	Destr paravertebral n add-on		T	0207	7.137	$454.58		$90.92
64626	Destr paravertebrl nerve c/t	CH	T	0207	7.137	$454.58		$90.92
64627	Destr paravertebral n add-on	CH	T	0204	2.3254	$148.11	$40.10	$29.62
64630	Injection treatment of nerve	CH	T	0207	7.137	$454.58		$90.92
64640	Injection treatment of nerve	CH	T	0207	7.137	$454.58		$90.92
64650	Chemodenerv eccrine glands	CH	T	0206	4.1589	$264.89	$56.83	$52.98
64653	Chemodenerv eccrine glands	CH	T	0206	4.1589	$264.89	$56.83	$52.98
64680	Injection treatment of nerve		T	0207	7.137	$454.58		$90.92
64681	Injection treatment of nerve		T	0203	15.5687	$991.62	$240.30	$198.32
64702	Revise finger/toe nerve		T	0220	18.5069	$1,178.76		$235.75
64704	Revise hand/foot nerve		T	0220	18.5069	$1,178.76		$235.75
64708	Revise arm/leg nerve		T	0220	18.5069	$1,178.76		$235.75
64712	Revision of sciatic nerve		T	0220	18.5069	$1,178.76		$235.75
64713	Revision of arm nerve(s)		T	0220	18.5069	$1,178.76		$235.75
64714	Revise low back nerve(s)		T	0220	18.5069	$1,178.76		$235.75
64716	Revision of cranial nerve		T	0220	18.5069	$1,178.76		$235.75
64718	Revise ulnar nerve at elbow		T	0220	18.5069	$1,178.76		$235.75
64719	Revise ulnar nerve at wrist		T	0220	18.5069	$1,178.76		$235.75
64721	Carpal tunnel surgery		T	0220	18.5069	$1,178.76		$235.75
64722	Relieve pressure on nerve(s)		T	0220	18.5069	$1,178.76		$235.75
64726	Release foot/toe nerve		T	0220	18.5069	$1,178.76		$235.75
64727	Internal nerve revision		T	0220	18.5069	$1,178.76		$235.75
64732	Incision of brow nerve		T	0220	18.5069	$1,178.76		$235.75
64734	Incision of cheek nerve		T	0220	18.5069	$1,178.76		$235.75
64736	Incision of chin nerve		T	0220	18.5069	$1,178.76		$235.75
64738	Incision of jaw nerve		T	0220	18.5069	$1,178.76		$235.75
64740	Incision of tongue nerve		T	0220	18.5069	$1,178.76		$235.75

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
64742	Incision of facial nerve		T	0220	18.5069	$1,178.76		$235.75
64744	Incise nerve, back of head		T	0220	18.5069	$1,178.76		$235.75
64746	Incise diaphragm nerve		T	0220	18.5069	$1,178.76		$235.75
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	18.5069	$1,178.76		$235.75
64763	Incise hip/thigh nerve		T	0220	18.5069	$1,178.76		$235.75
64766	Incise hip/thigh nerve		T	0221	32.0518	$2,041.48	$463.60	$408.30
64771	Sever cranial nerve		T	0220	18.5069	$1,178.76		$235.75
64772	Incision of spinal nerve		T	0220	18.5069	$1,178.76		$235.75
64774	Remove skin nerve lesion		T	0220	18.5069	$1,178.76		$235.75
64776	Remove digit nerve lesion		T	0220	18.5069	$1,178.76		$235.75
64778	Digit nerve surgery add-on		T	0220	18.5069	$1,178.76		$235.75
64782	Remove limb nerve lesion		T	0220	18.5069	$1,178.76		$235.75
64783	Limb nerve surgery add-on		T	0220	18.5069	$1,178.76		$235.75
64784	Remove nerve lesion		T	0220	18.5069	$1,178.76		$235.75
64786	Remove sciatic nerve lesion		T	0221	32.0518	$2,041.48	$463.60	$408.30
64787	Implant nerve end		T	0220	18.5069	$1,178.76		$235.75
64788	Remove skin nerve lesion		T	0220	18.5069	$1,178.76		$235.75
64790	Removal of nerve lesion		T	0220	18.5069	$1,178.76		$235.75
64792	Removal of nerve lesion		T	0221	32.0518	$2,041.48	$463.60	$408.30
64795	Biopsy of nerve		T	0220	18.5069	$1,178.76		$235.75
64802	Remove sympathetic nerves		T	0220	18.5069	$1,178.76		$235.75
64804	Remove sympathetic nerves		T	0220	18.5069	$1,178.76		$235.75
64809	Remove sympathetic nerves		C					
64818	Remove sympathetic nerves		C					
64820	Remove sympathetic nerves		T	0220	18.5069	$1,178.76		$235.75
64821	Remove sympathetic nerves		T	0054	26.7322	$1,702.65		$340.53
64822	Remove sympathetic nerves		T	0054	26.7322	$1,702.65		$340.53
64823	Remove sympathetic nerves		T	0054	26.7322	$1,702.65		$340.53
64831	Repair of digit nerve		T	0221	32.0518	$2,041.48	$463.60	$408.30
64832	Repair nerve add-on		T	0221	32.0518	$2,041.48	$463.60	$408.30
64834	Repair of hand or foot nerve		T	0221	32.0518	$2,041.48	$463.60	$408.30
64835	Repair of hand or foot nerve		T	0221	32.0518	$2,041.48	$463.60	$408.30
64836	Repair of hand or foot nerve		T	0221	32.0518	$2,041.48	$463.60	$408.30
64837	Repair nerve add-on		T	0221	32.0518	$2,041.48	$463.60	$408.30
64840	Repair of leg nerve		T	0221	32.0518	$2,041.48	$463.60	$408.30
64856	Repair/transpose nerve		T	0221	32.0518	$2,041.48	$463.60	$408.30
64857	Repair arm/leg nerve		T	0221	32.0518	$2,041.48	$463.60	$408.30
64858	Repair sciatic nerve		T	0221	32.0518	$2,041.48	$463.60	$408.30
64859	Nerve surgery		T	0221	32.0518	$2,041.48	$463.60	$408.30
64861	Repair of arm nerves		T	0221	32.0518	$2,041.48	$463.60	$408.30
64862	Repair of low back nerves		T	0221	32.0518	$2,041.48	$463.60	$408.30
64864	Repair of facial nerve		T	0221	32.0518	$2,041.48	$463.60	$408.30
64865	Repair of facial nerve		T	0221	32.0518	$2,041.48	$463.60	$408.30
64866	Fusion of facial/other nerve		C					
64868	Fusion of facial/other nerve		C					
64870	Fusion of facial/other nerve		T	0221	32.0518	$2,041.48	$463.60	$408.30
64872	Subsequent repair of nerve		T	0221	32.0518	$2,041.48	$463.60	$408.30
64874	Repair & revise nerve add-on		T	0221	32.0518	$2,041.48	$463.60	$408.30
64876	Repair nerve/shorten bone		T	0221	32.0518	$2,041.48	$463.60	$408.30
64885	Nerve graft, head or neck		T	0221	32.0518	$2,041.48	$463.60	$408.30
64886	Nerve graft, head or neck		T	0221	32.0518	$2,041.48	$463.60	$408.30
64890	Nerve graft, hand or foot		T	0221	32.0518	$2,041.48	$463.60	$408.30
64891	Nerve graft, hand or foot		T	0221	32.0518	$2,041.48	$463.60	$408.30
64892	Nerve graft, arm or leg		T	0221	32.0518	$2,041.48	$463.60	$408.30
64893	Nerve graft, arm or leg		T	0221	32.0518	$2,041.48	$463.60	$408.30
64895	Nerve graft, hand or foot		T	0221	32.0518	$2,041.48	$463.60	$408.30
64896	Nerve graft, hand or foot		T	0221	32.0518	$2,041.48	$463.60	$408.30
64897	Nerve graft, arm or leg		T	0221	32.0518	$2,041.48	$463.60	$408.30
64898	Nerve graft, arm or leg		T	0221	32.0518	$2,041.48	$463.60	$408.30
64901	Nerve graft add-on		T	0221	32.0518	$2,041.48	$463.60	$408.30
64902	Nerve graft add-on		T	0221	32.0518	$2,041.48	$463.60	$408.30
64905	Nerve pedicle transfer		T	0221	32.0518	$2,041.48	$463.60	$408.30
64907	Nerve pedicle transfer		T	0221	32.0518	$2,041.48	$463.60	$408.30
64910	Nerve repair w/allograft		T	0220	18.5069	$1,178.76		$235.75
64911	Neurorraphy w/vein autograft		T	0220	18.5069	$1,178.76		$235.75
64999	Nervous system surgery		T	0204	2.3254	$148.11	$40.10	$29.62
65091	Revise eye		T	0242	37.3504	$2,378.96	$597.30	$475.79
65093	Revise eye with implant		T	0242	37.3504	$2,378.96	$597.30	$475.79
65101	Removal of eye		T	0242	37.3504	$2,378.96	$597.30	$475.79
65103	Remove eye/insert implant		T	0242	37.3504	$2,378.96	$597.30	$475.79
65105	Remove eye/attach implant		T	0242	37.3504	$2,378.96	$597.30	$475.79
65110	Removal of eye		T	0242	37.3504	$2,378.96	$597.30	$475.79
65112	Remove eye/revise socket		T	0242	37.3504	$2,378.96	$597.30	$475.79
65114	Remove eye/revise socket		T	0242	37.3504	$2,378.96	$597.30	$475.79
65125	Revise ocular implant		T	0240	19.228	$1,224.69	$309.50	$244.94

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
65130	Insert ocular implant		T	0241	24.8916	$1,585.42	$384.40	$317.08
65135	Insert ocular implant		T	0241	24.8916	$1,585.42	$384.40	$317.08
65140	Attach ocular implant		T	0242	37.3504	$2,378.96	$597.30	$475.79
65150	Revise ocular implant		T	0241	24.8916	$1,585.42	$384.40	$317.08
65155	Reinsert ocular implant		T	0242	37.3504	$2,378.96	$597.30	$475.79
65175	Removal of ocular implant		T	0240	19.228	$1,224.69	$309.50	$244.94
65205	Remove foreign body from eye		S	0698	1.1576	$73.73		$14.75
65210	Remove foreign body from eye		S	0698	1.1576	$73.73		$14.75
65220	Remove foreign body from eye		S	0698	1.1576	$73.73		$14.75
65222	Remove foreign body from eye		S	0698	1.1576	$73.73		$14.75
65235	Remove foreign body from eye		T	0233	16.5252	$1,052.54	$266.30	$210.51
65260	Remove foreign body from eye		T	0236	18.8779	$1,202.39		$240.48
65265	Remove foreign body from eye		T	0237	29.0019	$1,847.22		$369.44
65270	Repair of eye wound		T	0240	19.228	$1,224.69	$309.50	$244.94
65272	Repair of eye wound		T	0234	24.0821	$1,533.86	$511.30	$306.77
65273	Repair of eye wound		C					
65275	Repair of eye wound		T	0234	24.0821	$1,533.86	$511.30	$306.77
65280	Repair of eye wound		T	0236	18.8779	$1,202.39		$240.48
65285	Repair of eye wound		T	0672	38.1121	$2,427.47		$485.49
65286	Repair of eye wound		T	0232	5.1145	$325.76	$81.59	$65.15
65290	Repair of eye socket wound		T	0243	24.392	$1,553.60	$430.30	$310.72
65400	Removal of eye lesion		T	0233	16.5252	$1,052.54	$266.30	$210.51
65410	Biopsy of cornea		T	0233	16.5252	$1,052.54	$266.30	$210.51
65420	Removal of eye lesion		T	0233	16.5252	$1,052.54	$266.30	$210.51
65426	Removal of eye lesion		T	0234	24.0821	$1,533.86	$511.30	$306.77
65430	Corneal smear		S	0698	1.1576	$73.73		$14.75
65435	Curette/treat cornea		T	0239	7.1099	$452.85		$90.57
65436	Curette/treat cornea		T	0233	16.5252	$1,052.54	$266.30	$210.51
65450	Treatment of corneal lesion		S	0231	2.3117	$147.24		$29.45
65600	Revision of cornea		T	0240	19.228	$1,224.69	$309.50	$244.94
65710	Corneal transplant		T	0244	38.2919	$2,438.93	$803.20	$487.79
65730	Corneal transplant		T	0244	38.2919	$2,438.93	$803.20	$487.79
65750	Corneal transplant		T	0244	38.2919	$2,438.93	$803.20	$487.79
65755	Corneal transplant		T	0244	38.2919	$2,438.93	$803.20	$487.79
65760	Revision of cornea		E					
65765	Revision of cornea		E					
65767	Corneal tissue transplant		E					
65770	Revise cornea with implant		T	0293	83.0605	$5,290.37	$1,128.20	$1,058.07
65771	Radial keratotomy		E					
65772	Correction of astigmatism		T	0233	16.5252	$1,052.54	$266.30	$210.51
65775	Correction of astigmatism		T	0233	16.5252	$1,052.54	$266.30	$210.51
65780	Ocular reconst, transplant		T	0244	38.2919	$2,438.93	$803.20	$487.79
65781	Ocular reconst, transplant		T	0244	38.2919	$2,438.93	$803.20	$487.79
65782	Ocular reconst, transplant		T	0244	38.2919	$2,438.93	$803.20	$487.79
65800	Drainage of eye		T	0233	16.5252	$1,052.54	$266.30	$210.51
65805	Drainage of eye		T	0233	16.5252	$1,052.54	$266.30	$210.51
65810	Drainage of eye		T	0234	24.0821	$1,533.86	$511.30	$306.77
65815	Drainage of eye		T	0234	24.0821	$1,533.86	$511.30	$306.77
65820	Relieve inner eye pressure		T	0232	5.1145	$325.76	$81.59	$65.15
65850	Incision of eye		T	0234	24.0821	$1,533.86	$511.30	$306.77
65855	Laser surgery of eye		T	0247	5.2389	$333.68	$104.30	$66.74
65860	Incise inner eye adhesions		T	0247	5.2389	$333.68	$104.30	$66.74
65865	Incise inner eye adhesions		T	0233	16.5252	$1,052.54	$266.30	$210.51
65870	Incise inner eye adhesions		T	0234	24.0821	$1,533.86	$511.30	$306.77
65875	Incise inner eye adhesions		T	0234	24.0821	$1,533.86	$511.30	$306.77
65880	Incise inner eye adhesions		T	0233	16.5252	$1,052.54	$266.30	$210.51
65900	Remove eye lesion		T	0233	16.5252	$1,052.54	$266.30	$210.51
65920	Remove implant of eye		T	0234	24.0821	$1,533.86	$511.30	$306.77
65930	Remove blood clot from eye		T	0234	24.0821	$1,533.86	$511.30	$306.77
66020	Injection treatment of eye		T	0233	16.5252	$1,052.54	$266.30	$210.51
66030	Injection treatment of eye		T	0232	5.1145	$325.76	$81.59	$65.15
66130	Remove eye lesion		T	0234	24.0821	$1,533.86	$511.30	$306.77
66150	Glaucoma surgery		T	0234	24.0821	$1,533.86	$511.30	$306.77
66155	Glaucoma surgery		T	0234	24.0821	$1,533.86	$511.30	$306.77
66160	Glaucoma surgery		T	0234	24.0821	$1,533.86	$511.30	$306.77
66165	Glaucoma surgery		T	0234	24.0821	$1,533.86	$511.30	$306.77
66170	Glaucoma surgery		T	0234	24.0821	$1,533.86	$511.30	$306.77
66172	Incision of eye		T	0234	24.0821	$1,533.86	$511.30	$306.77
66180	Implant eye shunt		T	0673	40.8481	$2,601.74	$649.50	$520.35
66185	Revise eye shunt		T	0673	40.8481	$2,601.74	$649.50	$520.35
66220	Repair eye lesion		T	0672	38.1121	$2,427.47		$485.49
66225	Repair/graft eye lesion		T	0673	40.8481	$2,601.74	$649.50	$520.35
66250	Follow-up surgery of eye		T	0233	16.5252	$1,052.54	$266.30	$210.51
66500	Incision of iris		T	0232	5.1145	$325.76	$81.59	$65.15
66505	Incision of iris		T	0232	5.1145	$325.76	$81.59	$65.15
66600	Remove iris and lesion		T	0234	24.0821	$1,533.86	$511.30	$306.77
66605	Removal of iris		T	0234	24.0821	$1,533.86	$511.30	$306.77
66625	Removal of iris		T	0232	5.1145	$325.76	$81.59	$65.15

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
66630	Removal of iris		T	0234	24.0821	$1,533.86	$511.30	$306.77
66635	Removal of iris		T	0234	24.0821	$1,533.86	$511.30	$306.77
66680	Repair iris & ciliary body		T	0234	24.0821	$1,533.86	$511.30	$306.77
66682	Repair iris & ciliary body		T	0234	24.0821	$1,533.86	$511.30	$306.77
66700	Destruction, ciliary body		T	0233	16.5252	$1,052.54	$266.30	$210.51
66710	Ciliary transsleral therapy		T	0233	16.5252	$1,052.54	$266.30	$210.51
66711	Ciliary endoscopic ablation		T	0233	16.5252	$1,052.54	$266.30	$210.51
66720	Destruction, ciliary body		T	0233	16.5252	$1,052.54	$266.30	$210.51
66740	Destruction, ciliary body		T	0234	24.0821	$1,533.86	$511.30	$306.77
66761	Revision of iris		T	0247	5.2389	$333.68	$104.30	$66.74
66762	Revision of iris		T	0247	5.2389	$333.68	$104.30	$66.74
66770	Removal of inner eye lesion		T	0247	5.2389	$333.68	$104.30	$66.74
66820	Incision, secondary cataract		T	0232	5.1145	$325.76	$81.59	$65.15
66821	After cataract laser surgery		T	0247	5.2389	$333.68	$104.30	$66.74
66825	Reposition intraocular lens		T	0234	24.0821	$1,533.86	$511.30	$306.77
66830	Removal of lens lesion		T	0232	5.1145	$325.76	$81.59	$65.15
66840	Removal of lens material		T	0245	14.9022	$949.17	$217.00	$189.83
66850	Removal of lens material		T	0249	29.7487	$1,894.78	$524.60	$378.96
66852	Removal of lens material		T	0249	29.7487	$1,894.78	$524.60	$378.96
66920	Extraction of lens		T	0249	29.7487	$1,894.78	$524.60	$378.96
66930	Extraction of lens		T	0249	29.7487	$1,894.78	$524.60	$378.96
66940	Extraction of lens		T	0245	14.9022	$949.17	$217.00	$189.83
66982	Cataract surgery, complex		T	0246	24.2197	$1,542.63	$495.90	$308.53
66983	Cataract surg w/iol, 1 stage		T	0246	24.2197	$1,542.63	$495.90	$308.53
66984	Cataract surg w/iol, 1 stage		T	0246	24.2197	$1,542.63	$495.90	$308.53
66985	Insert lens prosthesis		T	0246	24.2197	$1,542.63	$495.90	$308.53
66986	Exchange lens prosthesis		T	0246	24.2197	$1,542.63	$495.90	$308.53
66990	Ophthalmic endoscope add-on		N					
66999	Eye surgery procedure		T	0232	5.1145	$325.76	$81.59	$65.15
67005	Partial removal of eye fluid		T	0237	29.0019	$1,847.22		$369.44
67010	Partial removal of eye fluid		T	0237	29.0019	$1,847.22		$369.44
67015	Release of eye fluid		T	0237	29.0019	$1,847.22		$369.44
67025	Replace eye fluid		T	0237	29.0019	$1,847.22		$369.44
67027	Implant eye drug system		T	0672	38.1121	$2,427.47		$485.49
67028	Injection eye drug	CH	S	0231	2.3117	$147.24		$29.45
67030	Incise inner eye strands		T	0236	18.8779	$1,202.39		$240.48
67031	Laser surgery, eye strands		T	0247	5.2389	$333.68	$104.30	$66.74
67036	Removal of inner eye fluid		T	0672	38.1121	$2,427.47		$485.49
67038	Strip retinal membrane		T	0672	38.1121	$2,427.47		$485.49
67039	Laser treatment of retina		T	0672	38.1121	$2,427.47		$485.49
67040	Laser treatment of retina		T	0672	38.1121	$2,427.47		$485.49
67101	Repair detached retina		T	0236	18.8779	$1,202.39		$240.48
67105	Repair detached retina	CH	T	0247	5.2389	$333.68	$104.30	$66.74
67107	Repair detached retina		T	0672	38.1121	$2,427.47		$485.49
67108	Repair detached retina		T	0672	38.1121	$2,427.47		$485.49
67110	Repair detached retina		T	0236	18.8779	$1,202.39		$240.48
67112	Rerepair detached retina		T	0672	38.1121	$2,427.47		$485.49
67115	Release encircling material		T	0236	18.8779	$1,202.39		$240.48
67120	Remove eye implant material		T	0236	18.8779	$1,202.39		$240.48
67121	Remove eye implant material		T	0237	29.0019	$1,847.22		$369.44
67141	Treatment of retina		T	0235	4.01	$255.41	$58.90	$51.08
67145	Treatment of retina	CH	T	0247	5.2389	$333.68	$104.30	$66.74
67208	Treatment of retinal lesion		T	0236	18.8779	$1,202.39		$240.48
67210	Treatment of retinal lesion	CH	T	0247	5.2389	$333.68	$104.30	$66.74
67218	Treatment of retinal lesion		T	0236	18.8779	$1,202.39		$240.48
67220	Treatment of choroid lesion		T	0235	4.01	$255.41	$58.90	$51.08
67221	Ocular photodynamic ther		T	0235	4.01	$255.41	$58.90	$51.08
67225	Eye photodynamic ther add-on		T	0235	4.01	$255.41	$58.90	$51.08
67227	Treatment of retinal lesion		T	0237	29.0019	$1,847.22		$369.44
67228	Treatment of retinal lesion	CH	T	0247	5.2389	$333.68	$104.30	$66.74
67250	Reinforce eye wall		T	0240	19.228	$1,224.69	$309.50	$244.94
67255	Reinforce/graft eye wall		T	0237	29.0019	$1,847.22		$369.44
67299	Eye surgery procedure		T	0235	4.01	$255.41	$58.90	$51.08
67311	Revise eye muscle		T	0243	24.392	$1,553.60	$430.30	$310.72
67312	Revise two eye muscles		T	0243	24.392	$1,553.60	$430.30	$310.72
67314	Revise eye muscle		T	0243	24.392	$1,553.60	$430.30	$310.72
67316	Revise two eye muscles		T	0243	24.392	$1,553.60	$430.30	$310.72
67318	Revise eye muscle(s)		T	0243	24.392	$1,553.60	$430.30	$310.72
67320	Revise eye muscle(s) add-on		T	0243	24.392	$1,553.60	$430.30	$310.72
67331	Eye surgery follow-up add-on		T	0243	24.392	$1,553.60	$430.30	$310.72
67332	Rerevise eye muscles add-on		T	0243	24.392	$1,553.60	$430.30	$310.72
67334	Revise eye muscle w/suture		T	0243	24.392	$1,553.60	$430.30	$310.72
67335	Eye suture during surgery		T	0243	24.392	$1,553.60	$430.30	$310.72
67340	Revise eye muscle add-on		T	0243	24.392	$1,553.60	$430.30	$310.72
67343	Release eye tissue		T	0243	24.392	$1,553.60	$430.30	$310.72
67345	Destroy nerve of eye muscle		T	0238	2.8636	$182.39		$36.48
67346	Biopsy, eye muscle		T	0699	14.2784	$909.43		$181.89
67399	Eye muscle surgery procedure		T	0243	24.392	$1,553.60	$430.30	$310.72

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
67400	Explore/biopsy eye socket		T	0241	24.8916	$1,585.42	$384.40	$317.08
67405	Explore/drain eye socket		T	0241	24.8916	$1,585.42	$384.40	$317.08
67412	Explore/treat eye socket		T	0241	24.8916	$1,585.42	$384.40	$317.08
67413	Explore/treat eye socket		T	0241	24.8916	$1,585.42	$384.40	$317.08
67414	Explr/decompress eye socket		T	0242	37.3504	$2,378.96	$597.30	$475.79
67415	Aspiration, orbital contents		T	0240	19.228	$1,224.69	$309.50	$244.94
67420	Explore/treat eye socket		T	0242	37.3504	$2,378.96	$597.30	$475.79
67430	Explore/treat eye socket		T	0242	37.3504	$2,378.96	$597.30	$475.79
67440	Explore/drain eye socket		T	0242	37.3504	$2,378.96	$597.30	$475.79
67445	Explr/decompress eye socket		T	0242	37.3504	$2,378.96	$597.30	$475.79
67450	Explore/biopsy eye socket		T	0242	37.3504	$2,378.96	$597.30	$475.79
67500	Inject/treat eye socket		S	0231	2.3117	$147.24		$29.45
67505	Inject/treat eye socket		T	0238	2.8636	$182.39		$36.48
67515	Inject/treat eye socket		T	0238	2.8636	$182.39		$36.48
67550	Insert eye socket implant		T	0242	37.3504	$2,378.96	$597.30	$475.79
67560	Revise eye socket implant		T	0241	24.8916	$1,585.42	$384.40	$317.08
67570	Decompress optic nerve		T	0242	37.3504	$2,378.96	$597.30	$475.79
67599	Orbit surgery procedure		T	0238	2.8636	$182.39		$36.48
67700	Drainage of eyelid abscess		T	0238	2.8636	$182.39		$36.48
67710	Incision of eyelid		T	0239	7.1099	$452.85		$90.57
67715	Incision of eyelid fold		T	0240	19.228	$1,224.69	$309.50	$244.94
67800	Remove eyelid lesion		T	0238	2.8636	$182.39		$36.48
67801	Remove eyelid lesions		T	0239	7.1099	$452.85		$90.57
67805	Remove eyelid lesions		T	0238	2.8636	$182.39		$36.48
67808	Remove eyelid lesion(s)		T	0240	19.228	$1,224.69	$309.50	$244.94
67810	Biopsy of eyelid		T	0238	2.8636	$182.39		$36.48
67820	Revise eyelashes		S	0698	1.1576	$73.73		$14.75
67825	Revise eyelashes		T	0238	2.8636	$182.39		$36.48
67830	Revise eyelashes		T	0239	7.1099	$452.85		$90.57
67835	Revise eyelashes		T	0240	19.228	$1,224.69	$309.50	$244.94
67840	Remove eyelid lesion		T	0239	7.1099	$452.85		$90.57
67850	Treat eyelid lesion		T	0239	7.1099	$452.85		$90.57
67875	Closure of eyelid by suture		T	0239	7.1099	$452.85		$90.57
67880	Revision of eyelid		T	0233	16.5252	$1,052.54	$266.30	$210.51
67882	Revision of eyelid		T	0240	19.228	$1,224.69	$309.50	$244.94
67900	Repair brow defect		T	0240	19.228	$1,224.69	$309.50	$244.94
67901	Repair eyelid defect		T	0240	19.228	$1,224.69	$309.50	$244.94
67902	Repair eyelid defect		T	0240	19.228	$1,224.69	$309.50	$244.94
67903	Repair eyelid defect		T	0240	19.228	$1,224.69	$309.50	$244.94
67904	Repair eyelid defect		T	0240	19.228	$1,224.69	$309.50	$244.94
67906	Repair eyelid defect		T	0240	19.228	$1,224.69	$309.50	$244.94
67908	Repair eyelid defect		T	0240	19.228	$1,224.69	$309.50	$244.94
67909	Revise eyelid defect		T	0240	19.228	$1,224.69	$309.50	$244.94
67911	Revise eyelid defect		T	0240	19.228	$1,224.69	$309.50	$244.94
67912	Correction eyelid w/implant		T	0240	19.228	$1,224.69	$309.50	$244.94
67914	Repair eyelid defect		T	0240	19.228	$1,224.69	$309.50	$244.94
67915	Repair eyelid defect		T	0240	19.228	$1,224.69	$309.50	$244.94
67916	Repair eyelid defect		T	0240	19.228	$1,224.69	$309.50	$244.94
67917	Repair eyelid defect		T	0240	19.228	$1,224.69	$309.50	$244.94
67921	Repair eyelid defect		T	0240	19.228	$1,224.69	$309.50	$244.94
67922	Repair eyelid defect		T	0240	19.228	$1,224.69	$309.50	$244.94
67923	Repair eyelid defect		T	0240	19.228	$1,224.69	$309.50	$244.94
67924	Repair eyelid defect		T	0240	19.228	$1,224.69	$309.50	$244.94
67930	Repair eyelid wound		T	0240	19.228	$1,224.69	$309.50	$244.94
67935	Repair eyelid wound		T	0240	19.228	$1,224.69	$309.50	$244.94
67938	Remove eyelid foreign body		S	0698	1.1576	$73.73		$14.75
67950	Revision of eyelid		T	0240	19.228	$1,224.69	$309.50	$244.94
67961	Revision of eyelid		T	0240	19.228	$1,224.69	$309.50	$244.94
67966	Revision of eyelid		T	0240	19.228	$1,224.69	$309.50	$244.94
67971	Reconstruction of eyelid		T	0241	24.8916	$1,585.42	$384.40	$317.08
67973	Reconstruction of eyelid		T	0241	24.8916	$1,585.42	$384.40	$317.08
67974	Reconstruction of eyelid		T	0241	24.8916	$1,585.42	$384.40	$317.08
67975	Reconstruction of eyelid		T	0240	19.228	$1,224.69	$309.50	$244.94
67999	Revision of eyelid		T	0238	2.8636	$182.39		$36.48
68020	Incise/drain eyelid lining		T	0240	19.228	$1,224.69	$309.50	$244.94
68040	Treatment of eyelid lesions		S	0698	1.1576	$73.73		$14.75
68100	Biopsy of eyelid lining		T	0232	5.1145	$325.76	$81.59	$65.15
68110	Remove eyelid lining lesion		T	0699	14.2784	$909.43		$181.89
68115	Remove eyelid lining lesion		T	0240	19.228	$1,224.69	$309.50	$244.94
68130	Remove eyelid lining lesion		T	0233	16.5252	$1,052.54	$266.30	$210.51
68135	Remove eyelid lining lesion		T	0239	7.1099	$452.85		$90.57
68200	Treat eyelid by injection		S	0230	0.7379	$47.00		$9.40
68320	Revise/graft eyelid lining		T	0240	19.228	$1,224.69	$309.50	$244.94
68325	Revise/graft eyelid lining		T	0241	24.8916	$1,585.42	$384.40	$317.08
68326	Revise/graft eyelid lining		T	0241	24.8916	$1,585.42	$384.40	$317.08
68328	Revise/graft eyelid lining		T	0241	24.8916	$1,585.42	$384.40	$317.08
68330	Revise eyelid lining		T	0234	24.0821	$1,533.86	$511.30	$306.77
68335	Revise/graft eyelid lining		T	0241	24.8916	$1,585.42	$384.40	$317.08

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
68340	Separate eyelid adhesions		T	0240	19.228	$1,224.69	$309.50	$244.94
68360	Revise eyelid lining		T	0234	24.0821	$1,533.86	$511.30	$306.77
68362	Revise eyelid lining		T	0234	24.0821	$1,533.86	$511.30	$306.77
68371	Harvest eye tissue, alograft		T	0233	16.5252	$1,052.54	$266.30	$210.51
68399	Eyelid lining surgery		T	0238	2.8636	$182.39		$36.48
68400	Incise/drain tear gland		T	0238	2.8636	$182.39		$36.48
68420	Incise/drain tear sac		T	0240	19.228	$1,224.69	$309.50	$244.94
68440	Incise tear duct opening		T	0238	2.8636	$182.39		$36.48
68500	Removal of tear gland		T	0241	24.8916	$1,585.42	$384.40	$317.08
68505	Partial removal, tear gland		T	0241	24.8916	$1,585.42	$384.40	$317.08
68510	Biopsy of tear gland		T	0240	19.228	$1,224.69	$309.50	$244.94
68520	Removal of tear sac		T	0241	24.8916	$1,585.42	$384.40	$317.08
68525	Biopsy of tear sac		T	0240	19.228	$1,224.69	$309.50	$244.94
68530	Clearance of tear duct		T	0240	19.228	$1,224.69	$309.50	$244.94
68540	Remove tear gland lesion		T	0241	24.8916	$1,585.42	$384.40	$317.08
68550	Remove tear gland lesion		T	0241	24.8916	$1,585.42	$384.40	$317.08
68700	Repair tear ducts		T	0241	24.8916	$1,585.42	$384.40	$317.08
68705	Revise tear duct opening		T	0238	2.8636	$182.39		$36.48
68720	Create tear sac drain		T	0241	24.8916	$1,585.42	$384.40	$317.08
68745	Create tear duct drain		T	0241	24.8916	$1,585.42	$384.40	$317.08
68750	Create tear duct drain		T	0241	24.8916	$1,585.42	$384.40	$317.08
68760	Close tear duct opening		S	0231	2.3117	$147.24		$29.45
68761	Close tear duct opening		S	0231	2.3117	$147.24		$29.45
68770	Close tear system fistula		T	0240	19.228	$1,224.69	$309.50	$244.94
68801	Dilate tear duct opening		S	0698	1.1576	$73.73		$14.75
68810	Probe nasolacrimal duct		S	0231	2.3117	$147.24		$29.45
68811	Probe nasolacrimal duct		T	0240	19.228	$1,224.69	$309.50	$244.94
68815	Probe nasolacrimal duct		T	0240	19.228	$1,224.69	$309.50	$244.94
68840	Explore/irrigate tear ducts		S	0698	1.1576	$73.73		$14.75
68850	Injection for tear sac x-ray		N					
68899	Tear duct system surgery		T	0238	2.8636	$182.39		$36.48
69000	Drain external ear lesion		T	0006	1.463	$93.18		$18.64
69005	Drain external ear lesion		T	0008	19.0457	$1,213.08		$242.62
69020	Drain outer ear canal lesion		T	0006	1.463	$93.18		$18.64
69090	Pierce earlobes		E					
69100	Biopsy of external ear	CH	T	0251	2.5765	$164.11		$32.82
69105	Biopsy of external ear canal		T	0253	16.6341	$1,059.48	$282.20	$211.90
69110	Remove external ear, partial		T	0021	16.5832	$1,056.23	$219.40	$211.25
69120	Removal of external ear		T	0254	24.3535	$1,551.15	$321.30	$310.23
69140	Remove ear canal lesion(s)		T	0254	24.3535	$1,551.15	$321.30	$310.23
69145	Remove ear canal lesion(s)		T	0021	16.5832	$1,056.23	$219.40	$211.25
69150	Extensive ear canal surgery		T	0252	7.6539	$487.50	$109.10	$97.50
69155	Extensive ear/neck surgery		C					
69200	Clear outer ear canal		X	0340	0.6416	$40.87		$8.17
69205	Clear outer ear canal		T	0022	21.4534	$1,366.43	$354.40	$273.29
69210	Remove impacted ear wax		X	0340	0.6416	$40.87		$8.17
69220	Clean out mastoid cavity	CH	T	0013	0.8046	$51.25		$10.25
69222	Clean out mastoid cavity	CH	T	0253	16.6341	$1,059.48	$282.20	$211.90
69300	Revise external ear		T	0254	24.3535	$1,551.15	$321.30	$310.23
69310	Rebuild outer ear canal		T	0256	40.5598	$2,583.38		$516.68
69320	Rebuild outer ear canal		T	0256	40.5598	$2,583.38		$516.68
69399	Outer ear surgery procedure		T	0251	2.5765	$164.11		$32.82
69400	Inflate middle ear canal		T	0251	2.5765	$164.11		$32.82
69401	Inflate middle ear canal		T	0251	2.5765	$164.11		$32.82
69405	Catheterize middle ear canal		T	0252	7.6539	$487.50	$109.10	$97.50
69420	Incision of eardrum		T	0251	2.5765	$164.11		$32.82
69421	Incision of eardrum		T	0253	16.6341	$1,059.48	$282.20	$211.90
69424	Remove ventilating tube	CH	T	0253	16.6341	$1,059.48	$282.20	$211.90
69433	Create eardrum opening		T	0252	7.6539	$487.50	$109.10	$97.50
69436	Create eardrum opening		T	0253	16.6341	$1,059.48	$282.20	$211.90
69440	Exploration of middle ear		T	0254	24.3535	$1,551.15	$321.30	$310.23
69450	Eardrum revision		T	0256	40.5598	$2,583.38		$516.68
69501	Mastoidectomy		T	0256	40.5598	$2,583.38		$516.68
69502	Mastoidectomy		T	0254	24.3535	$1,551.15	$321.30	$310.23
69505	Remove mastoid structures		T	0256	40.5598	$2,583.38		$516.68
69511	Extensive mastoid surgery		T	0256	40.5598	$2,583.38		$516.68
69530	Extensive mastoid surgery		T	0256	40.5598	$2,583.38		$516.68
69535	Remove part of temporal bone		C					
69540	Remove ear lesion		T	0253	16.6341	$1,059.48	$282.20	$211.90
69550	Remove ear lesion		T	0256	40.5598	$2,583.38		$516.68
69552	Remove ear lesion		T	0256	40.5598	$2,583.38		$516.68
69554	Remove ear lesion		C					
69601	Mastoid surgery revision		T	0256	40.5598	$2,583.38		$516.68
69602	Mastoid surgery revision		T	0256	40.5598	$2,583.38		$516.68
69603	Mastoid surgery revision		T	0256	40.5598	$2,583.38		$516.68
69604	Mastoid surgery revision		T	0256	40.5598	$2,583.38		$516.68
69605	Mastoid surgery revision		T	0256	40.5598	$2,583.38		$516.68
69610	Repair of eardrum		T	0254	24.3535	$1,551.15	$321.30	$310.23

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
69620	Repair of eardrum		T	0254	24.3535	$1,551.15	$321.30	$310.23
69631	Repair eardrum structures		T	0256	40.5598	$2,583.38		$516.68
69632	Rebuild eardrum structures		T	0256	40.5598	$2,583.38		$516.68
69633	Rebuild eardrum structures		T	0256	40.5598	$2,583.38		$516.68
69635	Repair eardrum structures		T	0256	40.5598	$2,583.38		$516.68
69636	Rebuild eardrum structures		T	0256	40.5598	$2,583.38		$516.68
69637	Rebuild eardrum structures		T	0256	40.5598	$2,583.38		$516.68
69641	Revise middle ear & mastoid		T	0256	40.5598	$2,583.38		$516.68
69642	Revise middle ear & mastoid		T	0256	40.5598	$2,583.38		$516.68
69643	Revise middle ear & mastoid		T	0256	40.5598	$2,583.38		$516.68
69644	Revise middle ear & mastoid		T	0256	40.5598	$2,583.38		$516.68
69645	Revise middle ear & mastoid		T	0256	40.5598	$2,583.38		$516.68
69646	Revise middle ear & mastoid		T	0256	40.5598	$2,583.38		$516.68
69650	Release middle ear bone		T	0254	24.3535	$1,551.15	$321.30	$310.23
69660	Revise middle ear bone		T	0256	40.5598	$2,583.38		$516.68
69661	Revise middle ear bone		T	0256	40.5598	$2,583.38		$516.68
69662	Revise middle ear bone		T	0256	40.5598	$2,583.38		$516.68
69666	Repair middle ear structures		T	0256	40.5598	$2,583.38		$516.68
69667	Repair middle ear structures		T	0256	40.5598	$2,583.38		$516.68
69670	Remove mastoid air cells		T	0256	40.5598	$2,583.38		$516.68
69676	Remove middle ear nerve		T	0256	40.5598	$2,583.38		$516.68
69700	Close mastoid fistula		T	0256	40.5598	$2,583.38		$516.68
69710	Implant/replace hearing aid		E					
69711	Remove/repair hearing aid		T	0256	40.5598	$2,583.38		$516.68
69714	Implant temple bone w/stimul		T	0256	40.5598	$2,583.38		$516.68
69715	Temple bne implnt w/stimulat		T	0256	40.5598	$2,583.38		$516.68
69717	Temple bone implant revision		T	0256	40.5598	$2,583.38		$516.68
69718	Revise temple bone implant		T	0256	40.5598	$2,583.38		$516.68
69720	Release facial nerve		T	0256	40.5598	$2,583.38		$516.68
69725	Release facial nerve		T	0256	40.5598	$2,583.38		$516.68
69740	Repair facial nerve		T	0256	40.5598	$2,583.38		$516.68
69745	Repair facial nerve		T	0256	40.5598	$2,583.38		$516.68
69799	Middle ear surgery procedure		T	0251	2.5765	$164.11		$32.82
69801	Incise inner ear		T	0256	40.5598	$2,583.38		$516.68
69802	Incise inner ear		T	0256	40.5598	$2,583.38		$516.68
69805	Explore inner ear		T	0256	40.5598	$2,583.38		$516.68
69806	Explore inner ear		T	0256	40.5598	$2,583.38		$516.68
69820	Establish inner ear window		T	0256	40.5598	$2,583.38		$516.68
69840	Revise inner ear window		T	0256	40.5598	$2,583.38		$516.68
69905	Remove inner ear		T	0256	40.5598	$2,583.38		$516.68
69910	Remove inner ear & mastoid		T	0256	40.5598	$2,583.38		$516.68
69915	Incise inner ear nerve		T	0256	40.5598	$2,583.38		$516.68
69930	Implant cochlear device		T	0259	404.3379	$25,753.49	$8,698.40	$5,150.70
69949	Inner ear surgery procedure		T	0251	2.5765	$164.11		$32.82
69950	Incise inner ear nerve		C					
69955	Release facial nerve		T	0256	40.5598	$2,583.38		$516.68
69960	Release inner ear canal		T	0256	40.5598	$2,583.38		$516.68
69970	Remove inner ear lesion	CH	T	0256	40.5598	$2,583.38		$516.68
69979	Temporal bone surgery		T	0251	2.5765	$164.11		$32.82
69990	Microsurgery add-on		N					
70010	Contrast x-ray of brain	CH	Q	0274	3.9008	$248.45	$62.80	$49.69
70015	Contrast x-ray of brain	CH	Q	0274	3.9008	$248.45	$62.80	$49.69
70030	X-ray eye for foreign body		X	0260	0.7259	$46.23		$9.25
70100	X-ray exam of jaw		X	0260	0.7259	$46.23		$9.25
70110	X-ray exam of jaw		X	0260	0.7259	$46.23		$9.25
70120	X-ray exam of mastoids		X	0260	0.7259	$46.23		$9.25
70130	X-ray exam of mastoids		X	0260	0.7259	$46.23		$9.25
70134	X-ray exam of middle ear		X	0261	1.2024	$76.58		$15.32
70140	X-ray exam of facial bones		X	0260	0.7259	$46.23		$9.25
70150	X-ray exam of facial bones		X	0260	0.7259	$46.23		$9.25
70160	X-ray exam of nasal bones		X	0260	0.7259	$46.23		$9.25
70170	X-ray exam of tear duct	CH	Q	0263	1.4802	$94.28	$21.44	$18.86
70190	X-ray exam of eye sockets		X	0260	0.7259	$46.23		$9.25
70200	X-ray exam of eye sockets		X	0260	0.7259	$46.23		$9.25
70210	X-ray exam of sinuses		X	0260	0.7259	$46.23		$9.25
70220	X-ray exam of sinuses		X	0260	0.7259	$46.23		$9.25
70240	X-ray exam, pituitary saddle		X	0260	0.7259	$46.23		$9.25
70250	X-ray exam of skull		X	0260	0.7259	$46.23		$9.25
70260	X-ray exam of skull		X	0261	1.2024	$76.58		$15.32
70300	X-ray exam of teeth		X	0262	0.5739	$36.55		$7.31
70310	X-ray exam of teeth		X	0262	0.5739	$36.55		$7.31
70320	Full mouth x-ray of teeth		X	0262	0.5739	$36.55		$7.31
70328	X-ray exam of jaw joint		X	0260	0.7259	$46.23		$9.25
70330	X-ray exam of jaw joints		X	0260	0.7259	$46.23		$9.25
70332	X-ray exam of jaw joint	CH	Q	0275	2.2785	$145.12	$44.13	$29.02
70336	Magnetic image, jaw joint		S	0335	5.0067	$318.89	$111.90	$63.78
70350	X-ray head for orthodontia		X	0260	0.7259	$46.23		$9.25
70355	Panoramic x-ray of jaws		X	0260	0.7259	$46.23		$9.25

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
70360	X-ray exam of neck		X	0260	0.7259	$46.23		$9.25
70370	Throat x-ray & fluoroscopy		X	0272	1.327	$84.52	$31.60	$16.90
70371	Speech evaluation, complex		X	0272	1.327	$84.52	$31.60	$16.90
70373	Contrast x-ray of larynx	CH	Q	0263	1.4802	$94.28	$21.44	$18.86
70380	X-ray exam of salivary gland		X	0260	0.7259	$46.23		$9.25
70390	X-ray exam of salivary duct	CH	Q	0263	1.4802	$94.28	$21.44	$18.86
70450	Ct head/brain w/o dye		S	0332	3.1487	$200.55	$75.20	$40.11
70460	Ct head/brain w/dye		S	0283	4.5485	$289.71	$100.30	$57.94
70470	Ct head/brain w/o & w/dye		S	0333	5.3374	$339.96	$119.00	$67.99
70480	Ct orbit/ear/fossa w/o dye		S	0332	3.1487	$200.55	$75.20	$40.11
70481	Ct orbit/ear/fossa w/dye		S	0283	4.5485	$289.71	$100.30	$57.94
70482	Ct orbit/ear/fossa w/o&w/dye		S	0333	5.3374	$339.96	$119.00	$67.99
70486	Ct maxillofacial w/o dye		S	0332	3.1487	$200.55	$75.20	$40.11
70487	Ct maxillofacial w/dye		S	0283	4.5485	$289.71	$100.30	$57.94
70488	Ct maxillofacial w/o & w/dye		S	0333	5.3374	$339.96	$119.00	$67.99
70490	Ct soft tissue neck w/o dye		S	0332	3.1487	$200.55	$75.20	$40.11
70491	Ct soft tissue neck w/dye		S	0283	4.5485	$289.71	$100.30	$57.94
70492	Ct sft tsue nck w/o & w/dye		S	0333	5.3374	$339.96	$119.00	$67.99
70496	Ct angiography, head		S	0662	5.2818	$336.41	$118.80	$67.28
70498	Ct angiography, neck		S	0662	5.2818	$336.41	$118.80	$67.28
70540	Mri orbit/face/neck w/o dye		S	0336	5.7101	$363.69	$139.50	$72.74
70542	Mri orbit/face/neck w/dye		S	0284	6.7963	$432.88	$148.40	$86.58
70543	Mri orbt/fac/nck w/o & w/dye		S	0337	8.6689	$552.15	$199.50	$110.43
70544	Mr angiography head w/o dye		S	0336	5.7101	$363.69	$139.50	$72.74
70545	Mr angiography head w/dye		S	0284	6.7963	$432.88	$148.40	$86.58
70546	Mr angiograph head w/o&w/dye		S	0337	8.6689	$552.15	$199.50	$110.43
70547	Mr angiography neck w/o dye		S	0336	5.7101	$363.69	$139.50	$72.74
70548	Mr angiography neck w/dye		S	0284	6.7963	$432.88	$148.40	$86.58
70549	Mr angiograph neck w/o&w/dye		S	0337	8.6689	$552.15	$199.50	$110.43
70551	Mri brain w/o dye		S	0336	5.7101	$363.69	$139.50	$72.74
70552	Mri brain w/dye		S	0284	6.7963	$432.88	$148.40	$86.58
70553	Mri brain w/o & w/dye		S	0337	8.6689	$552.15	$199.50	$110.43
70554	Fmri brain by tech		S	0336	5.7101	$363.69	$139.50	$72.74
70555	Fmri brain by phys/psych		S	0336	5.7101	$363.69	$139.50	$72.74
70557	Mri brain w/o dye		S	0336	5.7101	$363.69	$139.50	$72.74
70558	Mri brain w/dye		S	0284	6.7963	$432.88	$148.40	$86.58
70559	Mri brain w/o & w/dye		S	0337	8.6689	$552.15	$199.50	$110.43
71010	Chest x-ray		X	0260	0.7259	$46.23		$9.25
71015	Chest x-ray		X	0260	0.7259	$46.23		$9.25
71020	Chest x-ray		X	0260	0.7259	$46.23		$9.25
71021	Chest x-ray		X	0260	0.7259	$46.23		$9.25
71022	Chest x-ray		X	0260	0.7259	$46.23		$9.25
71023	Chest x-ray and fluoroscopy		X	0272	1.327	$84.52	$31.60	$16.90
71030	Chest x-ray		X	0260	0.7259	$46.23		$9.25
71034	Chest x-ray and fluoroscopy		X	0272	1.327	$84.52	$31.60	$16.90
71035	Chest x-ray		X	0260	0.7259	$46.23		$9.25
71040	Contrast x-ray of bronchi	CH	Q	0263	1.4802	$94.28	$21.44	$18.86
71060	Contrast x-ray of bronchi	CH	Q	0263	1.4802	$94.28	$21.44	$18.86
71090	X-ray & pacemaker insertion	CH	N					
71100	X-ray exam of ribs		X	0260	0.7259	$46.23		$9.25
71101	X-ray exam of ribs/chest		X	0260	0.7259	$46.23		$9.25
71110	X-ray exam of ribs		X	0260	0.7259	$46.23		$9.25
71111	X-ray exam of ribs/chest		X	0261	1.2024	$76.58		$15.32
71120	X-ray exam of breastbone		X	0260	0.7259	$46.23		$9.25
71130	X-ray exam of breastbone		X	0260	0.7259	$46.23		$9.25
71250	Ct thorax w/o dye		S	0332	3.1487	$200.55	$75.20	$40.11
71260	Ct thorax w/dye		S	0283	4.5485	$289.71	$100.30	$57.94
71270	Ct thorax w/o & w/dye		S	0333	5.3374	$339.96	$119.00	$67.99
71275	Ct angiography, chest		S	0662	5.2818	$336.41	$118.80	$67.28
71550	Mri chest w/o dye		S	0336	5.7101	$363.69	$139.50	$72.74
71551	Mri chest w/dye		S	0284	6.7963	$432.88	$148.40	$86.58
71552	Mri chest w/o & w/dye		S	0337	8.6689	$552.15	$199.50	$110.43
71555	Mri angio chest w or w/o dye		B					
72010	X-ray exam of spine		X	0260	0.7259	$46.23		$9.25
72020	X-ray exam of spine		X	0260	0.7259	$46.23		$9.25
72040	X-ray exam of neck spine		X	0260	0.7259	$46.23		$9.25
72050	X-ray exam of neck spine		X	0261	1.2024	$76.58		$15.32
72052	X-ray exam of neck spine		X	0261	1.2024	$76.58		$15.32
72069	X-ray exam of trunk spine		X	0260	0.7259	$46.23		$9.25
72070	X-ray exam of thoracic spine		X	0260	0.7259	$46.23		$9.25
72072	X-ray exam of thoracic spine		X	0260	0.7259	$46.23		$9.25
72074	X-ray exam of thoracic spine		X	0260	0.7259	$46.23		$9.25
72080	X-ray exam of trunk spine		X	0260	0.7259	$46.23		$9.25
72090	X-ray exam of trunk spine		X	0261	1.2024	$76.58		$15.32
72100	X-ray exam of lower spine		X	0260	0.7259	$46.23		$9.25
72110	X-ray exam of lower spine		X	0261	1.2024	$76.58		$15.32
72114	X-ray exam of lower spine		X	0261	1.2024	$76.58		$15.32
72120	X-ray exam of lower spine		X	0261	1.2024	$76.58		$15.32

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
72125	Ct neck spine w/o dye		S	0332	3.1487	$200.55	$75.20	$40.11
72126	Ct neck spine w/dye	CH	S	0316	11.7923	$751.09	$300.26	$150.22
72127	Ct neck spine w/o & w/dye		S	0333	5.3374	$339.96	$119.00	$67.99
72128	Ct chest spine w/o dye		S	0332	3.1487	$200.55	$75.20	$40.11
72129	Ct chest spine w/dye		S	0283	4.5485	$289.71	$100.30	$57.94
72130	Ct chest spine w/o & w/dye		S	0333	5.3374	$339.96	$119.00	$67.99
72131	Ct lumbar spine w/o dye		S	0332	3.1487	$200.55	$75.20	$40.11
72132	Ct lumbar spine w/dye	CH	S	0316	11.7923	$751.09	$300.26	$150.22
72133	Ct lumbar spine w/o & w/dye		S	0333	5.3374	$339.96	$119.00	$67.99
72141	Mri neck spine w/o dye		S	0336	5.7101	$363.69	$139.50	$72.74
72142	Mri neck spine w/dye		S	0284	6.7963	$432.88	$148.40	$86.58
72146	Mri chest spine w/o dye		S	0336	5.7101	$363.69	$139.50	$72.74
72147	Mri chest spine w/dye		S	0284	6.7963	$432.88	$148.40	$86.58
72148	Mri lumbar spine w/o dye		S	0336	5.7101	$363.69	$139.50	$72.74
72149	Mri lumbar spine w/dye		S	0284	6.7963	$432.88	$148.40	$86.58
72156	Mri neck spine w/o & w/dye		S	0337	8.6689	$552.15	$199.50	$110.43
72157	Mri chest spine w/o & w/dye		S	0337	8.6689	$552.15	$199.50	$110.43
72158	Mri lumbar spine w/o & w/dye		S	0337	8.6689	$552.15	$199.50	$110.43
72159	Mr angio spine w/o&w/dye		E					
72170	X-ray exam of pelvis		X	0260	0.7259	$46.23		$9.25
72190	X-ray exam of pelvis		X	0260	0.7259	$46.23		$9.25
72191	Ct angiograph pelv w/o&w/dye		S	0662	5.2818	$336.41	$118.80	$67.28
72192	Ct pelvis w/o dye		S	0332	3.1487	$200.55	$75.20	$40.11
72193	Ct pelvis w/dye		S	0283	4.5485	$289.71	$100.30	$57.94
72194	Ct pelvis w/o & w/dye		S	0333	5.3374	$339.96	$119.00	$67.99
72195	Mri pelvis w/o dye		S	0336	5.7101	$363.69	$139.50	$72.74
72196	Mri pelvis w/dye		S	0284	6.7963	$432.88	$148.40	$86.58
72197	Mri pelvis w/o & w/dye		S	0337	8.6689	$552.15	$199.50	$110.43
72198	Mr angio pelvis w/o & w/dye		B					
72200	X-ray exam sacroiliac joints		X	0260	0.7259	$46.23		$9.25
72202	X-ray exam sacroiliac joints		X	0260	0.7259	$46.23		$9.25
72220	X-ray exam of tailbone		X	0260	0.7259	$46.23		$9.25
72240	Contrast x-ray of neck spine	CH	Q	0274	3.9008	$248.45	$62.80	$49.69
72255	Contrast x-ray, thorax spine	CH	Q	0274	3.9008	$248.45	$62.80	$49.69
72265	Contrast x-ray, lower spine	CH	Q	0274	3.9008	$248.45	$62.80	$49.69
72270	Contrast x-ray, spine	CH	Q	0274	3.9008	$248.45	$62.80	$49.69
72275	Epidurography	CH	N					
72285	X-ray c/t spine disk	CH	Q	0388	9.03	$575.15	$169.68	$115.03
72291	Perq vertebroplasty, fluor	CH	N					
72292	Perq vertebroplasty, ct	CH	N					
72295	X-ray of lower spine disk	CH	Q	0388	9.03	$575.15	$169.68	$115.03
73000	X-ray exam of collar bone		X	0260	0.7259	$46.23		$9.25
73010	X-ray exam of shoulder blade		X	0260	0.7259	$46.23		$9.25
73020	X-ray exam of shoulder		X	0260	0.7259	$46.23		$9.25
73030	X-ray exam of shoulder		X	0260	0.7259	$46.23		$9.25
73040	Contrast x-ray of shoulder	CH	Q	0275	2.2785	$145.12	$44.13	$29.02
73050	X-ray exam of shoulders		X	0260	0.7259	$46.23		$9.25
73060	X-ray exam of humerus		X	0260	0.7259	$46.23		$9.25
73070	X-ray exam of elbow		X	0260	0.7259	$46.23		$9.25
73080	X-ray exam of elbow		X	0260	0.7259	$46.23		$9.25
73085	Contrast x-ray of elbow	CH	Q	0275	2.2785	$145.12	$44.13	$29.02
73090	X-ray exam of forearm		X	0260	0.7259	$46.23		$9.25
73092	X-ray exam of arm, infant		X	0260	0.7259	$46.23		$9.25
73100	X-ray exam of wrist		X	0260	0.7259	$46.23		$9.25
73110	X-ray exam of wrist		X	0260	0.7259	$46.23		$9.25
73115	Contrast x-ray of wrist	CH	Q	0275	2.2785	$145.12	$44.13	$29.02
73120	X-ray exam of hand		X	0260	0.7259	$46.23		$9.25
73130	X-ray exam of hand		X	0260	0.7259	$46.23		$9.25
73140	X-ray exam of finger(s)		X	0260	0.7259	$46.23		$9.25
73200	Ct upper extremity w/o dye		S	0332	3.1487	$200.55	$75.20	$40.11
73201	Ct upper extremity w/dye		S	0283	4.5485	$289.71	$100.30	$57.94
73202	Ct uppr extremity w/o&w/dye		S	0333	5.3374	$339.96	$119.00	$67.99
73206	Ct angio upr extrm w/o&w/dye		S	0662	5.2818	$336.41	$118.80	$67.28
73218	Mri upper extremity w/o dye		S	0336	5.7101	$363.69	$139.50	$72.74
73219	Mri upper extremity w/dye		S	0284	6.7963	$432.88	$148.40	$86.58
73220	Mri uppr extremity w/o&w/dye		S	0337	8.6689	$552.15	$199.50	$110.43
73221	Mri joint upr extrem w/o dye		S	0336	5.7101	$363.69	$139.50	$72.74
73222	Mri joint upr extrem w/dye		S	0284	6.7963	$432.88	$148.40	$86.58
73223	Mri joint upr extr w/o&w/dye		S	0337	8.6689	$552.15	$199.50	$110.43
73225	Mr angio upr extr w/o&w/dye		E					
73500	X-ray exam of hip		X	0260	0.7259	$46.23		$9.25
73510	X-ray exam of hip		X	0260	0.7259	$46.23		$9.25
73520	X-ray exam of hips		X	0261	1.2024	$76.58		$15.32
73525	Contrast x-ray of hip	CH	Q	0275	2.2785	$145.12	$44.13	$29.02
73530	X-ray exam of hip	CH	N					
73540	X-ray exam of pelvis & hips		X	0260	0.7259	$46.23		$9.25
73542	X-ray exam, sacroiliac joint	CH	Q	0275	2.2785	$145.12	$44.13	$29.02
73550	X-ray exam of thigh		X	0260	0.7259	$46.23		$9.25

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
73560	X-ray exam of knee, 1 or 2		X	0260	0.7259	$46.23		$9.25
73562	X-ray exam of knee, 3		X	0260	0.7259	$46.23		$9.25
73564	X-ray exam, knee, 4 or more		X	0260	0.7259	$46.23		$9.25
73565	X-ray exam of knees		X	0260	0.7259	$46.23		$9.25
73580	Contrast x-ray of knee joint	CH	Q	0275	2.2785	$145.12	$44.13	$29.02
73590	X-ray exam of lower leg		X	0260	0.7259	$46.23		$9.25
73592	X-ray exam of leg, infant		X	0260	0.7259	$46.23		$9.25
73600	X-ray exam of ankle		X	0260	0.7259	$46.23		$9.25
73610	X-ray exam of ankle		X	0260	0.7259	$46.23		$9.25
73615	Contrast x-ray of ankle	CH	Q	0275	2.2785	$145.12	$44.13	$29.02
73620	X-ray exam of foot		X	0260	0.7259	$46.23		$9.25
73630	X-ray exam of foot		X	0260	0.7259	$46.23		$9.25
73650	X-ray exam of heel		X	0260	0.7259	$46.23		$9.25
73660	X-ray exam of toe(s)		X	0260	0.7259	$46.23		$9.25
73700	Ct lower extremity w/o dye		S	0332	3.1487	$200.55	$75.20	$40.11
73701	Ct lower extremity w/dye		S	0283	4.5485	$289.71	$100.30	$57.94
73702	Ct lwr extremity w/o&w/dye		S	0333	5.3374	$339.96	$119.00	$67.99
73706	Ct angio lwr extr w/o&w/dye		S	0662	5.2818	$336.41	$118.80	$67.28
73718	Mri lower extremity w/o dye		S	0336	5.7101	$363.69	$139.50	$72.74
73719	Mri lower extremity w/dye		S	0284	6.7963	$432.88	$148.40	$86.58
73720	Mri lwr extremity w/o&w/dye		S	0337	8.6689	$552.15	$199.50	$110.43
73721	Mri jnt of lwr extre w/o dye		S	0336	5.7101	$363.69	$139.50	$72.74
73722	Mri joint of lwr extr w/dye		S	0284	6.7963	$432.88	$148.40	$86.58
73723	Mri joint lwr extr w/o&w/dye		S	0337	8.6689	$552.15	$199.50	$110.43
73725	Mr ang lwr ext w or w/o dye		B					
74000	X-ray exam of abdomen		X	0260	0.7259	$46.23		$9.25
74010	X-ray exam of abdomen		X	0260	0.7259	$46.23		$9.25
74020	X-ray exam of abdomen		X	0260	0.7259	$46.23		$9.25
74022	X-ray exam series, abdomen		X	0261	1.2024	$76.58		$15.32
74150	Ct abdomen w/o dye		S	0332	3.1487	$200.55	$75.20	$40.11
74160	Ct abdomen w/dye		S	0283	4.5485	$289.71	$100.30	$57.94
74170	Ct abdomen w/o & w/dye		S	0333	5.3374	$339.96	$119.00	$67.99
74175	Ct angio abdom w/o & w/dye		S	0662	5.2818	$336.41	$118.80	$67.28
74181	Mri abdomen w/o dye		S	0336	5.7101	$363.69	$139.50	$72.74
74182	Mri abdomen w/dye		S	0284	6.7963	$432.88	$148.40	$86.58
74183	Mri abdomen w/o & w/dye		S	0337	8.6689	$552.15	$199.50	$110.43
74185	Mri angio, abdom w orw/o dye		B					
74190	X-ray exam of peritoneum	CH	Q	0263	1.4802	$94.28	$21.44	$18.86
74210	Contrst x-ray exam of throat		S	0276	1.4387	$91.64	$34.90	$18.33
74220	Contrast x-ray, esophagus		S	0276	1.4387	$91.64	$34.90	$18.33
74230	Cine/vid x-ray, throat/esoph		S	0276	1.4387	$91.64	$34.90	$18.33
74235	Remove esophagus obstruction	CH	N					
74240	X-ray exam, upper gi tract		S	0276	1.4387	$91.64	$34.90	$18.33
74241	X-ray exam, upper gi tract		S	0276	1.4387	$91.64	$34.90	$18.33
74245	X-ray exam, upper gi tract		S	0277	2.2875	$145.70	$54.50	$29.14
74246	Contrst x-ray uppr gi tract		S	0276	1.4387	$91.64	$34.90	$18.33
74247	Contrst x-ray uppr gi tract		S	0276	1.4387	$91.64	$34.90	$18.33
74249	Contrst x-ray uppr gi tract		S	0277	2.2875	$145.70	$54.50	$29.14
74250	X-ray exam of small bowel		S	0276	1.4387	$91.64	$34.90	$18.33
74251	X-ray exam of small bowel		S	0277	2.2875	$145.70	$54.50	$29.14
74260	X-ray exam of small bowel		S	0276	1.4387	$91.64	$34.90	$18.33
74270	Contrast x-ray exam of colon		S	0276	1.4387	$91.64	$34.90	$18.33
74280	Contrast x-ray exam of colon		S	0277	2.2875	$145.70	$54.50	$29.14
74283	Contrast x-ray exam of colon		S	0276	1.4387	$91.64	$34.90	$18.33
74290	Contrast x-ray, gallbladder		S	0276	1.4387	$91.64	$34.90	$18.33
74291	Contrast x-rays, gallbladder		S	0276	1.4387	$91.64	$34.90	$18.33
74300	X-ray bile ducts/pancreas	CH	N					
74301	X-rays at surgery add-on	CH	N					
74305	X-ray bile ducts/pancreas	CH	N					
74320	Contrast x-ray of bile ducts	CH	Q	0263	1.4802	$94.28	$21.44	$18.86
74327	X-ray bile stone removal	CH	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	CH	N					
74350	X-ray guide, stomach tube	CH	N					
74355	X-ray guide, intestinal tube	CH	N					
74360	X-ray guide, GI dilation	CH	N					
74363	X-ray, bile duct dilation	CH	N					
74400	Contrst x-ray, urinary tract		S	0278	2.6114	$166.33	$59.40	$33.27
74410	Contrst x-ray, urinary tract		S	0278	2.6114	$166.33	$59.40	$33.27
74415	Contrst x-ray, urinary tract		S	0278	2.6114	$166.33	$59.40	$33.27
74420	Contrst x-ray, urinary tract		S	0278	2.6114	$166.33	$59.40	$33.27
74425	Contrst x-ray, urinary tract	CH	Q	0278	2.6114	$166.33	$59.40	$33.27
74430	Contrast x-ray, bladder	CH	Q	0278	2.6114	$166.33	$59.40	$33.27
74440	X-ray, male genital tract	CH	Q	0278	2.6114	$166.33	$59.40	$33.27
74445	X-ray exam of penis	CH	Q	0278	2.6114	$166.33	$59.40	$33.27
74450	X-ray, urethra/bladder	CH	Q	0278	2.6114	$166.33	$59.40	$33.27

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
74455	X-ray, urethra/bladder	CH	Q	0278	2.6114	$166.33	$59.40	$33.27
74470	X-ray exam of kidney lesion	CH	Q	0263	1.4802	$94.28	$21.44	$18.86
74475	X-ray control, cath insert	CH	Q	0263	1.4802	$94.28	$21.44	$18.86
74480	X-ray control, cath insert	CH	Q	0263	1.4802	$94.28	$21.44	$18.86
74485	X-ray guide, GU dilation	CH	Q	0263	1.4802	$94.28	$21.44	$18.86
74710	X-ray measurement of pelvis		X	0261	1.2024	$76.58		$15.32
74740	X-ray, female genital tract	CH	Q	0263	1.4802	$94.28	$21.44	$18.86
74742	X-ray, fallopian tube	CH	N					
74775	X-ray exam of perineum		S	0278	2.6114	$166.33	$59.40	$33.27
75552	Heart mri for morph w/o dye		S	0336	5.7101	$363.69	$139.50	$72.74
75553	Heart mri for morph w/dye		S	0284	6.7963	$432.88	$148.40	$86.58
75554	Cardiac MRI/function		S	0336	5.7101	$363.69	$139.50	$72.74
75555	Cardiac MRI/limited study		S	0336	5.7101	$363.69	$139.50	$72.74
75556	Cardiac MRI/flow mapping		E					
75600	Contrast x-ray exam of aorta	CH	Q	0280	11.3221	$721.14	$199.34	$144.23
75605	Contrast x-ray exam of aorta	CH	Q	0280	11.3221	$721.14	$199.34	$144.23
75625	Contrast x-ray exam of aorta	CH	Q	0280	11.3221	$721.14	$199.34	$144.23
75630	X-ray aorta, leg arteries	CH	Q	0280	11.3221	$721.14	$199.34	$144.23
75635	Ct angio abdominal arteries	CH	Q	0662	5.2818	$336.41	$118.80	$67.28
75650	Artery x-rays, head & neck	CH	Q	0280	11.3221	$721.14	$199.34	$144.23
75658	Artery x-rays, arm	CH	Q	0279	5.9365	$378.11	$97.07	$75.62
75660	Artery x-rays, head & neck	CH	Q	0668	3.3354	$212.44	$48.81	$42.49
75662	Artery x-rays, head & neck	CH	Q	0280	11.3221	$721.14	$199.34	$144.23
75665	Artery x-rays, head & neck	CH	Q	0280	11.3221	$721.14	$199.34	$144.23
75671	Artery x-rays, head & neck	CH	Q	0280	11.3221	$721.14	$199.34	$144.23
75676	Artery x-rays, neck	CH	Q	0280	11.3221	$721.14	$199.34	$144.23
75680	Artery x-rays, neck	CH	Q	0280	11.3221	$721.14	$199.34	$144.23
75685	Artery x-rays, spine	CH	Q	0280	11.3221	$721.14	$199.34	$144.23
75705	Artery x-rays, spine	CH	Q	0668	3.3354	$212.44	$48.81	$42.49
75710	Artery x-rays, arm/leg	CH	Q	0280	11.3221	$721.14	$199.34	$144.23
75716	Artery x-rays, arms/legs	CH	Q	0280	11.3221	$721.14	$199.34	$144.23
75722	Artery x-rays, kidney	CH	Q	0280	11.3221	$721.14	$199.34	$144.23
75724	Artery x-rays, kidneys	CH	Q	0280	11.3221	$721.14	$199.34	$144.23
75726	Artery x-rays, abdomen	CH	Q	0280	11.3221	$721.14	$199.34	$144.23
75731	Artery x-rays, adrenal gland	CH	Q	0280	11.3221	$721.14	$199.34	$144.23
75733	Artery x-rays, adrenals	CH	Q	0668	3.3354	$212.44	$48.81	$42.49
75736	Artery x-rays, pelvis	CH	Q	0280	11.3221	$721.14	$199.34	$144.23
75741	Artery x-rays, lung	CH	Q	0279	5.9365	$378.11	$97.07	$75.62
75743	Artery x-rays, lungs	CH	Q	0280	11.3221	$721.14	$199.34	$144.23
75746	Artery x-rays, lung	CH	Q	0279	5.9365	$378.11	$97.07	$75.62
75756	Artery x-rays, chest	CH	Q	0279	5.9365	$378.11	$97.07	$75.62
75774	Artery x-ray, each vessel	CH	N					
75790	Visualize A-V shunt	CH	Q	0279	5.9365	$378.11	$97.07	$75.62
75801	Lymph vessel x-ray, arm/leg	CH	Q	0263	1.4802	$94.28	$21.44	$18.86
75803	Lymph vessel x-ray,arms/legs	CH	Q	0263	1.4802	$94.28	$21.44	$18.86
75805	Lymph vessel x-ray, trunk	CH	Q	0263	1.4802	$94.28	$21.44	$18.86
75807	Lymph vessel x-ray, trunk	CH	Q	0263	1.4802	$94.28	$21.44	$18.86
75809	Nonvascular shunt, x-ray	CH	Q	0263	1.4802	$94.28	$21.44	$18.86
75810	Vein x-ray, spleen/liver	CH	Q	0279	5.9365	$378.11	$97.07	$75.62
75820	Vein x-ray, arm/leg	CH	Q	0668	3.3354	$212.44	$48.81	$42.49
75822	Vein x-ray, arms/legs	CH	Q	0668	3.3354	$212.44	$48.81	$42.49
75825	Vein x-ray, trunk	CH	Q	0279	5.9365	$378.11	$97.07	$75.62
75827	Vein x-ray, chest	CH	Q	0279	5.9365	$378.11	$97.07	$75.62
75831	Vein x-ray, kidney	CH	Q	0279	5.9365	$378.11	$97.07	$75.62
75833	Vein x-ray, kidneys	CH	Q	0279	5.9365	$378.11	$97.07	$75.62
75840	Vein x-ray, adrenal gland	CH	Q	0280	11.3221	$721.14	$199.34	$144.23
75842	Vein x-ray, adrenal glands	CH	Q	0280	11.3221	$721.14	$199.34	$144.23
75860	Vein x-ray, neck	CH	Q	0668	3.3354	$212.44	$48.81	$42.49
75870	Vein x-ray, skull	CH	Q	0668	3.3354	$212.44	$48.81	$42.49
75872	Vein x-ray, skull	CH	Q	0279	5.9365	$378.11	$97.07	$75.62
75880	Vein x-ray, eye socket	CH	Q	0668	3.3354	$212.44	$48.81	$42.49
75885	Vein x-ray, liver	CH	Q	0280	11.3221	$721.14	$199.34	$144.23
75887	Vein x-ray, liver	CH	Q	0279	5.9365	$378.11	$97.07	$75.62
75889	Vein x-ray, liver	CH	Q	0280	11.3221	$721.14	$199.34	$144.23
75891	Vein x-ray, liver	CH	Q	0279	5.9365	$378.11	$97.07	$75.62
75893	Venous sampling by catheter		Q	0668	3.3354	$212.44	$48.81	$42.49
75894	X-rays, transcath therapy	CH	N					
75896	X-rays, transcath therapy	CH	N					
75898	Follow-up angiography	CH	N					
75900	Intravascular cath exchange		C					
75901	Remove cva device obstruct	CH	N					
75902	Remove cva lumen obstruct	CH	N					
75940	X-ray placement, vein filter	CH	N					
75945	Intravascular us	CH	Q	0267	2.4859	$158.33	$60.50	$31.67
75946	Intravascular us add-on	CH	N					
75952	Endovasc repair abdom aorta		C					
75953	Abdom aneurysm endovas rpr		C					
75954	Iliac aneurysm endovas rpr		C					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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	CH	N					
75961	Retrieval, broken catheter	CH	N					
75962	Repair arterial blockage	CH	Q	0668	3.3354	$212.44	$48.81	$42.49
75964	Repair artery blockage, each	CH	N					
75966	Repair arterial blockage	CH	Q	0668	3.3354	$212.44	$48.81	$42.49
75968	Repair artery blockage, each	CH	N					
75970	Vascular biopsy	CH	N					
75978	Repair venous blockage	CH	Q	0668	3.3354	$212.44	$48.81	$42.49
75980	Contrast xray exam bile duct	CH	N					
75982	Contrast xray exam bile duct	CH	N					
75984	Xray control catheter change	CH	N					
75989	Abscess drainage under x-ray		N					
75992	Atherectomy, x-ray exam	CH	N					
75993	Atherectomy, x-ray exam	CH	N					
75994	Atherectomy, x-ray exam	CH	N					
75995	Atherectomy, x-ray exam	CH	N					
75996	Atherectomy, x-ray exam	CH	N					
76000	Fluoroscope examination	CH	Q	0272	1.327	$84.52	$31.60	$16.90
76001	Fluoroscope exam, extensive		N					
76010	X-ray, nose to rectum		X	0260	0.7259	$46.23		$9.25
76080	X-ray exam of fistula	CH	Q	0263	1.4802	$94.28	$21.44	$18.86
76098	X-ray exam, breast specimen		X	0260	0.7259	$46.23		$9.25
76100	X-ray exam of body section		X	0261	1.2024	$76.58		$15.32
76101	Complex body section x-ray		X	0263	1.4802	$94.28	$21.44	$18.86
76102	Complex body section x-rays	CH	X	0263	1.4802	$94.28	$21.44	$18.86
76120	Cine/video x-rays		X	0272	1.327	$84.52	$31.60	$16.90
76125	Cine/video x-rays add-on	CH	N					
76140	X-ray consultation		E					
76150	X-ray exam, dry process		X	0260	0.7259	$46.23		$9.25
76350	Special x-ray contrast study		N					
76376	3d render w/o postprocess	CH	N					
76377	3d rendering w/postprocess	CH	N					
76380	CAT scan follow-up study		S	0282	1.6768	$106.80	$37.80	$21.36
76390	Mr spectroscopy		E					
76496	Fluoroscopic procedure		X	0272	1.327	$84.52	$31.60	$16.90
76497	Ct procedure		S	0282	1.6768	$106.80	$37.80	$21.36
76498	Mri procedure		S	0335	5.0067	$318.89	$111.90	$63.78
76499	Radiographic procedure		X	0260	0.7259	$46.23		$9.25
76506	Echo exam of head		S	0265	0.9925	$63.22	$23.60	$12.64
76510	Ophth us, b & quant a	CH	T	0232	5.1145	$325.76	$81.59	$65.15
76511	Ophth us, quant a only		S	0266	1.5657	$99.72	$37.80	$19.94
76512	Ophth us, b w/non-quant a		S	0266	1.5657	$99.72	$37.80	$19.94
76513	Echo exam of eye, water bath		S	0266	1.5657	$99.72	$37.80	$19.94
76514	Echo exam of eye, thickness		X	0340	0.6416	$40.87		$8.17
76516	Echo exam of eye		S	0265	0.9925	$63.22	$23.60	$12.64
76519	Echo exam of eye		S	0266	1.5657	$99.72	$37.80	$19.94
76529	Echo exam of eye		S	0265	0.9925	$63.22	$23.60	$12.64
76536	Us exam of head and neck		S	0266	1.5657	$99.72	$37.80	$19.94
76604	Us exam, chest		S	0265	0.9925	$63.22	$23.60	$12.64
76645	Us exam, breast(s)		S	0265	0.9925	$63.22	$23.60	$12.64
76700	Us exam, abdom, complete		S	0266	1.5657	$99.72	$37.80	$19.94
76705	Echo exam of abdomen		S	0266	1.5657	$99.72	$37.80	$19.94
76770	Us exam abdo back wall, comp		S	0266	1.5657	$99.72	$37.80	$19.94
76775	Us exam abdo back wall, lim		S	0266	1.5657	$99.72	$37.80	$19.94
76776	Us exam k transpl w/doppler		S	0266	1.5657	$99.72	$37.80	$19.94
76800	Us exam, spinal canal		S	0266	1.5657	$99.72	$37.80	$19.94
76801	Ob us < 14 wks, single fetus		S	0266	1.5657	$99.72	$37.80	$19.94
76802	Ob us < 14 wks, add'l fetus		S	0265	0.9925	$63.22	$23.60	$12.64
76805	Ob us >/= 14 wks, sngl fetus		S	0266	1.5657	$99.72	$37.80	$19.94
76810	Ob us >/= 14 wks, addl fetus		S	0266	1.5657	$99.72	$37.80	$19.94
76811	Ob us, detailed, sngl fetus		S	0267	2.4859	$158.33	$60.50	$31.67
76812	Ob us, detailed, addl fetus		S	0265	0.9925	$63.22	$23.60	$12.64
76813	Ob us nuchal meas, 1 gest		S	0266	1.5657	$99.72	$37.80	$19.94
76814	Ob us nuchal meas, add-on		S	0265	0.9925	$63.22	$23.60	$12.64
76815	Ob us, limited, fetus(s)		S	0265	0.9925	$63.22	$23.60	$12.64
76816	Ob us, follow-up, per fetus		S	0265	0.9925	$63.22	$23.60	$12.64
76817	Transvaginal us, obstetric		S	0265	0.9925	$63.22	$23.60	$12.64
76818	Fetal biophys profile w/nst		S	0266	1.5657	$99.72	$37.80	$19.94
76819	Fetal biophys profil w/o nst		S	0266	1.5657	$99.72	$37.80	$19.94
76820	Umbilical artery echo		S	0096	1.5254	$97.16	$37.60	$19.43
76821	Middle cerebral artery echo		S	0096	1.5254	$97.16	$37.60	$19.43
76825	Echo exam of fetal heart	CH	S	0266	1.5657	$99.72	$37.80	$19.94
76826	Echo exam of fetal heart	CH	S	0265	0.9925	$63.22	$23.60	$12.64
76827	Echo exam of fetal heart	CH	S	0265	0.9925	$63.22	$23.60	$12.64

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
76828	Echo exam of fetal heart	CH	S	0265	0.9925	$63.22	$23.60	$12.64
76830	Transvaginal us, non-ob		S	0266	1.5657	$99.72	$37.80	$19.94
76831	Echo exam, uterus		S	0267	2.4859	$158.33	$60.50	$31.67
76856	Us exam, pelvic, complete		S	0266	1.5657	$99.72	$37.80	$19.94
76857	Us exam, pelvic, limited		S	0265	0.9925	$63.22	$23.60	$12.64
76870	Us exam, scrotum		S	0266	1.5657	$99.72	$37.80	$19.94
76872	Us, transrectal		S	0266	1.5657	$99.72	$37.80	$19.94
76873	Echograp trans r, pros study		S	0266	1.5657	$99.72	$37.80	$19.94
76880	Us exam, extremity		S	0266	1.5657	$99.72	$37.80	$19.94
76885	Us exam infant hips, dynamic		S	0265	0.9925	$63.22	$23.60	$12.64
76886	Us exam infant hips, static		S	0265	0.9925	$63.22	$23.60	$12.64
76930	Echo guide, cardiocentesis	CH	N					
76932	Echo guide for heart biopsy	CH	N					
76936	Echo guide for artery repair	CH	N					
76937	Us guide, vascular access		N					
76940	Us guide, tissue ablation	CH	N					
76941	Echo guide for transfusion	CH	N					
76942	Echo guide for biopsy	CH	N					
76945	Echo guide, villus sampling	CH	N					
76946	Echo guide for amniocentesis	CH	N					
76948	Echo guide, ova aspiration	CH	N					
76950	Echo guidance radiotherapy	CH	N					
76965	Echo guidance radiotherapy	CH	N					
76970	Ultrasound exam follow-up		S	0265	0.9925	$63.22	$23.60	$12.64
76975	GI endoscopic ultrasound	CH	Q	0267	2.4859	$158.33	$60.50	$31.67
76977	Us bone density measure		X	0340	0.6416	$40.87		$8.17
76998	Us guide, intraop	CH	N					
76999	Echo examination procedure		S	0265	0.9925	$63.22	$23.60	$12.64
77001	Fluoroguide for vein device		N					
77002	Needle localization by xray		N					
77003	Fluoroguide for spine inject		N					
77011	Ct scan for localization	CH	N					
77012	Ct scan for needle biopsy	CH	N					
77013	Ct guide for tissue ablation	CH	N					
77014	Ct scan for therapy guide	CH	N					
77021	Mr guidance for needle place	CH	N					
77022	Mri for tissue ablation	CH	N					
77031	Stereotact guide for brst bx	CH	N					
77032	Guidance for needle, breast	CH	N					
77051	Computer dx mammogram add-on		A					
77052	Comp screen mammogram add-on		A					
77053	X-ray of mammary duct	CH	Q	0263	1.4802	$94.28	$21.44	$18.86
77054	X-ray of mammary ducts	CH	Q	0263	1.4802	$94.28	$21.44	$18.86
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	0.7259	$46.23		$9.25
77072	X-rays for bone age		X	0260	0.7259	$46.23		$9.25
77073	X-rays, bone length studies		X	0260	0.7259	$46.23		$9.25
77074	X-rays, bone survey, limited		X	0261	1.2024	$76.58		$15.32
77075	X-rays, bone survey complete		X	0261	1.2024	$76.58		$15.32
77076	X-rays, bone survey, infant		X	0260	0.7259	$46.23		$9.25
77077	Joint survey, single view		X	0260	0.7259	$46.23		$9.25
77078	Ct bone density, axial		S	0288	1.192	$75.92	$28.90	$15.18
77079	Ct bone density, peripheral		S	0282	1.6768	$106.80	$37.80	$21.36
77080	Dxa bone density, axial		S	0288	1.192	$75.92	$28.90	$15.18
77081	Dxa bone density/peripheral		S	0665	0.5225	$33.28	$13.31	$6.66
77082	Dxa bone density, vert fx		X	0260	0.7259	$46.23		$9.25
77083	Radiographic absorptiometry		X	0261	1.2024	$76.58		$15.32
77084	Magnetic image, bone marrow		S	0335	5.0067	$318.89	$111.90	$63.78
77261	Radiation therapy planning		B					
77262	Radiation therapy planning		B					
77263	Radiation therapy planning		B					
77280	Set radiation therapy field		X	0304	1.6409	$104.51	$38.60	$20.90
77285	Set radiation therapy field		X	0305	4.1775	$266.08	$91.30	$53.22
77290	Set radiation therapy field		X	0305	4.1775	$266.08	$91.30	$53.22
77295	Set radiation therapy field		X	0310	14.0797	$896.78	$325.20	$179.36
77299	Radiation therapy planning		X	0304	1.6409	$104.51	$38.60	$20.90
77300	Radiation therapy dose plan		X	0304	1.6409	$104.51	$38.60	$20.90
77301	Radiotherapy dose plan, imrt		X	0310	14.0797	$896.78	$325.20	$179.36
77305	Teletx isodose plan simple		X	0304	1.6409	$104.51	$38.60	$20.90
77310	Teletx isodose plan intermed		X	0305	4.1775	$266.08	$91.30	$53.22
77315	Teletx isodose plan complex		X	0305	4.1775	$266.08	$91.30	$53.22
77321	Special teletx port plan		X	0305	4.1775	$266.08	$91.30	$53.22
77326	Brachytx isodose calc simp		X	0304	1.6409	$104.51	$38.60	$20.90
77327	Brachytx isodose calc interm		X	0305	4.1775	$266.08	$91.30	$53.22

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
77328	Brachytx isodose plan compl		X	0305	4.1775	$266.08	$91.30	$53.22
77331	Special radiation dosimetry		X	0304	1.6409	$104.51	$38.60	$20.90
77332	Radiation treatment aid(s)		X	0303	3.0657	$195.26	$66.90	$39.05
77333	Radiation treatment aid(s)		X	0303	3.0657	$195.26	$66.90	$39.05
77334	Radiation treatment aid(s)		X	0303	3.0657	$195.26	$66.90	$39.05
77336	Radiation physics consult		X	0304	1.6409	$104.51	$38.60	$20.90
77370	Radiation physics consult		X	0304	1.6409	$104.51	$38.60	$20.90
77371	Srs, multisource		S	0127	123.4696	$7,864.15		$1,572.83
77372	Srs, linear based		B					
77373	Sbrt delivery		B					
77399	External radiation dosimetry		X	0304	1.6409	$104.51	$38.60	$20.90
77401	Radiation treatment delivery		S	0300	1.5	$95.54		$19.11
77402	Radiation treatment delivery		S	0300	1.5	$95.54		$19.11
77403	Radiation treatment delivery		S	0300	1.5	$95.54		$19.11
77404	Radiation treatment delivery		S	0300	1.5	$95.54		$19.11
77406	Radiation treatment delivery		S	0300	1.5	$95.54		$19.11
77407	Radiation treatment delivery		S	0300	1.5	$95.54		$19.11
77408	Radiation treatment delivery		S	0300	1.5	$95.54		$19.11
77409	Radiation treatment delivery		S	0300	1.5	$95.54		$19.11
77411	Radiation treatment delivery		S	0301	2.2933	$146.07		$29.21
77412	Radiation treatment delivery		S	0301	2.2933	$146.07		$29.21
77413	Radiation treatment delivery		S	0301	2.2933	$146.07		$29.21
77414	Radiation treatment delivery		S	0301	2.2933	$146.07		$29.21
77416	Radiation treatment delivery		S	0301	2.2933	$146.07		$29.21
77417	Radiology port film(s)	CH	N					
77418	Radiation tx delivery, imrt		S	0412	5.7275	$364.80		$72.96
77421	Stereoscopic x-ray guidance	CH	N					
77422	Neutron beam tx, simple		S	0301	2.2933	$146.07		$29.21
77423	Neutron beam tx, complex		S	0301	2.2933	$146.07		$29.21
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	6.0275	$383.91		$76.78
77499	Radiation therapy management		B					
77520	Proton trmt, simple w/o comp		S	0664	13.2746	$845.50		$169.10
77522	Proton trmt, simple w/comp		S	0664	13.2746	$845.50		$169.10
77523	Proton trmt, intermediate		S	0667	15.8841	$1,011.71		$202.34
77525	Proton treatment, complex		S	0667	15.8841	$1,011.71		$202.34
77600	Hyperthermia treatment	CH	S	0299	6.0275	$383.91		$76.78
77605	Hyperthermia treatment	CH	S	0299	6.0275	$383.91		$76.78
77610	Hyperthermia treatment	CH	S	0299	6.0275	$383.91		$76.78
77615	Hyperthermia treatment	CH	S	0299	6.0275	$383.91		$76.78
77620	Hyperthermia treatment	CH	S	0299	6.0275	$383.91		$76.78
77750	Infuse radioactive materials		S	0301	2.2933	$146.07		$29.21
77761	Apply intrcav radiat simple		S	0312	8.3915	$534.48		$106.90
77762	Apply intrcav radiat interm		S	0312	8.3915	$534.48		$106.90
77763	Apply intrcav radiat compl		S	0312	8.3915	$534.48		$106.90
77776	Apply interstit radiat simpl		S	0312	8.3915	$534.48		$106.90
77777	Apply interstit radiat inter		S	0312	8.3915	$534.48		$106.90
77778	Apply interstit radiat compl	CH	Q	0651	15.4158	$981.88		$196.38
77781	High intensity brachytherapy		S	0313	11.6098	$739.46		$147.89
77782	High intensity brachytherapy		S	0313	11.6098	$739.46		$147.89
77783	High intensity brachytherapy		S	0313	11.6098	$739.46		$147.89
77784	High intensity brachytherapy		S	0313	11.6098	$739.46		$147.89
77789	Apply surface radiation		S	0300	1.5	$95.54		$19.11
77790	Radiation handling		N					
77799	Radium/radioisotope therapy		S	0312	8.3915	$534.48		$106.90
78000	Thyroid, single uptake		S	0389	1.5806	$100.67	$33.80	$20.13
78001	Thyroid, multiple uptakes		S	0389	1.5806	$100.67	$33.80	$20.13
78003	Thyroid suppress/stimul		S	0392	3.281	$208.98	$49.30	$41.80
78006	Thyroid imaging with uptake		S	0390	2.8272	$180.07	$57.60	$36.01
78007	Thyroid image, mult uptakes		S	0391	3.654	$232.73	$66.10	$46.55
78010	Thyroid imaging		S	0390	2.8272	$180.07	$57.60	$36.01
78011	Thyroid imaging with flow		S	0390	2.8272	$180.07	$57.60	$36.01
78015	Thyroid met imaging		S	0406	4.4988	$286.54	$98.10	$57.31
78016	Thyroid met imaging/studies		S	0406	4.4988	$286.54	$98.10	$57.31
78018	Thyroid met imaging, body		S	0406	4.4988	$286.54	$98.10	$57.31
78020	Thyroid met uptake	CH	N					
78070	Parathyroid nuclear imaging		S	0391	3.654	$232.73	$66.10	$46.55
78075	Adrenal nuclear imaging		S	0391	3.654	$232.73	$66.10	$46.55
78099	Endocrine nuclear procedure		S	0390	2.8272	$180.07	$57.60	$36.01
78102	Bone marrow imaging, ltd		S	0400	4.1916	$266.98	$93.20	$53.40
78103	Bone marrow imaging, mult		S	0400	4.1916	$266.98	$93.20	$53.40
78104	Bone marrow imaging, body		S	0400	4.1916	$266.98	$93.20	$53.40
78110	Plasma volume, single		S	0393	5.526	$351.97	$82.00	$70.39
78111	Plasma volume, multiple		S	0393	5.526	$351.97	$82.00	$70.39
78120	Red cell mass, single		S	0393	5.526	$351.97	$82.00	$70.39

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
78121	Red cell mass, multiple		S	0393	5.526	$351.97	$82.00	$70.39
78122	Blood volume		S	0393	5.526	$351.97	$82.00	$70.39
78130	Red cell survival study		S	0393	5.526	$351.97	$82.00	$70.39
78135	Red cell survival kinetics		S	0393	5.526	$351.97	$82.00	$70.39
78140	Red cell sequestration		S	0393	5.526	$351.97	$82.00	$70.39
78185	Spleen imaging		S	0400	4.1916	$266.98	$93.20	$53.40
78190	Platelet survival, kinetics		S	0392	3.281	$208.98	$49.30	$41.80
78191	Platelet survival		S	0392	3.281	$208.98	$49.30	$41.80
78195	Lymph system imaging		S	0400	4.1916	$266.98	$93.20	$53.40
78199	Blood/lymph nuclear exam		S	0400	4.1916	$266.98	$93.20	$53.40
78201	Liver imaging		S	0394	4.5297	$288.51	$102.60	$57.70
78202	Liver imaging with flow		S	0394	4.5297	$288.51	$102.60	$57.70
78205	Liver imaging (3D)		S	0394	4.5297	$288.51	$102.60	$57.70
78206	Liver image (3d) with flow		S	0394	4.5297	$288.51	$102.60	$57.70
78215	Liver and spleen imaging		S	0394	4.5297	$288.51	$102.60	$57.70
78216	Liver & spleen image/flow		S	0394	4.5297	$288.51	$102.60	$57.70
78220	Liver function study		S	0394	4.5297	$288.51	$102.60	$57.70
78223	Hepatobiliary imaging		S	0394	4.5297	$288.51	$102.60	$57.70
78230	Salivary gland imaging		S	0395	3.8546	$245.51	$89.70	$49.10
78231	Serial salivary imaging		S	0395	3.8546	$245.51	$89.70	$49.10
78232	Salivary gland function exam		S	0395	3.8546	$245.51	$89.70	$49.10
78258	Esophageal motility study		S	0395	3.8546	$245.51	$89.70	$49.10
78261	Gastric mucosa imaging		S	0395	3.8546	$245.51	$89.70	$49.10
78262	Gastroesophageal reflux exam		S	0395	3.8546	$245.51	$89.70	$49.10
78264	Gastric emptying study		S	0395	3.8546	$245.51	$89.70	$49.10
78267	Breath tst attain/anal c-14		A					
78268	Breath test analysis, c-14		A					
78270	Vit B-12 absorption exam		S	0392	3.281	$208.98	$49.30	$41.80
78271	Vit b-12 absrp exam, int fac		S	0392	3.281	$208.98	$49.30	$41.80
78272	Vit B-12 absorp, combined		S	0392	3.281	$208.98	$49.30	$41.80
78278	Acute GI blood loss imaging		S	0395	3.8546	$245.51	$89.70	$49.10
78282	GI protein loss exam		S	0395	3.8546	$245.51	$89.70	$49.10
78290	Meckel'ts divert exam		S	0395	3.8546	$245.51	$89.70	$49.10
78291	Leveen/shunt patency exam		S	0395	3.8546	$245.51	$89.70	$49.10
78299	GI nuclear procedure		S	0395	3.8546	$245.51	$89.70	$49.10
78300	Bone imaging, limited area		S	0396	3.9566	$252.01	$95.00	$50.40
78305	Bone imaging, multiple areas		S	0396	3.9566	$252.01	$95.00	$50.40
78306	Bone imaging, whole body		S	0396	3.9566	$252.01	$95.00	$50.40
78315	Bone imaging, 3 phase		S	0396	3.9566	$252.01	$95.00	$50.40
78320	Bone imaging (3D)		S	0396	3.9566	$252.01	$95.00	$50.40
78350	Bone mineral, single photon		E					
78351	Bone mineral, dual photon		E					
78399	Musculoskeletal nuclear exam		S	0396	3.9566	$252.01	$95.00	$50.40
78414	Non-imaging heart function		S	0398	5.4404	$346.52	$100.00	$69.30
78428	Cardiac shunt imaging		S	0398	5.4404	$346.52	$100.00	$69.30
78445	Vascular flow imaging		S	0397	3.0424	$193.78	$49.50	$38.76
78456	Acute venous thrombus image		S	0397	3.0424	$193.78	$49.50	$38.76
78457	Venous thrombosis imaging		S	0397	3.0424	$193.78	$49.50	$38.76
78458	Ven thrombosis images, bilat		S	0397	3.0424	$193.78	$49.50	$38.76
78459	Heart muscle imaging (PET)		S	0307	42.5674	$2,711.25		$542.25
78460	Heart muscle blood, single		S	0398	5.4404	$346.52	$100.00	$69.30
78461	Heart muscle blood, multiple	CH	S	0398	5.4404	$346.52	$100.00	$69.30
78464	Heart image (3d), single		S	0398	5.4404	$346.52	$100.00	$69.30
78465	Heart image (3d), multiple		S	0377	12.0147	$765.25	$158.80	$153.05
78466	Heart infarct image		S	0398	5.4404	$346.52	$100.00	$69.30
78468	Heart infarct image (ef)		S	0398	5.4404	$346.52	$100.00	$69.30
78469	Heart infarct image (3D)		S	0398	5.4404	$346.52	$100.00	$69.30
78472	Gated heart, planar, single		S	0398	5.4404	$346.52	$100.00	$69.30
78473	Gated heart, multiple	CH	S	0398	5.4404	$346.52	$100.00	$69.30
78478	Heart wall motion add-on	CH	N					
78480	Heart function add-on	CH	N					
78481	Heart first pass, single		S	0398	5.4404	$346.52	$100.00	$69.30
78483	Heart first pass, multiple	CH	S	0398	5.4404	$346.52	$100.00	$69.30
78491	Heart image (pet), single		S	0307	42.5674	$2,711.25		$542.25
78492	Heart image (pet), multiple		S	0307	42.5674	$2,711.25		$542.25
78494	Heart image, spect		S	0398	5.4404	$346.52	$100.00	$69.30
78496	Heart first pass add-on	CH	N					
78499	Cardiovascular nuclear exam		S	0398	5.4404	$346.52	$100.00	$69.30
78580	Lung perfusion imaging		S	0401	3.2976	$210.03	$78.10	$42.01
78584	Lung V/Q image single breath		S	0378	5.1617	$328.76	$125.30	$65.75
78585	Lung V/Q imaging		S	0378	5.1617	$328.76	$125.30	$65.75
78586	Aerosol lung image, single		S	0401	3.2976	$210.03	$78.10	$42.01
78587	Aerosol lung image, multiple		S	0401	3.2976	$210.03	$78.10	$42.01
78588	Perfusion lung image		S	0378	5.1617	$328.76	$125.30	$65.75
78591	Vent image, 1 breath, 1 proj		S	0401	3.2976	$210.03	$78.10	$42.01
78593	Vent image, 1 proj, gas		S	0401	3.2976	$210.03	$78.10	$42.01
78594	Vent image, mult proj, gas		S	0401	3.2976	$210.03	$78.10	$42.01
78596	Lung differential function		S	0378	5.1617	$328.76	$125.30	$65.75

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
78599	Respiratory nuclear exam		S	0401	3.2976	$210.03	$78.10	$42.01
78600	Brain imaging, ltd static	CH	S	0403	3.3325	$212.26	$82.39	$42.45
78601	Brain imaging, ltd w/flow	CH	S	0403	3.3325	$212.26	$82.39	$42.45
78605	Brain imaging, complete	CH	S	0403	3.3325	$212.26	$82.39	$42.45
78606	Brain imaging, compl w/flow		S	0402	8.8414	$563.14	$114.10	$112.63
78607	Brain imaging (3D)		S	0402	8.8414	$563.14	$114.10	$112.63
78608	Brain imaging (PET)		S	0308	17.3837	$1,107.22		$221.44
78609	Brain imaging (PET)		E					
78610	Brain flow imaging only		S	0402	8.8414	$563.14	$114.10	$112.63
78615	Cerebral vascular flow image		S	0402	8.8414	$563.14	$114.10	$112.63
78630	Cerebrospinal fluid scan	CH	S	0402	8.8414	$563.14	$114.10	$112.63
78635	CSF ventriculography	CH	S	0402	8.8414	$563.14	$114.10	$112.63
78645	CSF shunt evaluation		S	0403	3.3325	$212.26	$82.39	$42.45
78647	Cerebrospinal fluid scan	CH	S	0402	8.8414	$563.14	$114.10	$112.63
78650	CSF leakage imaging	CH	S	0402	8.8414	$563.14	$114.10	$112.63
78660	Nuclear exam of tear flow		S	0403	3.3325	$212.26	$82.39	$42.45
78699	Nervous system nuclear exam	CH	S	0403	3.3325	$212.26	$82.39	$42.45
78700	Kidney imaging, morphol		S	0404	5.0935	$324.42	$84.10	$64.88
78701	Kidney imaging with flow		S	0404	5.0935	$324.42	$84.10	$64.88
78707	K flow/funct image w/o drug		S	0404	5.0935	$324.42	$84.10	$64.88
78708	K flow/funct image w/drug	CH	S	0404	5.0935	$324.42	$84.10	$64.88
78709	K flow/funct image, multiple	CH	S	0404	5.0935	$324.42	$84.10	$64.88
78710	Kidney imaging (3D)		S	0404	5.0935	$324.42	$84.10	$64.88
78725	Kidney function study		S	0389	1.5806	$100.67	$33.80	$20.13
78730	Urinary bladder retention		X	0340	0.6416	$40.87		$8.17
78740	Ureteral reflux study		S	0404	5.0935	$324.42	$84.10	$64.88
78761	Testicular imaging w/flow		S	0404	5.0935	$324.42	$84.10	$64.88
78799	Genitourinary nuclear exam		S	0404	5.0935	$324.42	$84.10	$64.88
78800	Tumor imaging, limited area		S	0406	4.4988	$286.54	$98.10	$57.31
78801	Tumor imaging, mult areas		S	0406	4.4988	$286.54	$98.10	$57.31
78802	Tumor imaging, whole body	CH	S	0414	7.4985	$477.60	$190.92	$95.52
78803	Tumor imaging (3D)	CH	S	0414	7.4985	$477.60	$190.92	$95.52
78804	Tumor imaging, whole body		S	0408	16.0595	$1,022.88		$204.58
78805	Abscess imaging, ltd area	CH	S	0414	7.4985	$477.60	$190.92	$95.52
78806	Abscess imaging, whole body	CH	S	0414	7.4985	$477.60	$190.92	$95.52
78807	Nuclear localization/abscess	CH	S	0414	7.4985	$477.60	$190.92	$95.52
78811	Tumor imaging (pet), limited		S	0308	17.3837	$1,107.22		$221.44
78812	Tumor image (pet)/skul-thigh		S	0308	17.3837	$1,107.22		$221.44
78813	Tumor image (pet) full body		S	0308	17.3837	$1,107.22		$221.44
78814	Tumor image pet/ct, limited	CH	S	0308	17.3837	$1,107.22		$221.44
78815	Tumorimage pet/ct skul-thigh	CH	S	0308	17.3837	$1,107.22		$221.44
78816	Tumor image pet/ct full body	CH	S	0308	17.3837	$1,107.22		$221.44
78890	Nuclear medicine data proc		N					
78891	Nuclear med data proc		N					
78999	Nuclear diagnostic exam		S	0389	1.5806	$100.67	$33.80	$20.13
79005	Nuclear rx, oral admin		S	0407	3.4563	$220.14	$78.10	$44.03
79101	Nuclear rx, iv admin		S	0407	3.4563	$220.14	$78.10	$44.03
79200	Nuclear rx, intracav admin		S	0413	5.4891	$349.62		$69.92
79300	Nuclr rx, interstit colloid		S	0407	3.4563	$220.14	$78.10	$44.03
79403	Hematopoietic nuclear tx		S	0413	5.4891	$349.62		$69.92
79440	Nuclear rx, intra-articular		S	0413	5.4891	$349.62		$69.92
79445	Nuclear rx, intra-arterial		S	0407	3.4563	$220.14	$78.10	$44.03
79999	Nuclear medicine therapy		S	0407	3.4563	$220.14	$78.10	$44.03
80048	Basic metabolic panel		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		A					
80102	Drug confirmation		A					
80103	Drug analysis, tissue prep		N					
80150	Assay of amikacin		A					
80152	Assay of amitriptyline		A					
80154	Assay of benzodiazepines		A					
80156	Assay, carbamazepine, total		A					
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					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
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	0.2482	$15.81	$5.90	$3.16
80502	Lab pathology consultation		X	0342	0.0928	$5.91	$2.00	$1.18
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					
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					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
82252	Fecal bilirubin test		A					
82261	Assay of biotinidase		A					
82270	Occult blood, feces		A					
82271	Occult blood, other sources		A					
82272	Occult blood, feces, single		A					
82274	Assay test for blood, fecal		A					
82286	Assay of bradykinin		A					
82300	Assay of cadmium		A					
82306	Assay of vitamin D		A					
82307	Assay of vitamin D		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, blood carbon monoxide		A					
82376	Test for carbon monoxide		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					
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					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
82615	Test for urine cystines		A					
82626	Dehydroepiandrosterone		A					
82627	Dehydroepiandrosterone		A					
82633	Desoxycorticosterone		A					
82634	Deoxycortisol		A					
82638	Assay of dibucaine number		A					
82646	Assay of dihydrocodeinone		A					
82649	Assay of dihydromorphinone		A					
82651	Assay of dihydrotestosterone		A					
82652	Assay of dihydroxyvitamin d		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 of gammaglobulin igm		A					
82785	Assay of gammaglobulin ige		A					
82787	Igg 1, 2, 3 or 4, each		A					
82800	Blood pH		A					
82803	Blood gases: pH, pO2 & pCO2		A					
82805	Blood gases W/02 saturation		A					
82810	Blood gases, O2 sat only		A					
82820	Hemoglobin-oxygen affinity		A					
82926	Assay of gastric acid		A					
82928	Assay of gastric acid		A					
82938	Gastrin test		A					
82941	Assay of gastrin		A					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
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	Immunoassay, nonantibody		A					
83520	Immunoassay, RIA		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					
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					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
83864	Mucopolysaccharides		A					
83866	Mucopolysaccharides screen		A					
83872	Assay synovial fluid mucin		A					
83873	Assay of csf protein		A					
83874	Assay of myoglobin		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					
83945	Assay of oxalate		A					
83950	Oncoprotein, her-2/neu		A					
83970	Assay of parathormone		A					
83986	Assay of body fluid acidity		A					
83992	Assay for phencyclidine		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					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
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					
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					
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					
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					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
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					
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					
85097	Bone marrow interpretation		X	0343	0.5372	$34.22	$10.80	$6.84
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					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
85384	Fibrinogen		A					
85385	Fibrinogen		A					
85390	Fibrinolysins screen		A					
85396	Clotting assay, whole blood		N					
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	Platelet neutralization		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					
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	0.2482	$15.81	$5.90	$3.16
86078	Physician blood bank service		X	0343	0.5372	$34.22	$10.80	$6.84
86079	Physician blood bank service		X	0433	0.2482	$15.81	$5.90	$3.16
86140	C-reactive protein		A					
86141	C-reactive protein, hs		A					
86146	Glycoprotein antibody		A					
86147	Cardiolipin antibody		A					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
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					
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					
86353	Lymphocyte transformation		A					
86355	B cells, total count		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					
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					
86485	Skin test, candida		X	0341	0.0879	$5.60	$2.20	$1.12
86490	Coccidioidomycosis skin test		X	0341	0.0879	$5.60	$2.20	$1.12
86510	Histoplasmosis skin test		X	0341	0.0879	$5.60	$2.20	$1.12
86580	TB intradermal test		X	0341	0.0879	$5.60	$2.20	$1.12
86586	Skin test, unlisted		A					
86590	Streptokinase, antibody		A					
86592	Blood serology, qualitative		A					
86593	Blood serology, quantitative		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					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
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					
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					
86781	Treponema pallidum, confirm		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					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
86849	Immunology procedure		A					
86850	RBC antibody screen		X	0345	0.2211	$14.08		$2.82
86860	RBC antibody elution		X	0346	0.3464	$22.06		$4.41
86870	RBC antibody identification		X	0346	0.3464	$22.06		$4.41
86880	Coombs test, direct		X	0409	0.1246	$7.94	$2.20	$1.59
86885	Coombs test, indirect, qual		X	0409	0.1246	$7.94	$2.20	$1.59
86886	Coombs test, indirect, titer		X	0409	0.1246	$7.94	$2.20	$1.59
86890	Autologous blood process		X	0347	0.8166	$52.01	$11.20	$10.40
86891	Autologous blood, op salvage		X	0346	0.3464	$22.06		$4.41
86900	Blood typing, ABO		X	0409	0.1246	$7.94	$2.20	$1.59
86901	Blood typing, Rh (D)		X	0409	0.1246	$7.94	$2.20	$1.59
86903	Blood typing, antigen screen		X	0345	0.2211	$14.08		$2.82
86904	Blood typing, patient serum		X	0346	0.3464	$22.06		$4.41
86905	Blood typing, RBC antigens		X	0345	0.2211	$14.08		$2.82
86906	Blood typing, Rh phenotype		X	0345	0.2211	$14.08		$2.82
86910	Blood typing, paternity test		E					
86911	Blood typing, antigen system		E					
86920	Compatibility test, spin		X	0346	0.3464	$22.06		$4.41
86921	Compatibility test, incubate		X	0345	0.2211	$14.08		$2.82
86922	Compatibility test, antiglob		X	0346	0.3464	$22.06		$4.41
86923	Compatibility test, electric		X	0345	0.2211	$14.08		$2.82
86927	Plasma, fresh frozen		X	0345	0.2211	$14.08		$2.82
86930	Frozen blood prep		X	0347	0.8166	$52.01	$11.20	$10.40
86931	Frozen blood thaw		X	0347	0.8166	$52.01	$11.20	$10.40
86932	Frozen blood freeze/thaw		X	0347	0.8166	$52.01	$11.20	$10.40
86940	Hemolysins/agglutinins, auto		A					
86941	Hemolysins/agglutinins		A					
86945	Blood product/irradiation		X	0345	0.2211	$14.08		$2.82
86950	Leukacyte transfusion		X	0345	0.2211	$14.08		$2.82
86960	Vol reduction of blood/prod		X	0345	0.2211	$14.08		$2.82
86965	Pooling blood platelets		X	0346	0.3464	$22.06		$4.41
86970	RBC pretreatment		X	0345	0.2211	$14.08		$2.82
86971	RBC pretreatment		X	0345	0.2211	$14.08		$2.82
86972	RBC pretreatment		X	0346	0.3464	$22.06		$4.41
86975	RBC pretreatment, serum		X	0346	0.3464	$22.06		$4.41
86976	RBC pretreatment, serum		X	0345	0.2211	$14.08		$2.82
86977	RBC pretreatment, serum		X	0346	0.3464	$22.06		$4.41
86978	RBC pretreatment, serum		X	0346	0.3464	$22.06		$4.41
86985	Split blood or products		X	0345	0.2211	$14.08		$2.82
86999	Transfusion procedure		X	0345	0.2211	$14.08		$2.82
87001	Small animal inoculation		A					
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	Culture type, nucleic acid		A					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
87152	Culture type pulse field gel		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					
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	Cryptosporidum/gardia ag, if		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					
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					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
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					
87495	Cytomeg, dna, dir probe		A					
87496	Cytomeg, dna, amp probe		A					
87497	Cytomeg, dna, quant		A					
87498	Enterovirus, dna, amp probe		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					
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					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
87804	Influenza assay w/optic		A					
87807	Rsv assay w/optic		A					
87808	Trichomonas assay w/optic		A					
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					
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	Coroner's autopsy (necropsy)		E					
88099	Necropsy (autopsy) procedure		E					
88104	Cytopath fl nongyn, smears		X	0433	0.2482	$15.81	$5.90	$3.16
88106	Cytopath fl nongyn, filter		X	0433	0.2482	$15.81	$5.90	$3.16
88107	Cytopath fl nongyn, sm/fltr	CH	X	0343	0.5372	$34.22	$10.80	$6.84
88108	Cytopath, concentrate tech	CH	X	0343	0.5372	$34.22	$10.80	$6.84
88112	Cytopath, cell enhance tech		X	0343	0.5372	$34.22	$10.80	$6.84
88125	Forensic cytopathology		X	0433	0.2482	$15.81	$5.90	$3.16
88130	Sex chromatin identification		A					
88140	Sex chromatin identification		A					
88141	Cytopath, c/v, interpret		N					
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	0.2482	$15.81	$5.90	$3.16
88161	Cytopath smear, other source		X	0433	0.2482	$15.81	$5.90	$3.16
88162	Cytopath smear, other source	CH	X	0343	0.5372	$34.22	$10.80	$6.84
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	Cytopathology eval of fna		X	0343	0.5372	$34.22	$10.80	$6.84
88173	Cytopath eval, fna, report		X	0343	0.5372	$34.22	$10.80	$6.84
88174	Cytopath, c/v auto, in fluid		A					
88175	Cytopath c/v auto fluid redo		A					
88182	Cell marker study		X	0343	0.5372	$34.22	$10.80	$6.84
88184	Flowcytometry/ tc, 1 marker		X	0433	0.2482	$15.81	$5.90	$3.16
88185	Flowcytometry/tc, add-on		X	0433	0.2482	$15.81	$5.90	$3.16
88187	Flowcytometry/read, 2-8		X	0433	0.2482	$15.81	$5.90	$3.16
88188	Flowcytometry/read, 9-15		X	0433	0.2482	$15.81	$5.90	$3.16
88189	Flowcytometry/read, 16 & >		X	0343	0.5372	$34.22	$10.80	$6.84
88199	Cytopathology procedure		X	0342	0.0928	$5.91	$2.00	$1.18
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					
88262	Chromosome analysis, 15-20		A					
88263	Chromosome analysis, 45		A					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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	0.0928	$5.91	$2.00	$1.18
88300	Surgical path, gross		X	0433	0.2482	$15.81	$5.90	$3.16
88302	Tissue exam by pathologist		X	0433	0.2482	$15.81	$5.90	$3.16
88304	Tissue exam by pathologist		X	0343	0.5372	$34.22	$10.80	$6.84
88305	Tissue exam by pathologist		X	0343	0.5372	$34.22	$10.80	$6.84
88307	Tissue exam by pathologist		X	0344	0.8586	$54.69	$15.60	$10.94
88309	Tissue exam by pathologist		X	0344	0.8586	$54.69	$15.60	$10.94
88311	Decalcify tissue		X	0433	0.2482	$15.81	$5.90	$3.16
88312	Special stains		X	0433	0.2482	$15.81	$5.90	$3.16
88313	Special stains		X	0433	0.2482	$15.81	$5.90	$3.16
88314	Histochemical stain	CH	X	0433	0.2482	$15.81	$5.90	$3.16
88318	Chemical histochemistry		X	0433	0.2482	$15.81	$5.90	$3.16
88319	Enzyme histochemistry		X	0343	0.5372	$34.22	$10.80	$6.84
88321	Microslide consultation		X	0433	0.2482	$15.81	$5.90	$3.16
88323	Microslide consultation		X	0343	0.5372	$34.22	$10.80	$6.84
88325	Comprehensive review of data		X	0344	0.8586	$54.69	$15.60	$10.94
88329	Path consult introp		X	0433	0.2482	$15.81	$5.90	$3.16
88331	Path consult intraop, 1 bloc		X	0343	0.5372	$34.22	$10.80	$6.84
88332	Path consult intraop, add'l		X	0433	0.2482	$15.81	$5.90	$3.16
88333	Intraop cyto path consult, 1		X	0343	0.5372	$34.22	$10.80	$6.84
88334	Intraop cyto path consult, 2		X	0433	0.2482	$15.81	$5.90	$3.16
88342	Immunohistochemistry		X	0343	0.5372	$34.22	$10.80	$6.84
88346	Immunofluorescent study		X	0343	0.5372	$34.22	$10.80	$6.84
88347	Immunofluorescent study		X	0343	0.5372	$34.22	$10.80	$6.84
88348	Electron microscopy		X	0661	2.8336	$180.48	$62.00	$36.10
88349	Scanning electron microscopy		X	0661	2.8336	$180.48	$62.00	$36.10
88355	Analysis, skeletal muscle		X	0343	0.5372	$34.22	$10.80	$6.84
88356	Analysis, nerve		X	0344	0.8586	$54.69	$15.60	$10.94
88358	Analysis, tumor		X	0344	0.8586	$54.69	$15.60	$10.94
88360	Tumor immunohistochem/manual		X	0343	0.5372	$34.22	$10.80	$6.84
88361	Tumor immunohistochem/comput		X	0344	0.8586	$54.69	$15.60	$10.94
88362	Nerve teasing preparations		X	0344	0.8586	$54.69	$15.60	$10.94
88365	Insitu hybridization (fish)		X	0344	0.8586	$54.69	$15.60	$10.94
88367	Insitu hybridization, auto		X	0344	0.8586	$54.69	$15.60	$10.94
88368	Insitu hybridization, manual	CH	X	0343	0.5372	$34.22	$10.80	$6.84
88371	Protein, western blot tissue		A					
88372	Protein analysis w/probe		A					
88380	Microdissection		N					
88384	Eval molecular probes, 11-50		X	0433	0.2482	$15.81	$5.90	$3.16
88385	Eval molecul probes, 51-250		X	0343	0.5372	$34.22	$10.80	$6.84
88386	Eval molecul probes, 251-500		X	0344	0.8586	$54.69	$15.60	$10.94
88399	Surgical pathology procedure		X	0342	0.0928	$5.91	$2.00	$1.18
88400	Bilirubin total transcut		A					
89049	Chct for mal hyperthermia		X	0343	0.5372	$34.22	$10.80	$6.84
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		X	0360	1.6383	$104.35	$33.80	$20.87
89105	Sample intestinal contents		X	0360	1.6383	$104.35	$33.80	$20.87
89125	Specimen fat stain		A					
89130	Sample stomach contents		X	0360	1.6383	$104.35	$33.80	$20.87
89132	Sample stomach contents		X	0360	1.6383	$104.35	$33.80	$20.87
89135	Sample stomach contents		X	0360	1.6383	$104.35	$33.80	$20.87
89136	Sample stomach contents		X	0360	1.6383	$104.35	$33.80	$20.87
89140	Sample stomach contents		X	0360	1.6383	$104.35	$33.80	$20.87
89141	Sample stomach contents		X	0360	1.6383	$104.35	$33.80	$20.87
89160	Exam feces for meat fibers		A					
89190	Nasal smear for eosinophils		A					
89220	Sputum specimen collection		X	0343	0.5372	$34.22	$10.80	$6.84
89225	Starch granules, feces		A					
89230	Collect sweat for test	CH	X	0343	0.5372	$34.22	$10.80	$6.84
89235	Water load test		A					
89240	Pathology lab procedure		X	0342	0.0928	$5.91	$2.00	$1.18
89250	Cultr oocyte/embryo <4 days	CH	X	0344	0.8586	$54.69	$15.60	$10.94

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
89251	Cultr oocyte/embryo <4 days	CH	X	0344	0.8586	$54.69	$15.60	$10.94
89253	Embryo hatching	CH	X	0344	0.8586	$54.69	$15.60	$10.94
89254	Oocyte identification	CH	X	0344	0.8586	$54.69	$15.60	$10.94
89255	Prepare embryo for transfer	CH	X	0344	0.8586	$54.69	$15.60	$10.94
89257	Sperm identification	CH	X	0344	0.8586	$54.69	$15.60	$10.94
89258	Cryopreservation; embryo(s)	CH	X	0344	0.8586	$54.69	$15.60	$10.94
89259	Cryopreservation, sperm	CH	X	0344	0.8586	$54.69	$15.60	$10.94
89260	Sperm isolation, simple	CH	X	0344	0.8586	$54.69	$15.60	$10.94
89261	Sperm isolation, complex	CH	X	0344	0.8586	$54.69	$15.60	$10.94
89264	Identify sperm tissue	CH	X	0344	0.8586	$54.69	$15.60	$10.94
89268	Insemination of oocytes	CH	X	0344	0.8586	$54.69	$15.60	$10.94
89272	Extended culture of oocytes	CH	X	0344	0.8586	$54.69	$15.60	$10.94
89280	Assist oocyte fertilization	CH	X	0344	0.8586	$54.69	$15.60	$10.94
89281	Assist oocyte fertilization	CH	X	0344	0.8586	$54.69	$15.60	$10.94
89290	Biopsy, oocyte polar body	CH	X	0344	0.8586	$54.69	$15.60	$10.94
89291	Biopsy, oocyte polar body	CH	X	0344	0.8586	$54.69	$15.60	$10.94
89300	Semen analysis w/huhner		A					
89310	Semen analysis w/count		A					
89320	Semen analysis, complete		A					
89321	Semen analysis & motility		A					
89325	Sperm antibody test		A					
89329	Sperm evaluation test		A					
89330	Evaluation, cervical mucus		A					
89335	Cryopreserve testicular tiss	CH	X	0344	0.8586	$54.69	$15.60	$10.94
89342	Storage/year; embryo(s)	CH	X	0344	0.8586	$54.69	$15.60	$10.94
89343	Storage/year; sperm/semen	CH	X	0344	0.8586	$54.69	$15.60	$10.94
89344	Storage/year; reprod tissue	CH	X	0344	0.8586	$54.69	$15.60	$10.94
89346	Storage/year; oocyte(s)	CH	X	0344	0.8586	$54.69	$15.60	$10.94
89352	Thawing cryopresrved; embryo	CH	X	0344	0.8586	$54.69	$15.60	$10.94
89353	Thawing cryopresrved; sperm	CH	X	0344	0.8586	$54.69	$15.60	$10.94
89354	Thaw cryoprsvrd; reprod tiss	CH	X	0344	0.8586	$54.69	$15.60	$10.94
89356	Thawing cryopresrved; oocyte	CH	X	0344	0.8586	$54.69	$15.60	$10.94
90281	Human ig, im		E					
90283	Human ig, iv		E					
90287	Botulinum antitoxin		E					
90288	Botulism ig, iv		E					
90291	Cmv ig, iv		E					
90296	Diphtheria antitoxin		N					
90371	Hep b ig, im		K	1630		$132.42		$26.48
90375	Rabies ig, im/sc		K	9133		$64.82		$12.96
90376	Rabies ig, heat treated		K	9134		$69.40		$13.88
90378	Rsv ig, im, 50mg		E					
90379	Rsv ig, iv		E					
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		N					
90396	Varicella-zoster ig, im		K	9135		$121.58		$24.32
90399	Immune globulin		E					
90465	Immune admin 1 inj, < 8 yrs		B					
90466	Immune admin addl inj, < 8 y		B					
90467	Immune admin o or n, < 8 yrs		B					
90468	Immune admin o/n, addl < 8 y		B					
90471	Immunization admin		S	0437	0.4037	$25.71		$5.14
90472	Immunization admin, each add		S	0436	0.2201	$14.02		$2.80
90473	Immune admin oral/nasal		S	0436	0.2201	$14.02		$2.80
90474	Immune admin oral/nasal addl		S	0436	0.2201	$14.02		$2.80
90476	Adenovirus vaccine, type 4		N					
90477	Adenovirus vaccine, type 7		N					
90581	Anthrax vaccine, sc		N					
90585	Bcg vaccine, percut		K	9137		$112.56		$22.51
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					
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	H papilloma vacc 3 dose im		B					
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		L					
90660	Flu vaccine, nasal		L					
90665	Lyme disease vaccine, im		N					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
90669	Pneumococcal vacc, ped <5		E					
90675	Rabies vaccine, im		K	9139		$145.53		$29.11
90676	Rabies vaccine, id		K	9140	1.9483	$124.09		$24.82
90680	Rotovirus vacc 3 dose, oral		N					
90690	Typhoid vaccine, oral		N					
90691	Typhoid vaccine, im		N					
90692	Typhoid vaccine, h-p, sc/id		N					
90693	Typhoid vaccine, akd, sc		B					
90698	Dtap-hib-ip vaccine, im		N					
90700	Dtap vaccine, < 7 yrs, im		N					
90701	Dtp vaccine, im		N					
90702	Dt vaccine < 7, im		N					
90703	Tetanus vaccine, im		N					
90704	Mumps vaccine, sc		N					
90705	Measles vaccine, sc		N					
90706	Rubella vaccine, sc		N					
90707	Mmr vaccine, sc		N					
90708	Measles-rubella vaccine, sc		K	9141	0.9593	$61.10		$12.22
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		B					
90717	Yellow fever vaccine, sc		N					
90718	Td vaccine > 7, im		N					
90719	Diphtheria vaccine, im		N					
90720	Dtp/hib vaccine, im	CH	N					
90721	Dtap/hib vaccine, im		N					
90723	Dtap-hep b-ipv vaccine, im		E					
90725	Cholera vaccine, injectable		N					
90727	Plague vaccine, im	CH	N					
90732	Pneumococcal vaccine		L					
90733	Meningococcal vaccine, sc		K	9143		$88.59		$17.72
90734	Meningococcal vaccine, im		K	9145	1.1309	$72.03		$14.41
90735	Encephalitis vaccine, sc		K	9144		$98.17		$19.63
90736	Zoster vacc, sc		B					
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					
90760	Hydration iv infusion, init		S	0440	1.831	$116.62		$23.32
90761	Hydrate iv infusion, add-on		S	0437	0.4037	$25.71		$5.14
90765	Ther/proph/diag iv inf, init		S	0440	1.831	$116.62		$23.32
90766	Ther/proph/dg iv inf, add-on		S	0437	0.4037	$25.71		$5.14
90767	Tx/proph/dg addl seq iv inf		S	0437	0.4037	$25.71		$5.14
90768	Ther/diag concurrent inf		N					
90772	Ther/proph/diag inj, sc/im		S	0437	0.4037	$25.71		$5.14
90773	Ther/proph/diag inj, ia		S	0438	0.831	$52.93		$10.59
90774	Ther/proph/diag inj, iv push		S	0438	0.831	$52.93		$10.59
90775	Ther/proph/diag inj add-on		S	0438	0.831	$52.93		$10.59
90779	Ther/prop/diag inj/inf proc		S	0436	0.2201	$14.02		$2.80
90801	Psy dx interview	CH	Q	0323	1.672	$106.49		$21.30
90802	Intac psy dx interview	CH	Q	0323	1.672	$106.49		$21.30
90804	Psytx, office, 20-30 min	CH	Q	0322	1.2454	$79.32		$15.86
90805	Psytx, off, 20-30 min w/e&m	CH	Q	0322	1.2454	$79.32		$15.86
90806	Psytx, off, 45-50 min	CH	Q	0323	1.672	$106.49		$21.30
90807	Psytx, off, 45-50 min w/e&m	CH	Q	0323	1.672	$106.49		$21.30
90808	Psytx, office, 75-80 min	CH	Q	0323	1.672	$106.49		$21.30
90809	Psytx, off, 75-80, w/e&m	CH	Q	0323	1.672	$106.49		$21.30
90810	Intac psytx, off, 20-30 min	CH	Q	0322	1.2454	$79.32		$15.86
90811	Intac psytx, 20-30, w/e&m	CH	Q	0322	1.2454	$79.32		$15.86
90812	Intac psytx, off, 45-50 min	CH	Q	0323	1.672	$106.49		$21.30
90813	Intac psytx, 45-50 min w/e&m	CH	Q	0323	1.672	$106.49		$21.30
90814	Intac psytx, off, 75-80 min	CH	Q	0323	1.672	$106.49		$21.30
90815	Intac psytx, 75-80 w/e&m	CH	Q	0323	1.672	$106.49		$21.30
90816	Psytx, hosp, 20-30 min	CH	Q	0322	1.2454	$79.32		$15.86
90817	Psytx, hosp, 20-30 min w/e&m	CH	Q	0322	1.2454	$79.32		$15.86
90818	Psytx, hosp, 45-50 min	CH	Q	0323	1.672	$106.49		$21.30
90819	Psytx, hosp, 45-50 min w/e&m	CH	Q	0323	1.672	$106.49		$21.30
90821	Psytx, hosp, 75-80 min	CH	Q	0323	1.672	$106.49		$21.30
90822	Psytx, hosp, 75-80 min w/e&m	CH	Q	0323	1.672	$106.49		$21.30
90823	Intac psytx, hosp, 20-30 min	CH	Q	0322	1.2454	$79.32		$15.86
90824	Intac psytx, hsp 20-30 w/e&m	CH	Q	0322	1.2454	$79.32		$15.86
90826	Intac psytx, hosp, 45-50 min	CH	Q	0323	1.672	$106.49		$21.30

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
90827	Intac psytx, hsp 45-50 w/e&m	CH	Q	0323	1.672	$106.49		$21.30
90828	Intac psytx, hosp, 75-80 min	CH	Q	0323	1.672	$106.49		$21.30
90829	Intac psytx, hsp 75-80 w/e&m	CH	Q	0323	1.672	$106.49		$21.30
90845	Psychoanalysis	CH	Q	0323	1.672	$106.49		$21.30
90846	Family psytx w/o patient	CH	Q	0324	2.2233	$141.61		$28.32
90847	Family psytx w/patient	CH	Q	0324	2.2233	$141.61		$28.32
90849	Multiple family group psytx	CH	Q	0325	1.0119	$64.45	$14.04	$12.89
90853	Group psychotherapy	CH	Q	0325	1.0119	$64.45	$14.04	$12.89
90857	Intac group psytx	CH	Q	0325	1.0119	$64.45	$14.04	$12.89
90862	Medication management	CH	Q	0605	1.0016	$63.79		$12.76
90865	Narcosynthesis	CH	Q	0323	1.672	$106.49		$21.30
90870	Electroconvulsive therapy		S	0320	5.9448	$378.64	$80.00	$75.73
90875	Psychophysiological therapy		E					
90876	Psychophysiological therapy		E					
90880	Hypnotherapy	CH	Q	0323	1.672	$106.49		$21.30
90882	Environmental manipulation		E					
90885	Psy evaluation of records		N					
90887	Consultation with family		N					
90889	Preparation of report		N					
90899	Psychiatric service/therapy	CH	Q	0322	1.2454	$79.32		$15.86
90901	Biofeedback train, any meth		A					
90911	Biofeedback peri/uro/rectal	CH	T	0126	1.085	$69.11	$16.40	$13.82
90918	ESRD related services, month		E					
90919	ESRD related services, month		E					
90920	ESRD related services, month		E					
90921	ESRD related services, month		E					
90922	ESRD related services, day		E					
90923	Esrd related services, day		E					
90924	Esrd related services, day		E					
90925	Esrd related services, day		E					
90935	Hemodialysis, one evaluation		S	0170	6.7915	$432.57		$86.51
90937	Hemodialysis, repeated eval		B					
90940	Hemodialysis access study		N					
90945	Dialysis, one evaluation		S	0170	6.7915	$432.57		$86.51
90947	Dialysis, repeated eval		B					
90989	Dialysis training, complete		B					
90993	Dialysis training, incompl		B					
90997	Hemoperfusion		B					
90999	Dialysis procedure		B					
91000	Esophageal intubation		X	0361	4.0867	$260.29	$83.20	$52.06
91010	Esophagus motility study		X	0361	4.0867	$260.29	$83.20	$52.06
91011	Esophagus motility study		X	0361	4.0867	$260.29	$83.20	$52.06
91012	Esophagus motility study		X	0361	4.0867	$260.29	$83.20	$52.06
91020	Gastric motility studies		X	0361	4.0867	$260.29	$83.20	$52.06
91022	Duodenal motility study		X	0361	4.0867	$260.29	$83.20	$52.06
91030	Acid perfusion of esophagus		X	0361	4.0867	$260.29	$83.20	$52.06
91034	Gastroesophageal reflux test		X	0361	4.0867	$260.29	$83.20	$52.06
91035	G-esoph reflx tst w/electrod		X	0361	4.0867	$260.29	$83.20	$52.06
91037	Esoph imped function test		X	0361	4.0867	$260.29	$83.20	$52.06
91038	Esoph imped funct test > 1h		X	0361	4.0867	$260.29	$83.20	$52.06
91040	Esoph balloon distension tst		X	0360	1.6383	$104.35	$33.80	$20.87
91052	Gastric analysis test		X	0361	4.0867	$260.29	$83.20	$52.06
91055	Gastric intubation for smear		X	0360	1.6383	$104.35	$33.80	$20.87
91065	Breath hydrogen test		X	0360	1.6383	$104.35	$33.80	$20.87
91100	Pass intestine bleeding tube		X	0360	1.6383	$104.35	$33.80	$20.87
91105	Gastric intubation treatment		X	0360	1.6383	$104.35	$33.80	$20.87
91110	Gi tract capsule endoscopy		T	0142	9.6264	$613.13	$152.70	$122.63
91111	Esophageal capsule endoscopy		T	0141	8.673	$552.41	$143.30	$110.48
91120	Rectal sensation test		T	0126	1.085	$69.11	$16.40	$13.82
91122	Anal pressure record		T	0164	2.1659	$137.95		$27.59
91123	Irrigate fecal impaction		N					
91132	Electrogastrography		X	0360	1.6383	$104.35	$33.80	$20.87
91133	Electrogastrography w/test		X	0360	1.6383	$104.35	$33.80	$20.87
91299	Gastroenterology procedure		X	0360	1.6383	$104.35	$33.80	$20.87
92002	Eye exam, new patient		V	0605	1.0016	$63.79		$12.76
92004	Eye exam, new patient		V	0606	1.3665	$87.04		$17.41
92012	Eye exam established pat		V	0604	0.8381	$53.38		$10.68
92014	Eye exam & treatment		V	0605	1.0016	$63.79		$12.76
92015	Refraction		E					
92018	New eye exam & treatment		T	0699	14.2784	$909.43		$181.89
92019	Eye exam & treatment		T	0699	14.2784	$909.43		$181.89
92020	Special eye evaluation		S	0230	0.7379	$47.00		$9.40
92025	Corneal topography		S	0698	1.1576	$73.73		$14.75
92060	Special eye evaluation		S	0230	0.7379	$47.00		$9.40
92065	Orthoptic/pleoptic training		S	0230	0.7379	$47.00		$9.40
92070	Fitting of contact lens		N					
92081	Visual field examination(s)		S	0230	0.7379	$47.00		$9.40
92082	Visual field examination(s)		S	0230	0.7379	$47.00		$9.40

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
92083	Visual field examination(s)		S	0230	0.7379	$47.00		$9.40
92100	Serial tonometry exam(s)		N					
92120	Tonography & eye evaluation		S	0230	0.7379	$47.00		$9.40
92130	Water provocation tonography		S	0230	0.7379	$47.00		$9.40
92135	Opthalmic dx imaging		S	0230	0.7379	$47.00		$9.40
92136	Ophthalmic biometry		S	0698	1.1576	$73.73		$14.75
92140	Glaucoma provocative tests		S	0230	0.7379	$47.00		$9.40
92225	Special eye exam, initial		S	0230	0.7379	$47.00		$9.40
92226	Special eye exam, subsequent		S	0230	0.7379	$47.00		$9.40
92230	Eye exam with photos		S	0231	2.3117	$147.24		$29.45
92235	Eye exam with photos		S	0231	2.3117	$147.24		$29.45
92240	Icg angiography		S	0231	2.3117	$147.24		$29.45
92250	Eye exam with photos		S	0230	0.7379	$47.00		$9.40
92260	Ophthalmoscopy/dynamometry		S	0230	0.7379	$47.00		$9.40
92265	Eye muscle evaluation		S	0230	0.7379	$47.00		$9.40
92270	Electro-oculography		S	0230	0.7379	$47.00		$9.40
92275	Electroretinography		S	0231	2.3117	$147.24		$29.45
92283	Color vision examination		S	0230	0.7379	$47.00		$9.40
92284	Dark adaptation eye exam		S	0698	1.1576	$73.73		$14.75
92285	Eye photography		S	0230	0.7379	$47.00		$9.40
92286	Internal eye photography		S	0698	1.1576	$73.73		$14.75
92287	Internal eye photography		S	0698	1.1576	$73.73		$14.75
92310	Contact lens fitting		E					
92311	Contact lens fitting	CH	S	0230	0.7379	$47.00		$9.40
92312	Contact lens fitting	CH	S	0230	0.7379	$47.00		$9.40
92313	Contact lens fitting	CH	S	0230	0.7379	$47.00		$9.40
92314	Prescription of contact lens		E					
92315	Prescription of contact lens	CH	S	0230	0.7379	$47.00		$9.40
92316	Prescription of contact lens	CH	S	0230	0.7379	$47.00		$9.40
92317	Prescription of contact lens	CH	S	0230	0.7379	$47.00		$9.40
92325	Modification of contact lens	CH	S	0230	0.7379	$47.00		$9.40
92326	Replacement of contact lens	CH	S	0230	0.7379	$47.00		$9.40
92340	Fitting of spectacles		E					
92341	Fitting of spectacles		E					
92342	Fitting of spectacles		E					
92352	Special spectacles fitting	CH	S	0230	0.7379	$47.00		$9.40
92353	Special spectacles fitting	CH	S	0230	0.7379	$47.00		$9.40
92354	Special spectacles fitting	CH	S	0230	0.7379	$47.00		$9.40
92355	Special spectacles fitting	CH	S	0230	0.7379	$47.00		$9.40
92358	Eye prosthesis service	CH	S	0230	0.7379	$47.00		$9.40
92370	Repair & adjust spectacles		E					
92371	Repair & adjust spectacles	CH	S	0230	0.7379	$47.00		$9.40
92499	Eye service or procedure		S	0230	0.7379	$47.00		$9.40
92502	Ear and throat examination		T	0251	2.5765	$164.11		$32.82
92504	Ear microscopy examination		N					
92506	Speech/hearing evaluation		A					
92507	Speech/hearing therapy		A					
92508	Speech/hearing therapy		A					
92511	Nasopharyngoscopy		T	0071	0.8256	$52.58	$11.20	$10.52
92512	Nasal function studies		X	0363	0.8542	$54.41	$17.40	$10.88
92516	Facial nerve function test		X	0660	1.4408	$91.77	$28.00	$18.35
92520	Laryngeal function studies		X	0660	1.4408	$91.77	$28.00	$18.35
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					
92541	Spontaneous nystagmus test		X	0363	0.8542	$54.41	$17.40	$10.88
92542	Positional nystagmus test		X	0363	0.8542	$54.41	$17.40	$10.88
92543	Caloric vestibular test		X	0660	1.4408	$91.77	$28.00	$18.35
92544	Optokinetic nystagmus test		X	0363	0.8542	$54.41	$17.40	$10.88
92545	Oscillating tracking test		X	0363	0.8542	$54.41	$17.40	$10.88
92546	Sinusoidal rotational test		X	0660	1.4408	$91.77	$28.00	$18.35
92547	Supplemental electrical test	CH	N					
92548	Posturography		X	0660	1.4408	$91.77	$28.00	$18.35
92551	Pure tone hearing test, air		E					
92552	Pure tone audiometry, air		X	0364	0.4448	$28.33	$6.98	$5.67
92553	Audiometry, air & bone		X	0365	1.281	$81.59	$18.50	$16.32
92555	Speech threshold audiometry		X	0364	0.4448	$28.33	$6.98	$5.67
92556	Speech audiometry, complete		X	0364	0.4448	$28.33	$6.98	$5.67
92557	Comprehensive hearing test		X	0365	1.281	$81.59	$18.50	$16.32
92559	Group audiometric testing		E					
92560	Bekesy audiometry, screen		E					
92561	Bekesy audiometry, diagnosis		X	0364	0.4448	$28.33	$6.98	$5.67
92562	Loudness balance test		X	0364	0.4448	$28.33	$6.98	$5.67
92563	Tone decay hearing test		X	0364	0.4448	$28.33	$6.98	$5.67
92564	Sisi hearing test		X	0364	0.4448	$28.33	$6.98	$5.67
92565	Stenger test, pure tone		X	0364	0.4448	$28.33	$6.98	$5.67

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
92567	Tympanometry		X	0364	0.4448	$28.33	$6.98	$5.67
92568	Acoustic refl threshold tst		X	0364	0.4448	$28.33	$6.98	$5.67
92569	Acoustic reflex decay test		X	0364	0.4448	$28.33	$6.98	$5.67
92571	Filtered speech hearing test		X	0364	0.4448	$28.33	$6.98	$5.67
92572	Staggered spondaic word test		X	0366	1.8646	$118.76	$26.10	$23.75
92575	Sensorineural acuity test		X	0364	0.4448	$28.33	$6.98	$5.67
92576	Synthetic sentence test		X	0364	0.4448	$28.33	$6.98	$5.67
92577	Stenger test, speech		X	0366	1.8646	$118.76	$26.10	$23.75
92579	Visual audiometry (vra)		X	0365	1.281	$81.59	$18.50	$16.32
92582	Conditioning play audiometry		X	0365	1.281	$81.59	$18.50	$16.32
92583	Select picture audiometry		X	0364	0.4448	$28.33	$6.98	$5.67
92584	Electrocochleography	CH	S	0216	2.768	$176.30		$35.26
92585	Auditor evoke potent, compre		S	0216	2.768	$176.30		$35.26
92586	Auditor evoke potent, limit		S	0218	1.1861	$75.55		$15.11
92587	Evoked auditory test		X	0363	0.8542	$54.41	$17.40	$10.88
92588	Evoked auditory test		X	0660	1.4408	$91.77	$28.00	$18.35
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	0.4448	$28.33	$6.98	$5.67
92597	Oral speech device eval		A					
92601	Cochlear implt f/up exam < 7		X	0366	1.8646	$118.76	$26.10	$23.75
92602	Reprogram cochlear implt < 7		X	0366	1.8646	$118.76	$26.10	$23.75
92603	Cochlear implt f/up exam 7 >		X	0366	1.8646	$118.76	$26.10	$23.75
92604	Reprogram cochlear implt 7 >		X	0366	1.8646	$118.76	$26.10	$23.75
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					
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	1.281	$81.59	$18.50	$16.32
92621	Auditory function, + 15 min		N					
92625	Tinnitus assessment		X	0365	1.281	$81.59	$18.50	$16.32
92626	Eval aud rehab status		X	0365	1.281	$81.59	$18.50	$16.32
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	1.281	$81.59	$18.50	$16.32
92700	Ent procedure/service		X	0364	0.4448	$28.33	$6.98	$5.67
92950	Heart/lung resuscitation cpr		S	0094	2.5547	$162.72	$46.20	$32.54
92953	Temporary external pacing		S	0094	2.5547	$162.72	$46.20	$32.54
92960	Cardioversion electric, ext		S	0679	5.5905	$356.08	$95.30	$71.22
92961	Cardioversion, electric, int		S	0679	5.5905	$356.08	$95.30	$71.22
92970	Cardioassist, internal		C					
92971	Cardioassist, external		C					
92973	Percut coronary thrombectomy		T	0088	39.8001	$2,534.99	$655.20	$507.00
92974	Cath place, cardio brachytx		T	0103	15.2572	$971.78		$194.36
92975	Dissolve clot, heart vessel		C					
92977	Dissolve clot, heart vessel		T	0676	2.5179	$160.37		$32.07
92978	Intravasc us, heart add-on	CH	N					
92979	Intravasc us, heart add-on	CH	N					
92980	Insert intracoronary stent		T	0104	89.0212	$5,670.03		$1,134.01
92981	Insert intracoronary stent		T	0104	89.0212	$5,670.03		$1,134.01
92982	Coronary artery dilation		T	0083	46.0685	$2,934.24		$586.85
92984	Coronary artery dilation		T	0083	46.0685	$2,934.24		$586.85
92986	Revision of aortic valve		T	0083	46.0685	$2,934.24		$586.85
92987	Revision of mitral valve		T	0083	46.0685	$2,934.24		$586.85
92990	Revision of pulmonary valve		T	0083	46.0685	$2,934.24		$586.85
92992	Revision of heart chamber		C					
92993	Revision of heart chamber		C					
92995	Coronary atherectomy		T	0082	88.7717	$5,654.14		$1,130.83
92996	Coronary atherectomy add-on		T	0082	88.7717	$5,654.14		$1,130.83
92997	Pul art balloon repr, percut	CH	T	0083	46.0685	$2,934.24		$586.85
92998	Pul art balloon repr, percut	CH	T	0083	46.0685	$2,934.24		$586.85
93000	Electrocardiogram, complete		B					
93005	Electrocardiogram, tracing		S	0099	0.3912	$24.92		$4.98
93010	Electrocardiogram report		B					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
93012	Transmission of ecg		N					
93014	Report on transmitted ecg		B					
93015	Cardiovascular stress test		B					
93016	Cardiovascular stress test		B					
93017	Cardiovascular stress test		X	0100	2.8631	$182.36	$41.40	$36.47
93018	Cardiovascular stress test		B					
93024	Cardiac drug stress test		X	0100	2.8631	$182.36	$41.40	$36.47
93025	Microvolt t-wave assess		X	0100	2.8631	$182.36	$41.40	$36.47
93040	Rhythm ECG with report		B					
93041	Rhythm ECG, tracing		S	0099	0.3912	$24.92		$4.98
93042	Rhythm ECG, report		B					
93224	ECG monitor/report, 24 hrs		B					
93225	ECG monitor/record, 24 hrs		X	0097	1.0396	$66.22	$23.70	$13.24
93226	ECG monitor/report, 24 hrs		X	0097	1.0396	$66.22	$23.70	$13.24
93227	ECG monitor/review, 24 hrs		B					
93230	ECG monitor/report, 24 hrs		B					
93231	Ecg monitor/record, 24 hrs		X	0097	1.0396	$66.22	$23.70	$13.24
93232	ECG monitor/report, 24 hrs		X	0097	1.0396	$66.22	$23.70	$13.24
93233	ECG monitor/review, 24 hrs		B					
93235	ECG monitor/report, 24 hrs		B					
93236	ECG monitor/report, 24 hrs		X	0097	1.0396	$66.22	$23.70	$13.24
93237	ECG monitor/review, 24 hrs		B					
93268	ECG record/review		B					
93270	ECG recording		X	0097	1.0396	$66.22	$23.70	$13.24
93271	Ecg/monitoring and analysis		X	0097	1.0396	$66.22	$23.70	$13.24
93272	Ecg/review, interpret only		B					
93278	ECG/signal-averaged	CH	X	0340	0.6416	$40.87		$8.17
93303	Echo transthoracic		S	0269	6.5908	$419.79		$83.96
93304	Echo transthoracic		S	0697	4.8072	$306.18		$61.24
93307	Echo exam of heart		S	0269	6.5908	$419.79		$83.96
93308	Echo exam of heart		S	0697	4.8072	$306.18		$61.24
93312	Echo transesophageal		S	0270	8.42	$536.30	$141.30	$107.26
93313	Echo transesophageal		S	0270	8.42	$536.30	$141.30	$107.26
93314	Echo transesophageal		N					
93315	Echo transesophageal		S	0270	8.42	$536.30	$141.30	$107.26
93316	Echo transesophageal		S	0270	8.42	$536.30	$141.30	$107.26
93317	Echo transesophageal		N					
93318	Echo transesophageal intraop		S	0270	8.42	$536.30	$141.30	$107.26
93320	Doppler echo exam, heart	CH	N					
93321	Doppler echo exam, heart	CH	N					
93325	Doppler color flow add-on	CH	N					
93350	Echo transthoracic	CH	S	0697	4.8072	$306.18		$61.24
93501	Right heart catheterization		T	0080	39.8631	$2,539.00	$838.90	$507.80
93503	Insert/place heart catheter		T	0103	15.2572	$971.78		$194.36
93505	Biopsy of heart lining		T	0103	15.2572	$971.78		$194.36
93508	Cath placement, angiography		T	0080	39.8631	$2,539.00	$838.90	$507.80
93510	Left heart catheterization		T	0080	39.8631	$2,539.00	$838.90	$507.80
93511	Left heart catheterization		T	0080	39.8631	$2,539.00	$838.90	$507.80
93514	Left heart catheterization		T	0080	39.8631	$2,539.00	$838.90	$507.80
93524	Left heart catheterization		T	0080	39.8631	$2,539.00	$838.90	$507.80
93526	Rt & lT heart catheters		T	0080	39.8631	$2,539.00	$838.90	$507.80
93527	Rt & lT heart catheters		T	0080	39.8631	$2,539.00	$838.90	$507.80
93528	Rt & lT heart catheters		T	0080	39.8631	$2,539.00	$838.90	$507.80
93529	Rt, lt heart catheterization		T	0080	39.8631	$2,539.00	$838.90	$507.80
93530	Rt heart cath, congenital		T	0080	39.8631	$2,539.00	$838.90	$507.80
93531	R & l heart cath, congenital		T	0080	39.8631	$2,539.00	$838.90	$507.80
93532	R & l heart cath, congenital		T	0080	39.8631	$2,539.00	$838.90	$507.80
93533	R & l heart cath, congenital		T	0080	39.8631	$2,539.00	$838.90	$507.80
93539	Injection, cardiac cath		N					
93540	Injection, cardiac cath		N					
93541	Injection for lung angiogram		N					
93542	Injection for heart x-rays		N					
93543	Injection for heart x-rays		N					
93544	Injection for aortography		N					
93545	Inject for coronary x-rays		N					
93555	Imaging, cardiac cath		N					
93556	Imaging, cardiac cath		N					
93561	Cardiac output measurement		N					
93562	Cardiac output measurement		N					
93571	Heart flow reserve measure	CH	N					
93572	Heart flow reserve measure	CH	N					
93580	Transcath closure of asd		T	0434	141.9601	$9,041.86		$1,808.37
93581	Transcath closure of vsd		T	0434	141.9601	$9,041.86		$1,808.37
93600	Bundle of His recording	CH	S	0084	10.2918	$655.52		$131.10
93602	Intra-atrial recording	CH	S	0084	10.2918	$655.52		$131.10
93603	Right ventricular recording	CH	S	0084	10.2918	$655.52		$131.10
93609	Map tachycardia, add-on	CH	N					
93610	Intra-atrial pacing	CH	S	0084	10.2918	$655.52		$131.10

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
93612	Intraventricular pacing	CH	S	0084	10.2918	$655.52		$131.10
93613	Electrophys map 3d, add-on	CH	N					
93615	Esophageal recording	CH	S	0084	10.2918	$655.52		$131.10
93616	Esophageal recording	CH	S	0084	10.2918	$655.52		$131.10
93618	Heart rhythm pacing	CH	S	0084	10.2918	$655.52		$131.10
93619	Electrophysiology evaluation	CH	Q	0085	48.6296	$3,097.37		$619.47
93620	Electrophysiology evaluation	CH	Q	0085	48.6296	$3,097.37		$619.47
93621	Electrophysiology evaluation	CH	N					
93622	Electrophysiology evaluation	CH	N					
93623	Stimulation, pacing heart	CH	N					
93624	Electrophysiologic study		T	0085	48.6296	$3,097.37		$619.47
93631	Heart pacing, mapping	CH	N					
93640	Evaluation heart device		N					
93641	Electrophysiology evaluation		N					
93642	Electrophysiology evaluation		S	0084	10.2918	$655.52		$131.10
93650	Ablate heart dysrhythm focus	CH	Q	0085	48.6296	$3,097.37		$619.47
93651	Ablate heart dysrhythm focus	CH	Q	0086	90.7639	$5,781.03		$1,156.21
93652	Ablate heart dysrhythm focus	CH	Q	0086	90.7639	$5,781.03		$1,156.21
93660	Tilt table evaluation		S	0101	4.4249	$281.84	$100.20	$56.37
93662	Intracardiac ecg (ice)	CH	N					
93668	Peripheral vascular rehab		E					
93701	Bioimpedance, thoracic		S	0099	0.3912	$24.92		$4.98
93720	Total body plethysmography		B					
93721	Plethysmography tracing		X	0368	0.9541	$60.77	$22.70	$12.15
93722	Plethysmography report		B					
93724	Analyze pacemaker system		S	0690	0.359	$22.87	$8.60	$4.57
93727	Analyze ilr system		S	0690	0.359	$22.87	$8.60	$4.57
93731	Analyze pacemaker system		S	0690	0.359	$22.87	$8.60	$4.57
93732	Analyze pacemaker system		S	0690	0.359	$22.87	$8.60	$4.57
93733	Telephone analy, pacemaker		S	0690	0.359	$22.87	$8.60	$4.57
93734	Analyze pacemaker system		S	0690	0.359	$22.87	$8.60	$4.57
93735	Analyze pacemaker system		S	0690	0.359	$22.87	$8.60	$4.57
93736	Telephonic analy, pacemaker		S	0690	0.359	$22.87	$8.60	$4.57
93740	Temperature gradient studies		X	0368	0.9541	$60.77	$22.70	$12.15
93741	Analyze ht pace device sngl		S	0689	0.5936	$37.81		$7.56
93742	Analyze ht pace device sngl		S	0689	0.5936	$37.81		$7.56
93743	Analyze ht pace device dual		S	0689	0.5936	$37.81		$7.56
93744	Analyze ht pace device dual		S	0689	0.5936	$37.81		$7.56
93745	Set-up cardiovert-defibrill		S	0689	0.5936	$37.81		$7.56
93760	Cephalic thermogram		E					
93762	Peripheral thermogram		E					
93770	Measure venous pressure		N					
93784	Ambulatory BP monitoring		E					
93786	Ambulatory BP recording		X	0097	1.0396	$66.22	$23.70	$13.24
93788	Ambulatory BP analysis		X	0097	1.0396	$66.22	$23.70	$13.24
93790	Review/report BP recording		B					
93797	Cardiac rehab	CH	B					
93798	Cardiac rehab/monitor	CH	B					
93799	Cardiovascular procedure		X	0097	1.0396	$66.22	$23.70	$13.24
93875	Extracranial study		S	0096	1.5254	$97.16	$37.60	$19.43
93880	Extracranial study		S	0267	2.4859	$158.33	$60.50	$31.67
93882	Extracranial study		S	0267	2.4859	$158.33	$60.50	$31.67
93886	Intracranial study		S	0267	2.4859	$158.33	$60.50	$31.67
93888	Intracranial study		S	0265	0.9925	$63.22	$23.60	$12.64
93890	Tcd, vasoreactivity study		S	0266	1.5657	$99.72	$37.80	$19.94
93892	Tcd, emboli detect w/o inj		S	0266	1.5657	$99.72	$37.80	$19.94
93893	Tcd, emboli detect w/inj		S	0266	1.5657	$99.72	$37.80	$19.94
93922	Extremity study		S	0096	1.5254	$97.16	$37.60	$19.43
93923	Extremity study		S	0096	1.5254	$97.16	$37.60	$19.43
93924	Extremity study		S	0096	1.5254	$97.16	$37.60	$19.43
93925	Lower extremity study		S	0267	2.4859	$158.33	$60.50	$31.67
93926	Lower extremity study		S	0266	1.5657	$99.72	$37.80	$19.94
93930	Upper extremity study		S	0267	2.4859	$158.33	$60.50	$31.67
93931	Upper extremity study		S	0266	1.5657	$99.72	$37.80	$19.94
93965	Extremity study		S	0096	1.5254	$97.16	$37.60	$19.43
93970	Extremity study		S	0267	2.4859	$158.33	$60.50	$31.67
93971	Extremity study		S	0266	1.5657	$99.72	$37.80	$19.94
93975	Vascular study		S	0267	2.4859	$158.33	$60.50	$31.67
93976	Vascular study		S	0267	2.4859	$158.33	$60.50	$31.67
93978	Vascular study	CH	S	0267	2.4859	$158.33	$60.50	$31.67
93979	Vascular study		S	0266	1.5657	$99.72	$37.80	$19.94
93980	Penile vascular study		S	0267	2.4859	$158.33	$60.50	$31.67
93981	Penile vascular study	CH	S	0267	2.4859	$158.33	$60.50	$31.67
93990	Doppler flow testing		S	0266	1.5657	$99.72	$37.80	$19.94
94002	Vent mgmt inpat, init day		S	0079	2.6745	$170.35		$34.07
94003	Vent mgmt inpat, subq day		S	0079	2.6745	$170.35		$34.07
94004	Vent mgmt nf per day		B					
94005	Home vent mgmt supervision		B					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
94010	Breathing capacity test		X	0368	0.9541	$60.77	$22.70	$12.15
94014	Patient recorded spirometry		X	0367	0.5955	$37.93	$14.38	$7.59
94015	Patient recorded spirometry		X	0367	0.5955	$37.93	$14.38	$7.59
94016	Review patient spirometry		A					
94060	Evaluation of wheezing		X	0368	0.9541	$60.77	$22.70	$12.15
94070	Evaluation of wheezing		X	0369	2.7874	$177.54	$44.10	$35.51
94150	Vital capacity test		X	0367	0.5955	$37.93	$14.38	$7.59
94200	Lung function test (MBC/MVV)		X	0367	0.5955	$37.93	$14.38	$7.59
94240	Residual lung capacity		X	0368	0.9541	$60.77	$22.70	$12.15
94250	Expired gas collection		X	0367	0.5955	$37.93	$14.38	$7.59
94260	Thoracic gas volume		X	0368	0.9541	$60.77	$22.70	$12.15
94350	Lung nitrogen washout curve		X	0368	0.9541	$60.77	$22.70	$12.15
94360	Measure airflow resistance		X	0367	0.5955	$37.93	$14.38	$7.59
94370	Breath airway closing volume		X	0367	0.5955	$37.93	$14.38	$7.59
94375	Respiratory flow volume loop	CH	X	0368	0.9541	$60.77	$22.70	$12.15
94400	CO2 breathing response curve		X	0367	0.5955	$37.93	$14.38	$7.59
94450	Hypoxia response curve		X	0368	0.9541	$60.77	$22.70	$12.15
94452	Hast w/report		X	0368	0.9541	$60.77	$22.70	$12.15
94453	Hast w/oxygen titrate		X	0367	0.5955	$37.93	$14.38	$7.59
94610	Surfactant admin thru tube		S	0077	0.3904	$24.87	$7.70	$4.97
94620	Pulmonary stress test/simple		X	0368	0.9541	$60.77	$22.70	$12.15
94621	Pulm stress test/complex		X	0369	2.7874	$177.54	$44.10	$35.51
94640	Airway inhalation treatment		S	0077	0.3904	$24.87	$7.70	$4.97
94642	Aerosol inhalation treatment		S	0078	1.3636	$86.85		$17.37
94644	Cbt, 1st hour		S	0078	1.3636	$86.85		$17.37
94645	Cbt, each addl hour		S	0078	1.3636	$86.85		$17.37
94660	Pos airway pressure, CPAP	CH	S	0078	1.3636	$86.85		$17.37
94662	Neg press ventilation, cnp		S	0079	2.6745	$170.35		$34.07
94664	Evaluate pt use of inhaler		S	0077	0.3904	$24.87	$7.70	$4.97
94667	Chest wall manipulation		S	0077	0.3904	$24.87	$7.70	$4.97
94668	Chest wall manipulation		S	0077	0.3904	$24.87	$7.70	$4.97
94680	Exhaled air analysis, o2	CH	X	0368	0.9541	$60.77	$22.70	$12.15
94681	Exhaled air analysis, o2/co2		X	0368	0.9541	$60.77	$22.70	$12.15
94690	Exhaled air analysis		X	0367	0.5955	$37.93	$14.38	$7.59
94720	Monoxide diffusing capacity		X	0368	0.9541	$60.77	$22.70	$12.15
94725	Membrane diffusion capacity		X	0368	0.9541	$60.77	$22.70	$12.15
94750	Pulmonary compliance study	CH	X	0368	0.9541	$60.77	$22.70	$12.15
94760	Measure blood oxygen level		N					
94761	Measure blood oxygen level		N					
94762	Measure blood oxygen level	CH	Q	0097	1.0396	$66.22	$23.70	$13.24
94770	Exhaled carbon dioxide test		X	0367	0.5955	$37.93	$14.38	$7.59
94772	Breath recording, infant		X	0369	2.7874	$177.54	$44.10	$35.51
94774	Ped home apnea rec, compl		B					
94775	Ped home apnea rec, hk-up		X	0097	1.0396	$66.22	$23.70	$13.24
94776	Ped home apnea rec, downld		X	0097	1.0396	$66.22	$23.70	$13.24
94777	Ped home apnea rec, report		B					
94799	Pulmonary service/procedure		X	0367	0.5955	$37.93	$14.38	$7.59
95004	Percut allergy skin tests		X	0381	0.3014	$19.20		$3.84
95010	Percut allergy titrate test		X	0381	0.3014	$19.20		$3.84
95012	Exhaled nitric oxide meas		X	0367	0.5955	$37.93	$14.38	$7.59
95015	Id allergy titrate-drug/bug		X	0381	0.3014	$19.20		$3.84
95024	Id allergy test, drug/bug		X	0381	0.3014	$19.20		$3.84
95027	Id allergy titrate-airborne		X	0381	0.3014	$19.20		$3.84
95028	Id allergy test-delayed type		X	0381	0.3014	$19.20		$3.84
95044	Allergy patch tests		X	0381	0.3014	$19.20		$3.84
95052	Photo patch test		X	0381	0.3014	$19.20		$3.84
95056	Photosensitivity tests		X	0370	1.1024	$70.22		$14.04
95060	Eye allergy tests		X	0370	1.1024	$70.22		$14.04
95065	Nose allergy test		X	0381	0.3014	$19.20		$3.84
95070	Bronchial allergy tests		X	0369	2.7874	$177.54	$44.10	$35.51
95071	Bronchial allergy tests		X	0369	2.7874	$177.54	$44.10	$35.51
95075	Ingestion challenge test		X	0361	4.0867	$260.29	$83.20	$52.06
95115	Immunotherapy, one injection		S	0436	0.2201	$14.02		$2.80
95117	Immunotherapy injections		S	0437	0.4037	$25.71		$5.14
95120	Immunotherapy, one injection		B					
95125	Immunotherapy, many antigens		B					
95130	Immunotherapy, insect venom		B					
95131	Immunotherapy, insect venoms		B					
95132	Immunotherapy, insect venoms		B					
95133	Immunotherapy, insect venoms		B					
95134	Immunotherapy, insect venoms		B					
95144	Antigen therapy services		S	0437	0.4037	$25.71		$5.14
95145	Antigen therapy services		S	0437	0.4037	$25.71		$5.14
95146	Antigen therapy services		S	0437	0.4037	$25.71		$5.14
95147	Antigen therapy services		S	0437	0.4037	$25.71		$5.14
95148	Antigen therapy services		S	0437	0.4037	$25.71		$5.14
95149	Antigen therapy services		S	0437	0.4037	$25.71		$5.14
95165	Antigen therapy services		S	0437	0.4037	$25.71		$5.14

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
95170	Antigen therapy services		S	0437	0.4037	$25.71		$5.14
95180	Rapid desensitization		X	0370	1.1024	$70.22		$14.04
95199	Allergy immunology services		X	0381	0.3014	$19.20		$3.84
95250	Glucose monitoring, cont	CH	X	0097	1.0396	$66.22	$23.70	$13.24
95251	Gluc monitor, cont, phys i&r		B					
95805	Multiple sleep latency test		S	0209	11.5647	$736.59	$268.70	$147.32
95806	Sleep study, unattended		S	0213	2.3476	$149.53	$53.50	$29.91
95807	Sleep study, attended		S	0209	11.5647	$736.59	$268.70	$147.32
95808	Polysomnography, 1-3		S	0209	11.5647	$736.59	$268.70	$147.32
95810	Polysomnography, 4 or more		S	0209	11.5647	$736.59	$268.70	$147.32
95811	Polysomnography w/cpap		S	0209	11.5647	$736.59	$268.70	$147.32
95812	Eeg, 41-60 minutes		S	0213	2.3476	$149.53	$53.50	$29.91
95813	Eeg, over 1 hour		S	0213	2.3476	$149.53	$53.50	$29.91
95816	Eeg, awake and drowsy		S	0213	2.3476	$149.53	$53.50	$29.91
95819	Eeg, awake and asleep		S	0213	2.3476	$149.53	$53.50	$29.91
95822	Eeg, coma or sleep only		S	0213	2.3476	$149.53	$53.50	$29.91
95824	Eeg, cerebral death only	CH	S	0216	2.768	$176.30		$35.26
95827	Eeg, all night recording		S	0213	2.3476	$149.53	$53.50	$29.91
95829	Surgery electrocorticogram	CH	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	Tensilon test		S	0218	1.1861	$75.55		$15.11
95860	Muscle test, one limb		S	0218	1.1861	$75.55		$15.11
95861	Muscle test, 2 limbs		S	0218	1.1861	$75.55		$15.11
95863	Muscle test, 3 limbs		S	0218	1.1861	$75.55		$15.11
95864	Muscle test, 4 limbs		S	0218	1.1861	$75.55		$15.11
95865	Muscle test, larynx		S	0218	1.1861	$75.55		$15.11
95866	Muscle test, hemidiaphragm		S	0218	1.1861	$75.55		$15.11
95867	Muscle test cran nerv unilat		S	0218	1.1861	$75.55		$15.11
95868	Muscle test cran nerve bilat		S	0218	1.1861	$75.55		$15.11
95869	Muscle test, thor paraspinal	CH	S	0218	1.1861	$75.55		$15.11
95870	Muscle test, nonparaspinal		S	0215	0.5746	$36.60		$7.32
95872	Muscle test, one fiber		S	0218	1.1861	$75.55		$15.11
95873	Guide nerv destr, elec stim	CH	N					
95874	Guide nerv destr, needle emg	CH	N					
95875	Limb exercise test		S	0215	0.5746	$36.60		$7.32
95900	Motor nerve conduction test		S	0215	0.5746	$36.60		$7.32
95903	Motor nerve conduction test		S	0215	0.5746	$36.60		$7.32
95904	Sense nerve conduction test		S	0215	0.5746	$36.60		$7.32
95920	Intraop nerve test add-on	CH	N					
95921	Autonomic nerv function test		S	0215	0.5746	$36.60		$7.32
95922	Autonomic nerv function test		S	0215	0.5746	$36.60		$7.32
95923	Autonomic nerv function test	CH	S	0218	1.1861	$75.55		$15.11
95925	Somatosensory testing		S	0216	2.768	$176.30		$35.26
95926	Somatosensory testing		S	0216	2.768	$176.30		$35.26
95927	Somatosensory testing		S	0216	2.768	$176.30		$35.26
95928	C motor evoked, uppr limbs		S	0218	1.1861	$75.55		$15.11
95929	C motor evoked, lwr limbs		S	0218	1.1861	$75.55		$15.11
95930	Visual evoked potential test		S	0216	2.768	$176.30		$35.26
95933	Blink reflex test		S	0215	0.5746	$36.60		$7.32
95934	H-reflex test		S	0215	0.5746	$36.60		$7.32
95936	H-reflex test		S	0215	0.5746	$36.60		$7.32
95937	Neuromuscular junction test	CH	S	0218	1.1861	$75.55		$15.11
95950	Ambulatory eeg monitoring		S	0209	11.5647	$736.59	$268.70	$147.32
95951	EEG monitoring/videorecord		S	0209	11.5647	$736.59	$268.70	$147.32
95953	EEG monitoring/computer		S	0209	11.5647	$736.59	$268.70	$147.32
95954	EEG monitoring/giving drugs	CH	S	0218	1.1861	$75.55		$15.11
95955	EEG during surgery	CH	N					
95956	Eeg monitoring, cable/radio		S	0209	11.5647	$736.59	$268.70	$147.32
95957	EEG digital analysis	CH	N					
95958	EEG monitoring/function test		S	0213	2.3476	$149.53	$53.50	$29.91
95961	Electrode stimulation, brain		S	0216	2.768	$176.30		$35.26
95962	Electrode stim, brain add-on		S	0216	2.768	$176.30		$35.26
95965	Meg, spontaneous	CH	S	0067	61.5205	$3,918.43		$783.69
95966	Meg, evoked, single	CH	S	0065	17.1992	$1,095.47		$219.09
95967	Meg, evoked, each add'l	CH	S	0065	17.1992	$1,095.47		$219.09
95970	Analyze neurostim, no prog		S	0218	1.1861	$75.55		$15.11
95971	Analyze neurostim, simple		S	0692	1.9206	$122.33	$30.10	$24.47
95972	Analyze neurostim, complex	CH	S	0663	1.6671	$106.18		$21.24
95973	Analyze neurostim, complex		S	0663	1.6671	$106.18		$21.24
95974	Cranial neurostim, complex	CH	S	0663	1.6671	$106.18		$21.24
95975	Cranial neurostim, complex		S	0692	1.9206	$122.33	$30.10	$24.47
95978	Analyze neurostim brain/1h		S	0692	1.9206	$122.33	$30.10	$24.47

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
95979	Analyz neurostim brain addon		S	0663	1.6671	$106.18		$21.24
95990	Spin/brain pump refil & main		T	0125	2.3262	$148.16		$29.63
95991	Spin/brain pump refil & main		T	0125	2.3262	$148.16		$29.63
95999	Neurological procedure		S	0215	0.5746	$36.60		$7.32
96000	Motion analysis, video/3d		S	0216	2.768	$176.30		$35.26
96001	Motion test w/ft press meas		S	0216	2.768	$176.30		$35.26
96002	Dynamic surface emg		S	0218	1.1861	$75.55		$15.11
96003	Dynamic fine wire emg		S	0215	0.5746	$36.60		$7.32
96004	Phys review of motion tests		B					
96020	Functional brain mapping	CH	N					
96040	Genetic counseling, 30 min		B					
96101	Psycho testing by psych/phys	CH	Q	0382	2.6763	$170.46		$34.09
96102	Psycho testing by technician	CH	Q	0373	1.8183	$115.81		$23.16
96103	Psycho testing admin by comp	CH	Q	0373	1.8183	$115.81		$23.16
96105	Assessment of aphasia		A					
96110	Developmental test, lim	CH	Q	0373	1.8183	$115.81		$23.16
96111	Developmental test, extend	CH	Q	0382	2.6763	$170.46		$34.09
96116	Neurobehavioral status exam	CH	Q	0382	2.6763	$170.46		$34.09
96118	Neuropsych tst by psych/phys	CH	Q	0382	2.6763	$170.46		$34.09
96119	Neuropsych testing by tec	CH	Q	0382	2.6763	$170.46		$34.09
96120	Neuropsych tst admin w/comp	CH	Q	0373	1.8183	$115.81		$23.16
96150	Assess hlth/behave, init	CH	Q	0432	0.302	$19.24		$3.85
96151	Assess hlth/behave, subseq	CH	Q	0432	0.302	$19.24		$3.85
96152	Intervene hlth/behave, indiv	CH	Q	0432	0.302	$19.24		$3.85
96153	Intervene hlth/behave, group	CH	Q	0432	0.302	$19.24		$3.85
96154	Interv hlth/behav, fam w/pt	CH	Q	0432	0.302	$19.24		$3.85
96155	Interv hlth/behav fam no pt		E					
96401	Chemo, anti-neopl, sq/im		S	0438	0.831	$52.93		$10.59
96402	Chemo hormon antineopl sq/im		S	0438	0.831	$52.93		$10.59
96405	Chemo intralesional, up to 7		S	0438	0.831	$52.93		$10.59
96406	Chemo intralesional over 7		S	0438	0.831	$52.93		$10.59
96409	Chemo, iv push, sngl drug		S	0439	1.7152	$109.25		$21.85
96411	Chemo, iv push, addl drug		S	0439	1.7152	$109.25		$21.85
96413	Chemo, iv infusion, 1 hr		S	0441	2.4378	$155.27		$31.05
96415	Chemo, iv infusion, addl hr		S	0438	0.831	$52.93		$10.59
96416	Chemo prolong infuse w/pump		S	0441	2.4378	$155.27		$31.05
96417	Chemo iv infus each addl seq		S	0438	0.831	$52.93		$10.59
96420	Chemo, ia, push tecnique		S	0439	1.7152	$109.25		$21.85
96422	Chemo ia infusion up to 1 hr		S	0441	2.4378	$155.27		$31.05
96423	Chemo ia infuse each addl hr		S	0438	0.831	$52.93		$10.59
96425	Chemotherapy,infusion method		S	0441	2.4378	$155.27		$31.05
96440	Chemotherapy, intracavitary		S	0441	2.4378	$155.27		$31.05
96445	Chemotherapy, intracavitary		S	0441	2.4378	$155.27		$31.05
96450	Chemotherapy, into CNS		S	0441	2.4378	$155.27		$31.05
96521	Refill/maint, portable pump		S	0440	1.831	$116.62		$23.32
96522	Refill/maint pump/resvr syst		S	0440	1.831	$116.62		$23.32
96523	Irrig drug delivery device		Q	0624	0.5763	$36.71	$12.60	$7.34
96542	Chemotherapy injection		S	0438	0.831	$52.93		$10.59
96549	Chemotherapy, unspecified		S	0436	0.2201	$14.02		$2.80
96567	Photodynamic tx, skin	CH	T	0013	0.8046	$51.25		$10.25
96570	Photodynamic tx, 30 min		T	0015	1.5119	$96.30		$19.26
96571	Photodynamic tx, addl 15 min		T	0015	1.5119	$96.30		$19.26
96900	Ultraviolet light therapy		S	0001	0.5204	$33.15	$7.00	$6.63
96902	Trichogram		N					
96904	Whole body photography		N					
96910	Photochemotherapy with UV-B		S	0001	0.5204	$33.15	$7.00	$6.63
96912	Photochemotherapy with UV-A		S	0001	0.5204	$33.15	$7.00	$6.63
96913	Photochemotherapy, UV-A or B		S	0683	2.9292	$186.57		$37.31
96920	Laser tx, skin < 250 sq cm	CH	T	0015	1.5119	$96.30		$19.26
96921	Laser tx, skin 250-500 sq cm	CH	T	0015	1.5119	$96.30		$19.26
96922	Laser tx, skin > 500 sq cm	CH	T	0015	1.5119	$96.30		$19.26
96999	Dermatological procedure	CH	T	0012	0.2682	$17.08		$3.42
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					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
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	Active wound care/20 cm or <	CH	T	0015	1.5119	$96.30		$19.26
97598	Active wound care > 20 cm	CH	T	0015	1.5119	$96.30		$19.26
97602	Wound(s) care non-selective	CH	T	0015	1.5119	$96.30		$19.26
97605	Neg press wound tx, < 50 cm	CH	T	0013	0.8046	$51.25		$10.25
97606	Neg press wound tx, > 50 cm	CH	T	0015	1.5119	$96.30		$19.26
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	0.4877	$31.06		$6.21
98926	Osteopathic manipulation		S	0060	0.4877	$31.06		$6.21
98927	Osteopathic manipulation		S	0060	0.4877	$31.06		$6.21
98928	Osteopathic manipulation		S	0060	0.4877	$31.06		$6.21
98929	Osteopathic manipulation		S	0060	0.4877	$31.06		$6.21
98940	Chiropractic manipulation		S	0060	0.4877	$31.06		$6.21
98941	Chiropractic manipulation		S	0060	0.4877	$31.06		$6.21
98942	Chiropractic manipulation		S	0060	0.4877	$31.06		$6.21
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					
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					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
99148	Mod cs diff phys < 5 yrs		N					
99149	Mod cs diff phys 5 yrs +		N					
99150	Mod cs diff phys add-on		N					
99170	Anogenital exam, child		T	0191	0.1414	$9.01	$2.50	$1.80
99172	Ocular function screen		E					
99173	Visual acuity screen		E					
99175	Induction of vomiting		N					
99183	Hyperbaric oxygen therapy		B					
99185	Regional hypothermia		N					
99186	Total body hypothermia		N					
99190	Special pump services		C					
99191	Special pump services		C					
99192	Special pump services		C					
99195	Phlebotomy	CH	X	0624	0.5763	$36.71	$12.60	$7.34
99199	Special service/proc/report		B					
99201	Office/outpatient visit, new		V	0604	0.8381	$53.38		$10.68
99202	Office/outpatient visit, new		V	0605	1.0016	$63.79		$12.76
99203	Office/outpatient visit, new		V	0606	1.3665	$87.04		$17.41
99204	Office/outpatient visit, new		V	0607	1.7181	$109.43		$21.89
99205	Office/outpatient visit, new		V	0608	2.2077	$140.62		$28.12
99211	Office/outpatient visit, est		V	0604	0.8381	$53.38		$10.68
99212	Office/outpatient visit, est		V	0605	1.0016	$63.79		$12.76
99213	Office/outpatient visit, est		V	0605	1.0016	$63.79		$12.76
99214	Office/outpatient visit, est		V	0606	1.3665	$87.04		$17.41
99215	Office/outpatient visit, est		V	0607	1.7181	$109.43		$21.89
99217	Observation care discharge		B					
99218	Observation care		B					
99219	Observation care		B					
99220	Observation care		B					
99221	Initial hospital care		B					
99222	Initial hospital care		B					
99223	Initial hospital care		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					
99239	Hospital discharge day		B					
99241	Office consultation	CH	B					
99242	Office consultation	CH	B					
99243	Office consultation	CH	B					
99244	Office consultation	CH	B					
99245	Office consultation	CH	B					
99251	Inpatient consultation		C					
99252	Inpatient consultation		C					
99253	Inpatient consultation		C					
99254	Inpatient consultation		C					
99255	Inpatient consultation		C					
99281	Emergency dept visit		V	0609	0.8271	$52.68	$12.70	$10.54
99282	Emergency dept visit		V	0613	1.3789	$87.83	$21.00	$17.57
99283	Emergency dept visit		V	0614	2.1716	$138.32	$34.50	$27.66
99284	Emergency dept visit		V	0615	3.5191	$224.14	$48.40	$44.83
99285	Emergency dept visit		V	0616	5.4765	$348.81	$75.10	$69.76
99288	Direct advanced life support		B					
99289	Ped crit care transport		N					
99290	Ped crit care transport addl		N					
99291	Critical care, first hour		S	0617	6.8478	$436.16	$111.50	$87.23
99292	Critical care, add'l 30 min		N					
99293	Ped critical care, initial		C					
99294	Ped critical care, subseq		C					
99295	Neonate crit care, initial		C					
99296	Neonate critical care subseq		C					
99298	Ic for lbw infant < 1500 gm		C					
99299	Ic, lbw infant 1500-2500 gm		C					
99300	Ic, infant pbw 2501-5000 gm		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					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
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	Prolonged serv, w/o contact		N					
99359	Prolonged serv, w/o contact		N					
99360	Physician standby services		B					
99361	Physician/team conference		N					
99362	Physician/team conference		N					
99363	Anticoag mgmt, init		B					
99364	Anticoag mgmt, subseq		B					
99371	Physician phone consultation		B					
99372	Physician phone consultation		B					
99373	Physician phone consultation		B					
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					
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					
99411	Preventive counseling, group		E					
99412	Preventive counseling, group		E					
99420	Health risk assessment test		E					
99429	Unlisted preventive service		E					
99431	Initial care, normal newborn		V	0605	1.0016	$63.79		$12.76
99432	Newborn care, not in hosp		N					
99433	Normal newborn care/hospital		C					
99435	Newborn discharge day hosp		B					
99436	Attendance, birth		N					
99440	Newborn resuscitation		S	0094	2.5547	$162.72	$46.20	$32.54
99450	Basic life disability exam		E					
99455	Work related disability exam		B					
99456	Disability examination		B					
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					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
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		A					
A0380	Basic life support mileage		A					
A0382	Basic support routine suppls		A					
A0384	Bls defibrillation supplies		A					
A0390	Advanced life support mileag		A					
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	PI 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 mileage		E					
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		Y					
A4231	Infusion insulin pump needle		Y					
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					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
A4261	Cervical cap contraceptive		E					
A4262	Temporary tear duct plug		N					
A4263	Permanent tear duct plug		N					
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					
A4334	Urinary cath leg strap		A					
A4335	Incontinence supply		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					
A4361	Ostomy face plate		A					
A4362	Solid skin barrier		A					
A4363	Ostomy clamp, replacement		A					
A4364	Adhesive, liquid or equal		A					
A4365	Adhesive remover wipes		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					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
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					
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					
A4458	Reusable enema bag		E					
A4461	Surgicl dress hold non-reuse		A					
A4463	Surgical dress holder reuse		A					
A4465	Non-elastic extremity binder		A					
A4470	Gravlee jet washer		A					
A4480	Vabra aspirator		A					
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		A					
A4570	Splint		E					
A4575	Hyperbaric o2 chamber disps		E					
A4580	Cast supplies (plaster)		E					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
A4590	Special casting material		E					
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		N					
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	CH	N					
A4649	Surgical supplies		A					
A4651	Calibrated microcap tube		A					
A4652	Microcapillary tube sealant		A					
A4653	PD catheter anchor belt		A					
A4657	Syringe w/wo needle		A					
A4660	Sphyg/bp app w cuff and stet		A					
A4663	Dialysis blood pressure cuff		A					
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		A					
A4690	Dialyzer, each		A					
A4706	Bicarbonate conc sol per gal		A					
A4707	Bicarbonate conc pow per pac		A					
A4708	Acetate conc sol per gallon		A					
A4709	Acid conc sol per gallon		A					
A4714	Treated water per gallon		A					
A4719	"Y set" tubing		A					
A4720	Dialysat sol fld vol > 249cc		A					
A4721	Dialysat sol fld vol > 999cc		A					
A4722	Dialys sol fld vol > 1999cc		A					
A4723	Dialys sol fld vol > 2999cc		A					
A4724	Dialys sol fld vol > 3999cc		A					
A4725	Dialys sol fld vol > 4999cc		A					
A4726	Dialys sol fld vol > 5999cc		A					
A4728	Dialysate solution, non-dex		B					
A4730	Fistula cannulation set, ea		A					
A4736	Topical anesthetic, per gram		A					
A4737	Inj anesthetic per 10 ml		A					
A4740	Shunt accessory		A					
A4750	Art or venous blood tubing		A					
A4755	Comb art/venous blood tubing		A					
A4760	Dialysate sol test kit, each		A					
A4765	Dialysate conc pow per pack		A					
A4766	Dialysate conc sol add 10 ml		A					
A4770	Blood collection tube/vacuum		A					
A4771	Serum clotting time tube		A					
A4772	Blood glucose test strips		A					
A4773	Occult blood test strips		A					
A4774	Ammonia test strips		A					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
A4802	Protamine sulfate per 50 mg		A					
A4860	Disposable catheter tips		A					
A4870	Plumb/elec wk hm hemo equip		A					
A4890	Repair/maint cont hemo equip		A					
A4911	Drain bag/bottle		A					
A4913	Misc dialysis supplies noc		A					
A4918	Venous pressure clamp		A					
A4927	Non-sterile gloves		A					
A4928	Surgical mask		A					
A4929	Tourniquet for dialysis, ea		A					
A4930	Sterile, gloves per pair		A					
A4931	Reusable oral thermometer		A					
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					
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					
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>6≦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					
A6200	Compos drsg ≦16 no border		A					
A6201	Compos drsg >16≦48 no bdr		A					
A6202	Compos drsg >48 no border		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					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
A6216	Non-sterile gauze≦16 sq in		A					
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/salne		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					
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		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					
A6507	Cmprs burngarment foot-knee		A					
A6508	Cmprs burngarment foot-thigh		A					
A6509	Compres burn garment jacket		A					
A6510	Compres burn garment leotard		A					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
A6542	Gc stocking custom made		E					
A6543	Gc stocking lymphedema		E					
A6544	Gc stocking garter belt		E					
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					
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					
A7025	Replace chest compress vest		Y					
A7026	Replace chst cmprss sys hose		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		A					
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					
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					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
A9180	Lice treatment, topical		E					
A9270	Non-covered item or service		E					
A9275	Disp home glucose monitor		E					
A9279	Monitoring feature/deviceNOC		E					
A9280	Alert device, noc		E					
A9281	Reaching/grabbing device		E					
A9282	Wig any type		E					
A9300	Exercise equipment		E					
A9500	Tc99m sestamibi	CH	N					
A9502	Tc99m tetrofosmin	CH	N					
A9503	Tc99m medronate		N					
A9504	Tc99m apcitide		N					
A9505	TL201 thallium	CH	N					
A9507	In111 capromab	CH	N					
A9508	I131 iodobenguate, dx	CH	N					
A9510	Tc99m disofenin		N					
A9512	Tc99m pertechnetate		N					
A9516	I123 iodide cap, dx	CH	N					
A9517	I131 iodide cap, rx	CH	K	1064		$16.22		$3.24
A9521	Tc99m exametazime	CH	N					
A9524	I131 serum albumin, dx	CH	N					
A9526	Nitrogen N-13 ammonia	CH	N					
A9527	Iodine I-125 sodium iodide	CH	K	2632	0.4494	$28.62		$5.72
A9528	Iodine I-131 iodide cap, dx	CH	N					
A9529	I131 iodide sol, dx		N					
A9530	I131 iodide sol, rx	CH	K	1150		$11.74		$2.35
A9531	I131 max 100uCi		N					
A9532	I125 serum albumin, dx		N					
A9535	Injection, methylene blue		N					
A9536	Tc99m depreotide	CH	N					
A9537	Tc99m mebrofenin		N					
A9538	Tc99m pyrophosphate		N					
A9539	Tc99m pentetate	CH	N					
A9540	Tc99m MAA		N					
A9541	Tc99m sulfur colloid		N					
A9542	In111 ibritumomab, dx	CH	N					
A9543	Y90 ibritumomab, rx	CH	K	1643		$12,030.02		$2,406.00
A9544	I131 tositumomab, dx	CH	N					
A9545	I131 tositumomab, rx	CH	K	1645		$8,283.41		$1,656.68
A9546	Co57/58	CH	N					
A9547	In111 oxyquinoline	CH	N					
A9548	In111 pentetate	CH	N					
A9550	Tc99m gluceptate	CH	N					
A9551	Tc99m succimer	CH	N					
A9552	F18 fdg	CH	N					
A9553	Cr51 chromate	CH	N					
A9554	I125 iothalamate, dx		N					
A9555	Rb82 rubidium	CH	N					
A9556	Ga67 gallium	CH	N					
A9557	Tc99m bicisate	CH	N					
A9558	Xe133 xenon 10mci		N					
A9559	Co57 cyano	CH	N					
A9560	Tc99m labeled rbc	CH	N					
A9561	Tc99m oxidronate		N					
A9562	Tc99m mertiatide	CH	N					
A9563	P32 Na phosphate	CH	K	1675		$118.02		$23.60
A9564	P32 chromic phosphate	CH	K	1676		$122.17		$24.43
A9565	In111 pentetreotide	CH	N					
A9566	Tc99m fanolesomab	CH	N					
A9567	Technetium TC-99m aerosol	CH	N					
A9568	Technetium tc99m arcitumomab	CH	N					
A9600	Sr89 strontium	CH	K	0701		$610.07		$122.01
A9605	Sm 153 lexidronm	CH	K	0702		$1,446.05		$289.21
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					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
B4082	Enteral ng tubing w/o stylet		Y					
B4083	Enteral stomach tube levine		Y					
B4086	Gastrostomy/jejunostomy tube		Y					
B4100	Food thickener oral		E					
B4102	EF adult fluids and electro		Y					
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	1.5679	$99.86		$19.97
C1713	Anchor/screw bn/bn,tis/bn		N					
C1714	Cath, trans atherectomy, dir		N					
C1715	Brachytherapy needle		N					
C1716	Brachytx source, Gold 198	CH	K	1716	0.5016	$31.95		$6.39
C1717	Brachytx source, HDR Ir-192	CH	K	1717	2.7225	$173.40		$34.68
C1718	Brachytx source, Iodine 125	CH	B					
C1719	Brachytx sour,Non-HDR Ir-192	CH	K	1719	0.9012	$57.40		$11.48
C1720	Brachytx sour, Palladium 103	CH	B					
C1721	AICD, dual chamber		N					
C1722	AICD, single chamber		N					
C1724	Cath, trans atherec,rotation		N					
C1725	Cath, translumin non-laser		N					
C1726	Cath, bal dil, non-vascular		N					
C1727	Cath, bal tis dis, non-vas		N					
C1728	Cath, brachytx seed adm		N					
C1729	Cath, drainage		N					
C1730	Cath, EP, 19 or few elect		N					
C1731	Cath, EP, 20 or more elec		N					
C1732	Cath, EP, diag/abl, 3D/vect		N					
C1733	Cath, EP, othr than cool-tip		N					
C1750	Cath, hemodialysis,long-term		N					
C1751	Cath, inf, per/cent/midline		N					
C1752	Cath,hemodialysis,short-term		N					
C1753	Cath, intravas ultrasound		N					
C1754	Catheter, intradiscal		N					
C1755	Catheter, intraspinal		N					
C1756	Cath, pacing, transesoph		N					
C1757	Cath, thrombectomy/embolect		N					
C1758	Catheter, ureteral		N					
C1759	Cath, intra echocardiography		N					
C1760	Closure dev, vasc		N					
C1762	Conn tiss, human(inc fascia)		N					
C1763	Conn tiss, non-human		N					
C1764	Event recorder, cardiac		N					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
C1765	Adhesion barrier		N					
C1766	Intro/sheath,strble,non-peel		N					
C1767	Generator, neuro non-recharg		N					
C1768	Graft, vascular		N					
C1769	Guide wire		N					
C1770	Imaging coil, MR, insertable		N					
C1771	Rep dev, urinary, w/sling		N					
C1772	Infusion pump, programmable		N					
C1773	Ret dev, insertable		N					
C1776	Joint device (implantable)		N					
C1777	Lead, AICD, endo single coil		N					
C1778	Lead, neurostimulator		N					
C1779	Lead, pmkr, transvenous VDD		N					
C1780	Lens, intraocular (new tech)		N					
C1781	Mesh (implantable)		N					
C1782	Morcellator		N					
C1783	Ocular imp, aqueous drain de		N					
C1784	Ocular dev, intraop, det ret		N					
C1785	Pmkr, dual, rate-resp		N					
C1786	Pmkr, single, rate-resp		N					
C1787	Patient progr, neurostim		N					
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	CH	N					
C1821	Interspinous implant		H	1821				
C1874	Stent, coated/cov w/del sys		N					
C1875	Stent, coated/cov w/o del sy		N					
C1876	Stent, non-coa/non-cov w/del		N					
C1877	Stent, non-coat/cov w/o del		N					
C1878	Matrl for vocal cord		N					
C1879	Tissue marker, implantable		N					
C1880	Vena cava filter		N					
C1881	Dialysis access system		N					
C1882	AICD, other than sing/dual		N					
C1883	Adapt/ext, pacing/neuro lead		N					
C1884	Embolization Protect syst		N					
C1885	Cath, translumin angio laser		N					
C1887	Catheter, guiding		N					
C1888	Endovas non-cardiac abl cath		N					
C1891	Infusion pump,non-prog, perm		N					
C1892	Intro/sheath,fixed,peel-away		N					
C1893	Intro/sheath, fixed,non-peel		N					
C1894	Intro/sheath, non-laser		N					
C1895	Lead, AICD, endo dual coil		N					
C1896	Lead, AICD, non sing/dual		N					
C1897	Lead, neurostim test kit		N					
C1898	Lead, pmkr, other than trans		N					
C1899	Lead, pmkr/AICD combination		N					
C1900	Lead, coronary venous		N					
C2614	Probe, perc lumb disc		N					
C2615	Sealant, pulmonary, liquid		N					
C2616	Brachytx source, Yttrium-90	CH	K	2616	187.5212	$11,943.79		$2,388.76
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					
C2633	Brachytx source, Cesium-131	CH	B					
C2634	Brachytx source, HA, I-125	CH	K	2634	0.4699	$29.93		$5.99
C2635	Brachytx source, HA, P-103	CH	K	2635	0.7389	$47.06		$9.41
C2636	Brachytx linear source,P-103	CH	K	2636	0.5824	$37.09		$7.42
C2637	Brachytx, Ytterbium-169	CH	B					
C8900	MRA w/cont, abd		S	0284	6.7963	$432.88	$148.40	$86.58

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
C8901	MRA w/o cont, abd		S	0336	5.7101	$363.69	$139.50	$72.74
C8902	MRA w/o fol w/cont, abd		S	0337	8.6689	$552.15	$199.50	$110.43
C8903	MRI w/cont, breast, uni		S	0284	6.7963	$432.88	$148.40	$86.58
C8904	MRI w/o cont, breast, uni		S	0336	5.7101	$363.69	$139.50	$72.74
C8905	MRI w/o fol w/cont, brst, un		S	0337	8.6689	$552.15	$199.50	$110.43
C8906	MRI w/cont, breast, bi		S	0284	6.7963	$432.88	$148.40	$86.58
C8907	MRI w/o cont, breast, bi		S	0336	5.7101	$363.69	$139.50	$72.74
C8908	MRI w/o fol w/cont, breast,		S	0337	8.6689	$552.15	$199.50	$110.43
C8909	MRA w/cont, chest		S	0284	6.7963	$432.88	$148.40	$86.58
C8910	MRA w/o cont, chest		S	0336	5.7101	$363.69	$139.50	$72.74
C8911	MRA w/o fol w/cont, chest		S	0337	8.6689	$552.15	$199.50	$110.43
C8912	MRA w/cont, lwr ext		S	0284	6.7963	$432.88	$148.40	$86.58
C8913	MRA w/o cont, lwr ext		S	0336	5.7101	$363.69	$139.50	$72.74
C8914	MRA w/o fol w/cont, lwr ext		S	0337	8.6689	$552.15	$199.50	$110.43
C8918	MRA w/cont, pelvis		S	0284	6.7963	$432.88	$148.40	$86.58
C8919	MRA w/o cont, pelvis		S	0336	5.7101	$363.69	$139.50	$72.74
C8920	MRA w/o fol w/cont, pelvis		S	0337	8.6689	$552.15	$199.50	$110.43
C8957	Prolonged IV inf, req pump		S	0441	2.4378	$155.27		$31.05
C9003	Palivizumab, per 50 mg		K	9003		$677.97		$135.59
C9113	Inj pantoprazole sodium, via		N					
C9121	Injection, argatroban		K	9121		$17.87		$3.57
C9232	Injection, idursulfase		G	9232		$455.03		$91.01
C9233	Injection, ranibizumab		G	9233		$2,030.92		$406.18
C9234	Inj, alglucosidase alfa		K	9234		$126.00		$25.20
C9235	Injection, panitumumab		G	9235		$84.80		$16.96
C9350	Porous collagen tube per cm		G	9350		$485.91		$97.18
C9351	Acellular derm tissue percm2		G	9351		$41.59		$8.32
C9399	Unclassified drugs or biolog		A					
C9716	Radiofrequency energy to anu		T	0150	30.5544	$1,946.10	$437.10	$389.22
C9723	Dyn IR Perf Img		S	1502		$75.00		$15.00
C9724	EPS gast cardia plic		T	0422	24.648	$1,569.91	$445.06	$313.98
C9725	Place endorectal app		S	1507		$550.00		$110.00
C9726	Rxt breast appl place/remov		S	1508		$650.00		$130.00
C9727	Insert palate implants		S	1510		$850.00		$170.00
D0120	Periodic oral evaluation		E					
D0140	Limit oral eval problm focus		E					
D0145	Oral evaluation, pt < 3yrs		E					
D0150	Comprehensve oral evaluation		S	0330	9.278	$590.94		$118.19
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	9.278	$590.94		$118.19
D0250	Extraoral first film		S	0330	9.278	$590.94		$118.19
D0260	Extraoral ea additional film		S	0330	9.278	$590.94		$118.19
D0270	Dental bitewing single film		S	0330	9.278	$590.94		$118.19
D0272	Dental bitewings two films		S	0330	9.278	$590.94		$118.19
D0273	Bitewings - three films		E					
D0274	Dental bitewings four films		S	0330	9.278	$590.94		$118.19
D0277	Vert bitewings-sev to eight		S	0330	9.278	$590.94		$118.19
D0290	Dental film skull/facial bon		E					
D0310	Dental saliography		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					
D0363	Cone beam, three dimensional		E					
D0415	Collection of microorganisms		E					
D0416	Viral culture		B					
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	9.278	$590.94		$118.19
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					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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	Accession of brush biopsy		E					
D0502	Other oral pathology procedu		B					
D0999	Unspecified diagnostic proce		B					
D1110	Dental prophylaxis adult		E					
D1120	Dental prophylaxis child		E					
D1203	Topical fluor w/o prophy chi		E					
D1204	Topical fluor w/o prophy adu		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					
D1510	Space maintainer fxd unilat		S	0330	9.278	$590.94		$118.19
D1515	Fixed bilat space maintainer		S	0330	9.278	$590.94		$118.19
D1520	Remove unilat space maintain		S	0330	9.278	$590.94		$118.19
D1525	Remove bilat space maintain		S	0330	9.278	$590.94		$118.19
D1550	Recement space maintainer		S	0330	9.278	$590.94		$118.19
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					
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					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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	Dental sedative filling		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					
D2971	Add proc construct new crown		E					
D2975	Coping		E					
D2980	Crown repair		E					
D2999	Dental unspec restorative pr		S	0330	9.278	$590.94		$118.19
D3110	Pulp cap direct		E					
D3120	Pulp cap indirect		E					
D3220	Therapeutic pulpotomy		E					
D3221	Gross pulpal debridement		E					
D3230	Pulpal therapy anterior prim		E					
D3240	Pulpal therapy posterior pri		E					
D3310	Anterior		E					
D3320	Root canal therapy 2 canals		E					
D3330	Root canal therapy 3 canals		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					
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	9.278	$590.94		$118.19
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	9.278	$590.94		$118.19
D4210	Gingivectomy/plasty per quad		E					
D4211	Gingivectomy/plasty per toot		E					
D4230	Ana crown exp 4 or> per quad		E					
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	9.278	$590.94		$118.19
D4261	Osseous surgl-3teethperquad		E					
D4263	Bone replce graft first site		S	0330	9.278	$590.94		$118.19
D4264	Bone replce graft each add		S	0330	9.278	$590.94		$118.19
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	9.278	$590.94		$118.19
D4270	Pedicle soft tissue graft pr		S	0330	9.278	$590.94		$118.19
D4271	Free soft tissue graft proc		S	0330	9.278	$590.94		$118.19
D4273	Subepithelial tissue graft		S	0330	9.278	$590.94		$118.19
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	9.278	$590.94		$118.19

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
D4381	Localized delivery antimicro		S	0330	9.278	$590.94		$118.19
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					
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	9.278	$590.94		$118.19
D5912	Facial moulage complete		S	0330	9.278	$590.94		$118.19
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					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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	9.278	$590.94		$118.19
D5984	Radiation shield		S	0330	9.278	$590.94		$118.19
D5985	Radiation cone locator		S	0330	9.278	$590.94		$118.19
D5986	Fluoride applicator		E					
D5987	Commissure splint		S	0330	9.278	$590.94		$118.19
D5988	Surgical splint		E					
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					
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					
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					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
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					
D6920	Dental connector bar		S	0330	9.278	$590.94		$118.19
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	9.278	$590.94		$118.19
D7140	Extraction erupted tooth/exr		S	0330	9.278	$590.94		$118.19
D7210	Rem imp tooth w mucoper flp		S	0330	9.278	$590.94		$118.19
D7220	Impact tooth remov soft tiss		S	0330	9.278	$590.94		$118.19
D7230	Impact tooth remov part bony		S	0330	9.278	$590.94		$118.19
D7240	Impact tooth remov comp bony		S	0330	9.278	$590.94		$118.19
D7241	Impact tooth rem bony w/comp		S	0330	9.278	$590.94		$118.19
D7250	Tooth root removal		S	0330	9.278	$590.94		$118.19
D7260	Oral antral fistula closure		S	0330	9.278	$590.94		$118.19
D7261	Primary closure sinus perf		S	0330	9.278	$590.94		$118.19
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	9.278	$590.94		$118.19
D7292	Screw retained plate		E					
D7293	Temp anchorage dev w flap		E					
D7294	Temp anchorage dev w/o flap		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					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
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 stblz 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					
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	9.278	$590.94		$118.19
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/frenulotomy		E					
D7963	Frenuloplasty		E					
D7970	Excision hyperplastic tissue		E					
D7971	Excision pericoronal gingiva		E					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
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 call		E					
D9430	Office visit during hours		E					
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	9.278	$590.94		$118.19
D9910	Dent appl desensitizing med		E					
D9911	Appl desensitizing resin		E					
D9920	Behavior management		E					
D9930	Treatment of complications		S	0330	9.278	$590.94		$118.19
D9940	Dental occlusal guard		S	0330	9.278	$590.94		$118.19
D9941	Fabrication athletic guard		E					
D9942	Repair/reline occlusal guard		E					
D9950	Occlusion analysis		S	0330	9.278	$590.94		$118.19
D9951	Limited occlusal adjustment		S	0330	9.278	$590.94		$118.19
D9952	Complete occlusal adjustment		S	0330	9.278	$590.94		$118.19
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					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
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					
E0202	Phototherapy light w/ photom		Y					
E0203	Therapeutic lightbox tabletp		A					
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		Y					
E0221	Infrared heating pad system		Y					
E0225	Hydrocollator unit		Y					
E0230	Ice cap or collar		Y					
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		Y					
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		E					
E0251	Hosp bed fixd ht w/o mattres		E					
E0255	Hospital bed var ht w/ mattr		E					
E0256	Hospital bed var ht w/o matt		E					
E0260	Hosp bed semi-electr w/ matt		E					
E0261	Hosp bed semi-electr w/o mat		E					
E0265	Hosp bed total electr w/ mat		E					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
E0266	Hosp bed total elec w/o matt		E					
E0270	Hospital bed institutional t		E					
E0271	Mattress innerspring		E					
E0272	Mattress foam rubber		E					
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		E					
E0291	Hosp bed fx ht w/o rail w/o		Y					
E0292	Hosp bed var ht w/o rail w/o		E					
E0293	Hosp bed var ht w/o rail w/		Y					
E0294	Hosp bed semi-elect w/ mattr		E					
E0295	Hosp bed semi-elect w/o matt		Y					
E0296	Hosp bed total elect w/ matt		E					
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		E					
E0304	Hosp bed xtra hvy dty x wide		E					
E0305	Rails bed side half length		E					
E0310	Rails bed side full length		E					
E0315	Bed accessory brd/tbl/supprt		E					
E0316	Bed safety enclosure		Y					
E0325	Urinal male jug-type		Y					
E0326	Urinal female jug-type		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					
E0434	Portable liquid 02		Y					
E0435	Oxygen system liquid portabl		E					
E0439	Stationary liquid 02		Y					
E0440	Oxygen system liquid station		E					
E0441	Oxygen contents, gaseous		Y					
E0442	Oxygen contents, liquid		Y					
E0443	Portable 02 contents, gas		Y					
E0444	Portable 02 contents, liquid		Y					
E0445	Oximeter non-invasive		A					
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					
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					
E0572	Aerosol compressor adjust pr		Y					
E0574	Ultrasonic generator w svneb		Y					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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		A					
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		A					
E0619	Apnea monitor w recorder		A					
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					
E0655	Pneumatic appliance half arm		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 6 ft		Y					
E0694	Uvl md cabinet sys 6 ft		Y					
E0700	Safety equipment		E					
E0705	Transfer board or 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		A					
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					
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					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
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		A					
E0951	Loop heel		A					
E0952	Toe loop/holder, each		A					
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		A					
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		B					
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					
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					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
E1035	Patient transfer system		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		A					
E1060	Wheelchair detachable arms		A					
E1070	Wheelchair detachable foot r		A					
E1083	Hemi-wheelchair fixed arms		A					
E1084	Hemi-wheelchair detachable a		A					
E1085	Hemi-wheelchair fixed arms		A					
E1086	Hemi-wheelchair detachable a		A					
E1087	Wheelchair lightwt fixed arm		A					
E1088	Wheelchair lightweight det a		A					
E1089	Wheelchair lightwt fixed arm		A					
E1090	Wheelchair lightweight det a		A					
E1092	Wheelchair wide w/ leg rests		A					
E1093	Wheelchair wide w/ foot rest		A					
E1100	Whchr s-recl fxd arm leg res		A					
E1110	Wheelchair semi-recl detach		A					
E1130	Whlchr stand fxd arm ft rest		A					
E1140	Wheelchair standard detach a		A					
E1150	Wheelchair standard w/ leg r		Y					
E1160	Wheelchair fixed arms		A					
E1161	Manual adult wc w tiltinspac		A					
E1170	Whlchr ampu fxd arm leg rest		A					
E1171	Wheelchair amputee w/o leg r		A					
E1172	Wheelchair amputee detach ar		A					
E1180	Wheelchair amputee w/ foot r		A					
E1190	Wheelchair amputee w/ leg re		A					
E1195	Wheelchair amputee heavy dut		A					
E1200	Wheelchair amputee fixed arm		A					
E1220	Whlchr special size/constrc		A					
E1221	Wheelchair spec size w foot		A					
E1222	Wheelchair spec size w/ leg		A					
E1223	Wheelchair spec size w foot		A					
E1224	Wheelchair spec size w/ leg		A					
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		A					
E1250	Wheelchair lightwt fixed arm		A					
E1260	Wheelchair lightwt foot rest		A					
E1270	Wheelchair lightweight leg r		A					
E1280	Whchr h-duty det arm leg res		A					
E1285	Wheelchair heavy duty fixed		A					
E1290	Wheelchair hvy duty detach a		A					
E1295	Wheelchair heavy duty fixed		A					
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					
E1340	Repair for DME, per 15 min		Y					
E1353	Oxygen supplies regulator		Y					
E1355	Oxygen supplies stand/rack		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					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
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					
E1840	Adj shoulder ext/flex device		Y					
E1841	Static str shldr dev rom adj		Y					
E1902	AAC non-electronic board		A					
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					
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					
E2223	Valve replacement only each		Y					
E2224	Propulsion whl excludes tire		Y					
E2225	Caster wheel excludes tire		Y					
E2226	Caster fork replacement only		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					
E2300	Pwr seat elevation sys		Y					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
E2301	Pwr standing		Y					
E2310	Electro connect btw control		Y					
E2311	Electro connect btw 2 sys		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					
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					
E2393	Valve, pneumatic tire tube		Y					
E2394	Drive wheel excludes tire		Y					
E2395	Caster wheel excludes tire		Y					
E2396	Caster fork		Y					
E2399	Noc interface		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 ≦40min		Y					
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					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
E2615	Pos back post/lat wdth <22in		Y					
E2616	Pos back post/lat wdth≧22in		Y					
E2617	Custom fab w/c back cushion		Y					
E2618	Wc acc solid seat supp base		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					
E8000	Posterior gait trainer		E					
E8001	Upright gait trainer		E					
E8002	Anterior gait trainer		E					
G0008	Admin influenza virus vac		S	0350	0.4037	$25.71		
G0009	Admin pneumococcal vaccine		S	0350	0.4037	$25.71		
G0010	Admin hepatitis b vaccine		B					
G0027	Semen analysis		A					
G0101	CA screen;pelvic/breast exam		V	0604	0.8381	$53.38		$10.68
G0102	Prostate ca screening; dre		N					
G0103	PSA screening		A					
G0104	CA screen;flexi sigmoidscope		S	0159	4.7799	$304.45		$76.11
G0105	Colorectal scrn; hi risk ind		T	0158	8.0134	$510.40		$127.60
G0106	Colon CA screen;barium enema		S	0157	2.2613	$144.03		$28.81
G0108	Diab manage trn per indiv		A					
G0109	Diab manage trn ind/group		A					
G0117	Glaucoma scrn hgh risk direc		S	0230	0.7379	$47.00		$9.40
G0118	Glaucoma scrn hgh risk direc		S	0230	0.7379	$47.00		$9.40
G0120	Colon ca scrn; barium enema		S	0157	2.2613	$144.03		$28.81
G0121	Colon ca scrn not hi rsk ind		T	0158	8.0134	$510.40		$127.60
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)	CH	T	0013	0.8046	$51.25		$10.25
G0128	CORF skilled nursing service		B					
G0129	Partial hosp prog service		P	0033				
G0130	Single energy x-ray study		X	0260	0.7259	$46.23		$9.25
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					
G0166	Extrnl counterpulse, per tx		T	0678	1.7081	$108.79		$21.76
G0168	Wound closure by adhesive		B					
G0173	Linear acc stereo radsur com		S	0067	61.5205	$3,918.43		$783.69
G0175	OPPS Service,sched team conf		V	0608	2.2077	$140.62		$28.12
G0176	OPPS/PHP;activity therapy		P	0033				
G0177	OPPS/PHP; train & educ serv	CH	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	4.01	$255.41	$58.90	$51.08
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	CH	S	0077	0.3904	$24.87	$7.70	$4.97
G0238	Oth resp proc, indiv	CH	S	0077	0.3904	$24.87	$7.70	$4.97
G0239	Oth resp proc, group	CH	S	0077	0.3904	$24.87	$7.70	$4.97
G0245	Initial foot exam pt lops		V	0604	0.8381	$53.38		$10.68
G0246	Followup eval of foot pt lop		V	0605	1.0016	$63.79		$12.76
G0247	Routine footcare pt w lops	CH	T	0013	0.8046	$51.25		$10.25
G0248	Demonstrate use home inr mon	CH	X	0097	1.0396	$66.22	$23.70	$13.24
G0249	Provide test material,equipm	CH	X	0097	1.0396	$66.22	$23.70	$13.24
G0250	MD review interpret of test		M					
G0251	Linear acc based stero radio		S	0065	17.1992	$1,095.47		$219.09
G0252	PET imaging initial dx		E					
G0255	Current percep threshold tst		E					
G0257	Unsched dialysis ESRD pt hos		S	0170	6.7915	$432.57		$86.51
G0259	Inject for sacroiliac joint		N					
G0260	Inj for sacroiliac jt anesth	CH	T	0207	7.137	$454.58		$90.92
G0265	Cryopresevation Freeze+stora	CH	B					
G0266	Thawing + expansion froz cel	CH	B					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
G0267	Bone marrow or psc harvest	CH	B					
G0268	Removal of impacted wax md	CH	N					
G0269	Occlusive device in vein art		N					
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	CH	Q	0417	2.3401	$149.05		$29.81
G0289	Arthro, loose body + chondro		N					
G0290	Drug-eluting stents, single		T	0656	118.8818	$7,571.94		$1,514.39
G0291	Drug-eluting stents,each add		T	0656	118.8818	$7,571.94		$1,514.39
G0293	Non-cov surg proc,clin trial		X	0340	0.6416	$40.87		$8.17
G0294	Non-cov proc, clinical trial		X	0340	0.6416	$40.87		$8.17
G0295	Electromagnetic therapy onc		E					
G0297	Insert single chamber/cd	CH	B					
G0298	Insert dual chamber/cd	CH	B					
G0299	Inser/repos single icd+leads	CH	B					
G0300	Insert reposit lead dual+gen	CH	B					
G0302	Pre-op service LVRS complete	CH	S	0209	11.5647	$736.59	$268.70	$147.32
G0303	Pre-op service LVRS 10-15dos	CH	S	0209	11.5647	$736.59	$268.70	$147.32
G0304	Pre-op service LVRS 1-9 dos	CH	S	0213	2.3476	$149.53	$53.50	$29.91
G0305	Post op service LVRS min 6	CH	S	0213	2.3476	$149.53	$53.50	$29.91
G0306	CBC/diffwbc w/o platelet		A					
G0307	CBC without platelet		A					
G0308	ESRD related svc 4+mo < 2yrs		B					
G0309	ESRD related svc 2-3mo <2yrs		B					
G0310	ESRD related svc 1 vst <2yrs		B					
G0311	ESRD related svs 4+mo 2-11yr		B					
G0312	ESRD relate svs 2-3 mo 2-11y		B					
G0313	ESRD related svs 1 mon 2-11y		B					
G0314	ESRD related svs 4+ mo 12-19		B					
G0315	ESRD related svs 2-3mo/12-19		B					
G0316	ESRD related svs 1vis/12-19y		B					
G0317	ESRD related svs 4+mo 20+yrs		B					
G0318	ESRD related svs 2-3 mo 20+y		B					
G0319	ESRD related svs 1visit 20+y		B					
G0320	ESD related svs home undr 2		B					
G0321	ESRDrelatedsvs home mo 2-11y		B					
G0322	ESRD related svs hom mo12-19		B					
G0323	ESRD related svs home mo 20+		B					
G0324	ESRD relate svs home/dy <2yr		B					
G0325	ESRD relate home/day/ 2-11yr		B					
G0326	ESRD relate home/dy 12-19yr		B					
G0327	ESRD relate home/dy 20+yrs		B					
G0328	Fecal blood scrn immunoassay		A					
G0329	Electromagntic tx for ulcers		A					
G0332	Preadmin IV immunoglobulin	CH	S	0430	0.6123	$39.00		$7.80
G0333	Dispense fee initial 30 day		M					
G0337	Hospice evaluation preelecti		B					
G0339	Robot lin-radsurg com, first		S	0067	61.5205	$3,918.43		$783.69
G0340	Robt lin-radsurg fractx 2-5		S	0066	47.3767	$3,017.56		$603.51
G0341	Percutaneous islet celltrans		C					
G0342	Laparoscopy islet cell trans		C					
G0343	Laparotomy islet cell transp		C					
G0344	Initial preventive exam		V	0605	1.0016	$63.79		$12.76
G0364	Bone marrow aspirate &biopsy		T	0002	1.1915	$75.89		$15.18
G0365	Vessel mapping hemo access		S	0267	2.4859	$158.33	$60.50	$31.67
G0366	EKG for initial prevent exam		B					
G0367	EKG tracing for initial prev		S	0099	0.3912	$24.92		$4.98
G0368	EKG interpret & report preve		M					
G0372	MD service required for PMD		M					
G0375	Smoke/tobacco counselng 3-10		X	0031	0.166	$10.57		$2.11
G0376	Smoke/tobacco counseling >10		X	0031	0.166	$10.57		$2.11
G0377	Administra Part D vaccine		S	0437	0.4037	$25.71		$5.14
G0378	Hospital observation per hr	CH	N					
G0379	Direct admit hospital observ		Q	0604	0.8381	$53.38		$10.68
G0380	Lev 1 hosp type B ED visit		V	0604	0.8381	$53.38		$10.68
G0381	Lev 2 hosp type B ED visit		V	0605	1.0016	$63.79		$12.76
G0382	Lev 3 hosp type B ED visit		V	0606	1.3665	$87.04		$17.41
G0383	Lev 4 hosp type B ED visit		V	0607	1.7181	$109.43		$21.89
G0384	Lev 5 hosp type B ED visit		V	0608	2.2077	$140.62		$28.12
G0389	Ultrasound exam AAA screen		S	0266	1.5657	$99.72	$37.80	$19.94
G0390	Trauma Respons w/hosp criti		S	0618	5.6539	$360.11	$144.04	$72.02
G0392	AV fistula or graft arterial	CH	T	0083	46.0685	$2,934.24		$586.85
G0393	AV fistula or graft venous	CH	T	0083	46.0685	$2,934.24		$586.85

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
G0394	Blood occult test,colorectal		A					
G3001	Admin + supply, tositumomab		S	0442	30.2249	$1,925.11		$385.02
G8006	AMI pt recd aspirin at arriv		M					
G8007	AMI pt did not receiv aspiri		M					
G8008	AMI pt ineligible for aspiri		M					
G8009	AMI pt recd Bblock at arr		M					
G8010	AMI pt did not rec bblock		M					
G8011	AMI pt inelig Bbloc at arriv		M					
G8012	Pneum pt recv antibiotic 4 h		M					
G8013	Pneum pt w/o antibiotic 4 hr		M					
G8014	Pneum pt not elig antibiotic		M					
G8015	Diabetic pt w/ HBA1c>9%		M					
G8016	Diabetic pt w/ HBA1c<or=9%		M					
G8017	DM pt inelig for HBA1c measu		M					
G8018	Care not provided for HbA1c		M					
G8019	Diabetic pt w/LDL≧ 100mg/dl		M					
G8020	Diab pt w/LDL< 100mg/dl		M					
G8021	Diab pt inelig for LDL meas		M					
G8022	Care not provided for LDL		M					
G8023	DM pt w BP≧140/80		M					
G8024	Diabetic pt wBP<140/80		M					
G8025	Diabetic pt inelig for BP me		M					
G8026	Diabet pt w no care re BP me		M					
G8027	HF p w/LVSD on ACE-I/ARB		M					
G8028	HF pt w/LVSD not on ACE-I/AR		M					
G8029	HF pt not elig for ACE-I/ARB		M					
G8030	HF pt w/LVSD on Bblocker		M					
G8031	HF pt w/LVSD not on Bblocker		M					
G8032	HF pt not elig for Bblocker		M					
G8033	PMI-CAD pt on Bblocker		M					
G8034	PMI-CAD pt not on Bblocker		M					
G8035	PMI-CAD pt inelig Bblocker		M					
G8036	AMI-CAD pt doc on antiplatel		M					
G8037	AMI-CAD pt not docu on antip		M					
G8038	AMI-CAD inelig antiplate mea		M					
G8039	CAD pt w/LDL>100mg/dl		M					
G8040	CAD pt w/LDL<or=100mg/dl		M					
G8041	CAD pt not eligible for LDL		M					
G8051	Osteoporosis assess		M					
G8052	Osteopor pt not assess		M					
G8053	Pt inelig for osteopor meas		M					
G8054	Falls assess not docum 12 mo		M					
G8055	Falls assess w/ 12 mon		M					
G8056	Not elig for falls assessmen		M					
G8057	Hearing assess receive		M					
G8058	Pt w/o hearing assess		M					
G8059	Pt inelig for hearing assess		M					
G8060	Urinary incont pt assess		M					
G8061	Pt not assess for urinary in		M					
G8062	Pt not elig for urinary inco		M					
G8075	ESRD pt w/ dialy of URR≧65%		M					
G8076	ESRD pt w/ dialy of URR<65%		M					
G8077	ESRD pt not elig for URR/KtV		M					
G8078	ESRD pt w/Hct>or=33		M					
G8079	ESRD pt w/Hct<33		M					
G8080	ESRD pt inelig for HCT/Hgb		M					
G8081	ESRD pt w/ auto AV fistula		M					
G8082	ESRD pt w other fistula		M					
G8085	ESRD PT inelig auto AV FISTU		M					
G8093	COPD pt rec smoking cessat		M					
G8094	COPD pt w/o smoke cessat int		M					
G8099	Osteopo pt given Ca+VitD sup		M					
G8100	Osteop pt inelig for Ca+VitD		M					
G8103	New dx osteo pt w/antiresorp		M					
G8104	Osteo pt inelig for antireso		M					
G8106	Bone dens meas test perf		M					
G8107	Bone dens meas test inelig		M					
G8108	Pt receiv influenza vacc		M					
G8109	Pt w/o influenza vacc		M					
G8110	Pt inelig for influenza vacc		M					
G8111	Pt receiv mammogram		M					
G8112	Pt not doc mammogram		M					
G8113	Pt ineligible mammography		M					
G8114	Care not provided for mamogr		M					
G8115	Pt receiv pneumo vacc		M					
G8116	Pt did not rec pneumo vacc		M					
G8117	Pt was inelig for pneumo vac		M					
G8126	Pt treat w/antidepress12wks		M					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
G8127	Pt not treat w/antidepres12w		M					
G8128	Pt inelig for antidepres med		M					
G8129	Pt treat w/antidepres for 6m		M					
G8130	Pt not treat w/antidepres 6m		M					
G8131	Pt inelig for antidepres med		M					
G8152	Pt w/AB 1 hr prior to incisi		M					
G8153	Pt not doc for AB 1 hr prior		M					
G8154	Pt ineligi for AB therapy		M					
G8155	Pt recd thromboemb prophylax		M					
G8156	Pt did not rec thromboembo		M					
G8157	Pt ineligi for thrombolism		M					
G8158	Pt recd CABG w/ IMA		M					
G8159	Pt w/CABG w/o IMA		M					
G8160	Pt inelig for CABG w/IMA		M					
G8161	Iso CABG pt rec preop bblock		M					
G8162	Iso CABG pt w/o preop Bblock		M					
G8163	Iso CABG pt inelig for preo		M					
G8164	Iso CABG pt w/prolng intub		M					
G8165	Iso CABG pt w/o prolng intub		M					
G8166	Iso CABG req surg rexpo		M					
G8167	Iso CABG w/o surg explo		M					
G8170	CEA/ext bypass pt on aspirin		M					
G8171	Pt w/carot endarct/ext bypas		M					
G8172	CEA/ext bypass pt not on asp		M					
G8182	CAD pt care not prov LDL		M					
G8183	HF/atrial fib pt on warfarin		M					
G8184	HF/atrial fib pt inelig warf		M					
G8185	Osteoarth pt w/ assess pain		M					
G8186	Osteoarth pt inelig assess		M					
G8191	Antibiotic given prior surg		M					
G8192	Antib given prior surg incis		M					
G8193	Antibio not doc prior surg		M					
G8194	Pt not elig for antibiotic		M					
G8195	Antibiotic given prior surg		M					
G8196	Antibio not docum prior surg		M					
G8197	Antib order prior to surg		M					
G8198	Cefazolin documented ordered		M					
G8199	Cefazolin given prophylaxis		M					
G8200	Cefazolin not docum prophy		M					
G8201	Pt not eligi for cefazolin		M					
G8202	Order given to d/c antibio		M					
G8203	Antib was D/C 24hrs surg tim		M					
G8204	MD not doc order to d/c anti		M					
G8205	Pt not eligi for proph antib		M					
G8206	MD doc prophylactic AB given		M					
G8207	Clini doc order to D/C antib		M					
G8208	Clini doc AB was D/C 48 h		M					
G8209	Clinician did not doc		M					
G8210	Clini doc pt ineligib anti		M					
G8211	Clini doc proph AB giv		M					
G8212	Clini order given for VTE		M					
G8213	Clini given VTE prop		M					
G8214	Clini not doc order VTE		M					
G8215	Clini doc pt inelig VTE		M					
G8216	Pt received DVT prophylaxis		M					
G8217	Pt not received DVT proph		M					
G8218	Pt inelig DVT prophylaxis		M					
G8219	Received DVT proph day 2		M					
G8220	Pt not rec DVT proph day 2		M					
G8221	Pt inelig for DVT proph		M					
G8222	Pt prescribe platelet at D/C		M					
G8223	Pt not doc for presc antipla		M					
G8224	Pt inelig for antiplat proph		M					
G8225	Pt prescrib anticoag at D/C		M					
G8226	Pt no prescr anticoa at D/C		M					
G8227	Pt not doc to have perm/AF		M					
G8228	Clin pt inelig anticoag D/C		M					
G8229	Pt doc to have admin t-PA		M					
G8230	Pt inelig t-PA isch strok>3h		M					
G8231	Pt not doc for admin t-PA		M					
G8232	Pt received dysphagia screen		M					
G8234	Pt not doc dysphagia screen		M					
G8235	Pt received NPO		M					
G8236	Pt inelig dysphagia screen		M					
G8237	Pt doc rec rehab serv		M					
G8238	Pt not doc to rec rehab serv		M					
G8239	Inter carotid stenosis <30%		M					
G8240	Inter carotid stenosis 30-99%		M					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
G8241	Pt inelig candidate ito meas		M					
G8242	Pt doc to have CT/MRI w/les		M					
G8243	Pt not doc MRI/CT w/o lesion		M					
G8245	Clini doc prese/abs alarm		M					
G8246	Pt inelig hx w new/chg mole		M					
G8247	Pt w/alarm symp upper endo		M					
G8248	Pt w/one alarm symp not doc		M					
G8249	Pt inelig for upper endo		M					
G8250	Pt w/Barretts esoph endo re		M					
G8251	Pt not doc w/Barretts, endo		M					
G8252	Pt inelig for esophag biop		M					
G8253	Pt rec order for barium		M					
G8254	Pt w/no doc order for barium		M					
G8255	Clini doc pt inelig bar swal		M					
G8256	Clini doc rev D/C meds w/med		M					
G8257	Pt not doc rev meds D/C		M					
G8258	Pt inelig for d/c meds rev		M					
G8259	Pt doc to hav decision maker		M					
G8260	Pt not doc to have dec maker		M					
G8261	Clin doc pt inelig dec maker		M					
G8262	Pt doc assess uriny incon		M					
G8263	Pt not doc assess urinary in		M					
G8264	Pt inelig assess urinary inc		M					
G8265	Pt doc rec charc urin incon		M					
G8266	Pt not doc charc urin incon		M					
G8267	Pt doc rec plan urinary inco		M					
G8268	Pt not doc rec care urin inc		M					
G8269	Clin not prov care urin inco		M					
G8270	Pt receiv screen for fall		M					
G8271	Pt no doc screen fall		M					
G8272	Clin doc pt inelig fall risk		M					
G8273	Clin not prov care scre fall		M					
G8274	Clini not doc pres/abs alarm		M					
G8275	Pt hx w/ new moles		M					
G8276	Pt not doc mole change		M					
G8277	Pt inelig for assess mole		M					
G8278	Pt doc rec PE skin		M					
G8279	Pt not doc rec PE		M					
G8280	Pt inelig PE skin		M					
G8281	Pt rec counsel for self-exam		M					
G8282	Pt not doc to rec couns		M					
G8283	Pt inelig for counsel		M					
G8284	Pt doc to rec pres osteo		M					
G8285	Pt did not rec pres osteo		M					
G8286	Pt inelig to rec pres osteo		M					
G8287	Clin not prov care for pharm		M					
G8288	Pt doc rec Ca/Vit D		M					
G8289	Pt not doc rec Ca/Vit D		M					
G8290	Clin doc pt inelig Ca/Vit D		M					
G8291	Clin no pro care pt Ca/Vit D		M					
G8292	COPD pt w/spir results		M					
G8293	COPD pt w/o spir results		M					
G8294	COPD pt inelig spir results		M					
G8295	COPD pt doc bronch ther		M					
G8296	COPD pt not doc bronch ther		M					
G8297	COPD pt inelig bronch therap		M					
G8298	Pt doc optic nerve eval		M					
G8299	Pt not doc optic nerv eval		M					
G8300	Pt inelig for optic nerv eva		M					
G8301	Clin not prov care POAG		M					
G8302	Pt doc w/ target IOP		M					
G8303	Pt not doc w/ IOP		M					
G8304	Clin doc pt inelig IOP		M					
G8305	Clin not prov care POAG		M					
G8306	POAG w/ IOP rec care plan		M					
G8307	POAG w/ IOP no care plan		M					
G8308	POAG w/ IOP not doc plan		M					
G8309	Pt doc rec antioxidant		M					
G8310	Pt not doc rec antiox		M					
G8311	Pt inelig for antioxidant		M					
G8312	Clin no prov care for antiox		M					
G8313	Pt doc rec macular exam		M					
G8314	Pt not doc to rec mac exam		M					
G8315	Clin doc pt inelig mac exam		M					
G8316	Clin no pro care for mac deg		M					
G8317	Pt doc to have visual func		M					
G8318	Pt doc not have visual func		M					
G8319	Pt inelig for vis func stat		M					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
G8320	Clin not prov care catarac		M					
G8321	Pt doc to pre axial leng		M					
G8322	Pt not doc pre axial leng		M					
G8323	Pt inelig for pre surg axial		M					
G8324	Clin not prov care for IOL		M					
G8325	Pt rec fund exam prior surg		M					
G8326	Pt not doc rec fundus exam		M					
G8327	Pt inelig for pre surg fundu		M					
G8328	Clin not prov care fund eval		M					
G8329	Pt doc rec dilated macular		M					
G8330	Pt not doc rec dilated mac		M					
G8331	Pt inelig dilate fundus		M					
G8332	Clin prov no care diabetic r		M					
G8333	Pt doc to have macular exam		M					
G8334	Doc of macular not giv MD		M					
G8335	Clin doc pt inelig macular		M					
G8336	Clin did not pro care diabet		M					
G8337	Clin doc pt was test osteo		M					
G8338	Clin not doc pt test osteo		M					
G8339	Pt inelig for test osteo		M					
G8340	Pt doc have DEXA		M					
G8341	Pt not doc for DEXA		M					
G8342	Clin doc pt inelig DEXA		M					
G8343	Clin not prov care DEXA		M					
G8344	Pt doc have DEXA perform		M					
G8345	Pt not doc have DEXA		M					
G8346	Clin doc pt inelig DEXA		M					
G8347	Clin not prov care DEXA		M					
G8348	Int carotid stenosis meas		M					
G8349	Pt inelig for doc of alarm		M					
G8350	Pt doc 12 lead ECG		M					
G8351	Pt not doc ECG		M					
G8352	Pt inelig for ECG		M					
G8353	Pt doc rec aspirin 24hrs ER		M					
G8354	Pt not rec aspirin prior ER		M					
G8355	Clin doc pt inelig aspirin		M					
G8356	Pt doc to have ECG		M					
G8357	Pt not doc to have ECG		M					
G8358	Clin doc pt inelig ECG		M					
G8359	Pt doc vital signs recorded		M					
G8360	Pt not doc vital signs recor		M					
G8361	Pt doc to have 02 SAT assess		M					
G8362	Pt not doc 02 SAT assess		M					
G8363	Clin doc pt inelig 02 SAT		M					
G8364	Pt doc mental status assess		M					
G8365	Pt not doc mental status		M					
G8366	Pt doc to have empiric AB		M					
G8367	Pt not doc have empiric AB		M					
G8368	Clin doc pt inelig empiri AB		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					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
G9052	Onc surveillance for disease		E					
G9053	Onc expectant management pt		E					
G9054	Onc supervision palliative		E					
G9055	Onc visit unspecified NOS		E					
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 unknown 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					
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					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
G9139	Onc dx CML dx status unknown		M					
GXXX1	MD serv cardiac rehab w/o EC		S	0095	0.5868	$37.38	$13.80	$7.48
GXXX2	MD serv cardiac rehab w ECG		S	0095	0.5868	$37.38	$13.80	$7.48
J0120	Tetracyclin injection		N					
J0128	Abarelix injection		K	9216		$67.97		$13.59
J0129	Abatacept injection		G	9230		$18.69		$3.74
J0130	Abciximab injection		K	1605		$409.26		$81.85
J0132	Acetylcysteine injection	CH	N					
J0133	Acyclovir injection		N					
J0135	Adalimumab injection		K	1083		$316.02		$63.20
J0150	Injection adenosine 6 MG		K	0379		$22.65		$4.53
J0152	Adenosine injection		K	0917		$68.50		$13.70
J0170	Adrenalin epinephrin inject		N					
J0180	Agalsidase beta injection		K	9208		$126.00		$25.20
J0190	Inj biperiden lactate/5 mg	CH	N					
J0200	Alatrofloxacin mesylate		N					
J0205	Alglucerase injection		K	0900		$38.85		$7.77
J0207	Amifostine		K	7000		$476.10		$95.22
J0210	Methyldopate hcl injection		K	2210		$10.01		$2.00
J0215	Alefacept		K	1633		$25.82		$5.16
J0256	Alpha 1 proteinase inhibitor		K	0901		$3.24		$0.65
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		$10.28		$2.06
J0288	Ampho b cholesteryl sulfate		K	0735		$11.89		$2.38
J0289	Amphotericin b liposome inj		K	0736		$17.07		$3.41
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	Anadulafungin injection		G	0760		$1.91		$0.38
J0350	Injection anistreplase 30 u		K	1606	42.2935	$2,693.80		$538.76
J0360	Hydralazine hcl injection		N					
J0364	Apomorphine hydrochloride	CH	N					
J0365	Aprotonin, 10,000 kiu		K	1682		$2.50		$0.50
J0380	Inj metaraminol bitartrate	CH	N					
J0390	Chloroquine injection		N					
J0395	Arbutamine HCl injection	CH	N					
J0456	Azithromycin		N					
J0460	Atropine sulfate injection		N					
J0470	Dimecaprol injection		N					
J0475	Baclofen 10 MG injection		K	9032		$195.18		$39.04
J0476	Baclofen intrathecal trial		K	1631		$70.92		$14.18
J0480	Basiliximab		K	1683		$1,347.14		$269.43
J0500	Dicyclomine injection		N					
J0515	Inj benztropine mesylate		N					
J0520	Bethanechol chloride inject	CH	K	0879	0.5128	$32.66		$6.53
J0530	Penicillin g benzathine inj		N					
J0540	Penicillin g benzathine inj		N					
J0550	Penicillin g benzathine inj		N					
J0560	Penicillin g benzathine inj		N					
J0570	Penicillin g benzathine inj		N					
J0580	Penicillin g benzathine inj		N					
J0583	Bivalirudin		K	3041		$1.72		$0.34
J0585	Botulinum toxin a per unit		K	0902		$5.05		$1.01
J0587	Botulinum toxin type B		K	9018		$8.30		$1.66
J0592	Buprenorphine hydrochloride		N					
J0594	Busulfan injection		K	1178		$8.80		$1.76
J0595	Butorphanol tartrate 1 mg		N					
J0600	Edetate calcium disodium inj	CH	N					
J0610	Calcium gluconate injection		N					
J0620	Calcium glycer & lact/10 ML		N					
J0630	Calcitonin salmon injection		N					
J0636	Inj calcitriol per 0.1 mcg		N					
J0637	Caspofungin acetate		K	9019		$30.07		$6.01
J0640	Leucovorin calcium injection		N					
J0670	Inj mepivacaine HCL/10 ml		N					
J0690	Cefazolin sodium injection		N					
J0692	Cefepime HCl for injection		N					
J0694	Cefoxitin sodium injection		N					
J0696	Ceftriaxone sodium injection		N					
J0697	Sterile cefuroxime injection		N					
J0698	Cefotaxime sodium injection		N					
J0702	Betamethasone acet&sod phosp		N					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
J0704	Betamethasone sod phosp/4 MG		N					
J0706	Caffeine citrate injection	CH	N					
J0710	Cephapirin sodium injection		N					
J0713	Inj ceftazidime per 500 mg		N					
J0715	Ceftizoxime sodium / 500 MG		N					
J0720	Chloramphenicol sodium injec		N					
J0725	Chorionic gonadotropin/1000u		N					
J0735	Clonidine hydrochloride		K	0935		$62.86		$12.57
J0740	Cidofovir injection		K	9033		$754.62		$150.92
J0743	Cilastatin sodium injection		N					
J0744	Ciprofloxacin iv		N					
J0745	Inj codeine phosphate /30 MG		N					
J0760	Colchicine injection		N					
J0770	Colistimethate sodium inj		N					
J0780	Prochlorperazine injection		N					
J0795	Corticorelin ovine triflutal		K	1684		$4.26		$0.85
J0800	Corticotropin injection		K	1280		$126.52		$25.30
J0835	Inj cosyntropin per 0.25 MG		K	0835		$63.25		$12.65
J0850	Cytomegalovirus imm IV /vial		K	0903		$859.86		$171.97
J0878	Daptomycin injection		K	9124		$0.33		$0.07
J0881	Darbepoetin alfa, non-esrd		K	1685		$3.11		$0.62
J0882	Darbepoetin alfa, esrd use		A					
J0885	Epoetin alfa, non-esrd		K	1686		$9.36		$1.87
J0886	Epoetin alfa 1000 units ESRD		A					
J0894	Decitabine injection		G	9231	0.4157	$26.48		$5.30
J0895	Deferoxamine mesylate inj	CH	N					
J0900	Testosterone enanthate inj		N					
J0945	Brompheniramine maleate inj		N					
J0970	Estradiol valerate injection		N					
J1000	Depo-estradiol cypionate inj		N					
J1020	Methylprednisolone 20 MG inj		N					
J1030	Methylprednisolone 40 MG inj		N					
J1040	Methylprednisolone 80 MG inj		N					
J1051	Medroxyprogesterone inj		N					
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		$511.48		$102.30
J1165	Phenytoin sodium injection		N					
J1170	Hydromorphone injection		N					
J1180	Dyphylline injection		N					
J1190	Dexrazoxane HCl injection		K	0726		$172.43		$34.49
J1200	Diphenhydramine hcl injectio		N					
J1205	Chlorothiazide sodium inj		K	0747		$122.67		$24.53
J1212	Dimethyl sulfoxide 50% 50 ML		N					
J1230	Methadone injection		N					
J1240	Dimenhydrinate injection		N					
J1245	Dipyridamole injection		N					
J1250	Inj dobutamine HCL/250 mg		N					
J1260	Dolasetron mesylate		K	0750		$6.05		$1.21
J1265	Dopamine injection		N					
J1270	Injection, doxercalciferol		N					
J1320	Amitriptyline injection		N					
J1324	Enfuvirtide injection		K	0767		$22.69		$4.54
J1325	Epoprostenol injection		N					
J1327	Eptifibatide injection		K	1607		$15.90		$3.18
J1330	Ergonovine maleate injection	CH	N					
J1335	Ertapenem injection		N					
J1364	Erythro lactobionate /500 MG		N					
J1380	Estradiol valerate 10 MG inj		N					
J1390	Estradiol valerate 20 MG inj		N					
J1410	Inj estrogen conjugate 25 MG		K	9038		$60.32		$12.06
J1430	Ethanolamine oleate 100 mg		K	1688		$78.26		$15.65
J1435	Injection estrone per 1 MG		N					
J1436	Etidronate disodium inj		K	1436		$70.73		$14.15
J1438	Etanercept injection		K	1608		$160.03		$32.01
J1440	Filgrastim 300 mcg injection		K	0728		$187.68		$37.54
J1441	Filgrastim 480 mcg injection		K	7049		$297.75		$59.55
J1450	Fluconazole		N					
J1451	Fomepizole, 15 mg		K	1689		$12.28		$2.46
J1452	Intraocular Fomivirsen na	CH	N					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
J1455	Foscarnet sodium injection	CH	N					
J1457	Gallium nitrate injection	CH	K	0878		$1.47		$0.29
J1458	Galsulfase injection		K	9224		$297.09		$59.42
J1460	Gamma globulin 1 CC inj		K	3043		$11.31		$2.26
J1470	Gamma globulin 2 CC inj	CH	K	0898		$22.63		$4.53
J1480	Gamma globulin 3 CC inj	CH	K	0899		$33.93		$6.79
J1490	Gamma globulin 4 CC inj	CH	K	0904		$45.25		$9.05
J1500	Gamma globulin 5 CC inj	CH	K	0919		$56.56		$11.31
J1510	Gamma globulin 6 CC inj	CH	K	0920		$67.91		$13.58
J1520	Gamma globulin 7 CC inj	CH	K	0921		$79.14		$15.83
J1530	Gamma globulin 8 CC inj	CH	K	0922		$90.50		$18.10
J1540	Gamma globulin 9 CC inj	CH	K	0923		$101.88		$20.38
J1550	Gamma globulin 10 CC inj	CH	K	0924		$113.13		$22.63
J1560	Gamma globulin > 10 CC inj	CH	K	0933		$113.13		$22.63
J1562	Immune globulin subcutaneous		K	0804		$12.60		$2.52
J1565	RSV-ivig		K	0906		$16.02		$3.20
J1566	Immune globulin, powder		K	2731		$25.48		$5.10
J1567	Immune globulin, liquid		K	2732		$30.28		$6.06
J1570	Ganciclovir sodium injection		N					
J1580	Garamycin gentamicin inj		N					
J1590	Gatifloxacin injection		N					
J1595	Injection glatiramer acetate		N					
J1600	Gold sodium thiomaleate inj		N					
J1610	Glucagon hydrochloride/1 MG		K	9042		$65.64		$13.13
J1620	Gonadorelin hydroch/ 100 mcg		K	7005		$178.59		$35.72
J1626	Granisetron HCl injection		K	0764		$7.43		$1.49
J1630	Haloperidol injection		N					
J1631	Haloperidol decanoate inj		N					
J1640	Hemin, 1 mg		K	1690		$6.74		$1.35
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	K	0883		$5.82		$1.16
J1655	Tinzaparin sodium injection	CH	N					
J1670	Tetanus immune globulin inj		K	1670		$96.35		$19.27
J1675	Histrelin acetate		B					
J1700	Hydrocortisone acetate inj		N					
J1710	Hydrocortisone sodium ph inj		N					
J1720	Hydrocortisone sodium succ i		N					
J1730	Diazoxide injection		K	1740		$113.24		$22.65
J1740	Ibandronate sodium injection		G	9229		$138.71		$27.74
J1742	Ibutilide fumarate injection		K	9044		$264.40		$52.88
J1745	Infliximab injection		K	7043		$53.25		$10.65
J1751	Iron dextran 165 injection		K	1691		$11.61		$2.32
J1752	Iron dextran 267 injection		K	1692		$10.32		$2.06
J1756	Iron sucrose injection		K	9046		$0.37		$0.08
J1785	Injection imiglucerase /unit		K	0916		$3.89		$0.78
J1790	Droperidol injection		N					
J1800	Propranolol injection		N					
J1810	Droperidol/fentanyl inj		E					
J1815	Insulin injection		N					
J1817	Insulin for insulin pump use		N					
J1825	Interferon beta-1a		E					
J1830	Interferon beta-1b / .25 MG		K	0910		$84.12		$16.82
J1835	Itraconazole injection		K	9047		$38.05		$7.61
J1840	Kanamycin sulfate 500 MG inj		N					
J1850	Kanamycin sulfate 75 MG inj		N					
J1885	Ketorolac tromethamine inj		N					
J1890	Cephalothin sodium injection		N					
J1931	Laronidase injection		K	9209		$23.64		$4.73
J1940	Furosemide injection		N					
J1945	Lepirudin		K	1693		$153.42		$30.68
J1950	Leuprolide acetate /3.75 MG		K	0800		$429.83		$85.97
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		$24.93		$4.99
J2060	Lorazepam injection		N					
J2150	Mannitol injection		N					
J2170	Mecasermin injection		K	0805		$11.81		$2.36
J2175	Meperidine hydrochl /100 MG		N					
J2180	Meperidine/promethazine inj		N					
J2185	Meropenem	CH	N					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
J2210	Methylergonovin maleate inj		N					
J2248	Micafungin sodium injection		G	9227		$1.71		$0.34
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	CH	K	1694		$6.46		$1.29
J2280	Inj, moxifloxacin 100 mg		N					
J2300	Inj nalbuphine hydrochloride		N					
J2310	Inj naloxone hydrochloride		N					
J2315	Naltrexone, depot form		K	0759		$1.88		$0.38
J2320	Nandrolone decanoate 50 MG		N					
J2321	Nandrolone decanoate 100 MG		N					
J2322	Nandrolone decanoate 200 MG		N					
J2325	Nesiritide injection		K	1695		$31.36		$6.27
J2353	Octreotide injection, depot		K	1207		$95.86		$19.17
J2354	Octreotide inj, non-depot		N					
J2355	Oprelvekin injection		K	7011		$244.98		$49.00
J2357	Omalizumab injection		K	9300		$16.79		$3.36
J2360	Orphenadrine injection		N					
J2370	Phenylephrine hcl injection		N					
J2400	Chloroprocaine hcl injection		N					
J2405	Ondansetron hcl injection		K	0768		$3.37		$0.67
J2410	Oxymorphone hcl injection		N					
J2425	Palifermin injection		K	1696		$11.32		$2.26
J2430	Pamidronate disodium /30 MG		K	0730		$30.49		$6.10
J2440	Papaverin hcl injection		N					
J2460	Oxytetracycline injection		N					
J2469	Palonosetron HCl		K	9210		$15.85		$3.17
J2501	Paricalcitol		N					
J2503	Pegaptanib sodium injection	CH	K	1697		$1,054.70		$210.94
J2504	Pegademase bovine, 25 iu		K	1739		$176.16		$35.23
J2505	Injection, pegfilgrastim 6mg		K	9119		$2,142.92		$428.58
J2510	Penicillin g procaine inj		N					
J2513	Pentastarch 10% solution	CH	K	0880	0.3707	$23.61		$4.72
J2515	Pentobarbital sodium inj		N					
J2540	Penicillin g potassium inj		N					
J2543	Piperacillin/tazobactam		N					
J2545	Pentamidine isethionte/300mg		B					
J2550	Promethazine hcl injection		N					
J2560	Phenobarbital sodium inj		N					
J2590	Oxytocin injection		N					
J2597	Inj desmopressin acetate		N					
J2650	Prednisolone acetate inj		N					
J2670	Totazoline hcl injection		N					
J2675	Inj progesterone per 50 MG		N					
J2680	Fluphenazine decanoate 25 MG		N					
J2690	Procainamide hcl injection		N					
J2700	Oxacillin sodium injeciton		N					
J2710	Neostigmine methylslfte inj		N					
J2720	Inj protamine sulfate/10 MG		N					
J2725	Inj protirelin per 250 mcg		N					
J2730	Pralidoxime chloride inj		N					
J2760	Phentolaine mesylate inj		N					
J2765	Metoclopramide hcl injection		N					
J2770	Quinupristin/dalfopristin		K	2770		$116.70		$23.34
J2780	Ranitidine hydrochloride inj		N					
J2783	Rasburicase		K	0738		$131.28		$26.26
J2788	Rho d immune globulin 50 mcg		K	9023		$26.41		$5.28
J2790	Rho d immune globulin inj		K	0884		$80.71		$16.14
J2792	Rho(D) immune globulin h, sd		K	1609		$15.76		$3.15
J2794	Risperidone, long acting		K	9125		$4.80		$0.96
J2795	Ropivacaine HCl injection		N					
J2800	Methocarbamol injection		N					
J2805	Sincalide injection		N					
J2810	Inj theophylline per 40 MG		N					
J2820	Sargramostim injection		K	0731		$25.08		$5.02
J2850	Inj secretin synthetic human		K	1700		$20.12		$4.02
J2910	Aurothioglucose injeciton		N					
J2916	Na ferric gluconate complex		N					
J2920	Methylprednisolone injection		N					
J2930	Methylprednisolone injection		N					
J2940	Somatrem injection		K	2940	1.0916	$69.53		$13.91
J2941	Somatropin injection		K	7034		$46.75		$9.35
J2950	Promazine hcl injection		N					
J2993	Reteplase injection		K	9005		$891.03		$178.21
J2995	Inj streptokinase /250000 IU		K	0911	1.1851	$75.48		$15.10

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
J2997	Alteplase recombinant		K	7048		$32.48		$6.50
J3000	Streptomycin injection		N					
J3010	Fentanyl citrate injeciton		N					
J3030	Sumatriptan succinate / 6 MG		K	3030		$58.82		$11.76
J3070	Pentazocine injection		N					
J3100	Tenecteplase injection		K	9002		$2,024.13		$404.83
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		$758.16		$151.63
J3243	Tigecycline injection		G	9228		$0.91		$0.18
J3246	Tirofiban HCl		K	7041		$7.66		$1.53
J3250	Trimethobenzamide hcl inj		N					
J3260	Tobramycin sulfate injection		N					
J3265	Injection torsemide 10 mg/ml		N					
J3280	Thiethylperazine maleate inj		N					
J3285	Treprostinil injection		K	1701		$55.36		$11.07
J3301	Triamcinolone acetonide inj		N					
J3302	Triamcinolone diacetate inj		N					
J3303	Triamcinolone hexacetonl inj		N					
J3305	Inj trimetrexate glucoronate		K	7045		$143.89		$28.78
J3310	Perphenazine injeciton		N					
J3315	Triptorelin pamoate		K	9122		$153.97		$30.79
J3320	Spectinomycn di-hcl inj	CH	N					
J3350	Urea injection		K	9051		$73.46		$14.69
J3355	Urofollitropin, 75 iu		K	1741		$50.22		$10.04
J3360	Diazepam injection		N					
J3364	Urokinase 5000 IU injection	CH	K	0881		$9.07		$1.81
J3365	Urokinase 250,000 IU inj		K	7036		$453.41		$90.68
J3370	Vancomycin hcl injection		N					
J3396	Verteporfin injection		K	1203		$8.84		$1.77
J3400	Triflupromazine hcl inj		N					
J3410	Hydroxyzine hcl injection		N					
J3411	Thiamine hcl 100 mg		N					
J3415	Pyridoxine hcl 100 mg		N					
J3420	Vitamin b12 injection		N					
J3430	Vitamin k phytonadione inj		N					
J3465	Injection, voriconazole		K	1052		$4.94		$0.99
J3470	Hyaluronidase injection		N					
J3471	Ovine, up to 999 USP units		N					
J3472	Ovine, 1000 USP units		K	1703		$133.77		$26.75
J3473	Hyaluronidase recombinant		G	0806		$0.40		$0.08
J3475	Inj magnesium sulfate		N					
J3480	Inj potassium chloride		N					
J3485	Zidovudine		N					
J3486	Ziprasidone mesylate		N					
J3487	Zoledronic acid		K	9115		$204.09		$40.82
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					
J7187	Inj Vonwillebrand factor IU		K	1704		$0.88		$0.18
J7189	Factor viia		K	1705		$1.11		$0.22
J7190	Factor viii		K	0925		$0.70		$0.14
J7191	Factor VIII (porcine)	CH	N					
J7192	Factor viii recombinant		K	0927		$1.07		$0.21
J7193	Factor IX non-recombinant		K	0931		$0.89		$0.18
J7194	Factor ix complex		K	0928		$0.75		$0.15
J7195	Factor IX recombinant		K	0932		$0.99		$0.20
J7197	Antithrombin iii injection		K	0930		$1.62		$0.32
J7198	Anti-inhibitor		K	0929		$1.35		$0.27
J7199	Hemophilia clot factor noc		B					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
J7308	Aminolevulinic acid hcl top		K	7308		$104.43		$20.89
J7310	Ganciclovir long act implant		K	0913		$4,707.42		$941.48
J7311	Fluocinolone acetonide implt	CH	K	9225		$19,162.50		$3,832.50
J7319	Sodium Hyaluronate Injection		E					
J7330	Cultured chondrocytes implnt		B					
J7340	Metabolic active D/E tissue		K	1632		$28.51		$5.70
J7341	Non-human, metabolic tissue	CH	N					
J7342	Metabolically active tissue		K	9054		$31.36		$6.27
J7343	Nonmetabolic act d/e tissue		K	1629		$18.13		$3.63
J7344	Nonmetabolic active tissue		K	9156		$88.37		$17.67
J7345	Non-human, non-metab tissue		K	0837		$35.76		$7.15
J7346	Injectable human tissue		K	9222		$728.44		$145.69
J7500	Azathioprine oral 50mg		N					
J7501	Azathioprine parenteral		K	0887		$47.99		$9.60
J7502	Cyclosporine oral 100 mg		K	0888		$3.57		$0.71
J7504	Lymphocyte immune globulin		K	0890		$314.19		$62.84
J7505	Monoclonal antibodies		K	7038		$886.70		$177.34
J7506	Prednisone oral		N					
J7507	Tacrolimus oral per 1 MG		K	0891		$3.63		$0.73
J7509	Methylprednisolone oral		N					
J7510	Prednisolone oral per 5 mg		N					
J7511	Antithymocyte globuln rabbit		K	9104		$324.66		$64.93
J7513	Daclizumab, parenteral		K	1612		$297.03		$59.41
J7515	Cyclosporine oral 25 mg		N					
J7516	Cyclosporin parenteral 250mg		N					
J7517	Mycophenolate mofetil oral		K	9015		$2.60		$0.52
J7518	Mycophenolic acid		K	9219		$2.25		$0.45
J7520	Sirolimus, oral		K	9020		$7.15		$1.43
J7525	Tacrolimus injection		K	9006		$139.11		$27.82
J7599	Immunosuppressive drug noc		N					
J7607	Levalbuterol comp con		B					
J7608	Acetylcysteine inh sol u d		B					
J7609	Albuterol comp unit		B					
J7610	Albuterol comp con		B					
J7611	Albuterol non-comp con		B					
J7612	Levalbuterol non-comp con		B					
J7613	Albuterol non-comp unit		B					
J7614	Levalbuterol non-comp unit		B					
J7615	Levalbuterol comp unit		B					
J7620	Albuterol ipratrop non-comp		B					
J7622	Beclomethasone comp unit		B					
J7624	Betamethasone comp unit		B					
J7626	Budesonide non-comp unit		B					
J7627	Budesonide comp unit		B					
J7628	Bitolterol mesylate comp con		B					
J7629	Bitolterol mesylate comp unt		B					
J7631	Cromolyn sodium inh sol u d		B					
J7633	Budesonide non-comp con		B					
J7634	Budesonide comp con		B					
J7635	Atropine comp con		B					
J7636	Atropine comp unit		B					
J7637	Dexamethasone comp con		B					
J7638	Dexamethasone comp unit		B					
J7639	Dornase alpha inhal sol u d		B					
J7640	Formoterol comp unit		E					
J7641	Flunisolide comp unit		B					
J7642	Glycopyrrolate comp con		B					
J7643	Glycopyrrolate comp unit		B					
J7644	Ipratropium bromide non-comp		B					
J7645	Ipratropium bromide comp		B					
J7647	Isoetharine comp con		B					
J7648	Isoetharine non-comp con		B					
J7649	Isoetharine non-comp unit		B					
J7650	Isoetharine comp unit		B					
J7657	Isoproterenol comp con		B					
J7658	Isoproterenol non-comp con		B					
J7659	Isoproterenol non-comp unit		B					
J7660	Isoproterenol comp unit		B					
J7667	Metaproterenol comp con		B					
J7668	Metaproterenol non-comp con		B					
J7669	Metaproterenol non-comp unit		B					
J7670	Metaproterenol comp unit		B					
J7674	Methacholine chloride, neb		N					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
J7680	Terbutaline sulf comp con		B					
J7681	Terbutaline sulf comp unit		B					
J7682	Tobramycin non-comp unit		B					
J7683	Triamcinolone comp con		B					
J7684	Triamcinolone comp unit		B					
J7685	Tobramycin comp unit		B					
J7699	Inhalation solution for DME		Y					
J7799	Non-inhalation drug for DME		N					
J8498	Antiemetic rectal/supp NOS		B					
J8499	Oral prescrip drug non chemo		E					
J8501	Oral aprepitant	CH	K	0868		$5.02		$1.00
J8510	Oral busulfan		K	7015		$2.12		$0.42
J8515	Cabergoline, oral 0.25mg		E					
J8520	Capecitabine, oral, 150 mg		K	7042		$3.94		$0.79
J8521	Capecitabine, oral, 500 mg	CH	K	0934		$13.12		$2.62
J8530	Cyclophosphamide oral 25 MG		N					
J8540	Oral dexamethasone		N					
J8560	Etoposide oral 50 MG		K	0802		$29.32		$5.86
J8565	Gefitinib oral		E					
J8597	Antiemetic drug oral NOS		N					
J8600	Melphalan oral 2 MG	CH	K	0882	0.0681	$4.34		$0.87
J8610	Methotrexate oral 2.5 MG		N					
J8650	Nabilone oral		K	0808		$16.80		$3.36
J8700	Temozolomide		K	1086		$7.34		$1.47
J8999	Oral prescription drug chemo		B					
J9000	Doxorubic hcl 10 MG vl chemo	CH	N					
J9001	Doxorubicin hcl liposome inj		K	7046		$385.81		$77.16
J9010	Alemtuzumab injection		K	9110		$536.10		$107.22
J9015	Aldesleukin/single use vial		K	0807		$755.78		$151.16
J9017	Arsenic trioxide		K	9012		$33.84		$6.77
J9020	Asparaginase injection		K	0814		$54.20		$10.84
J9025	Azacitidine injection		K	1709		$4.26		$0.85
J9027	Clofarabine injection	CH	K	1710		$115.64		$23.13
J9031	Bcg live intravesical vac		K	0809		$109.63		$21.93
J9035	Bevacizumab injection		K	9214		$56.98		$11.40
J9040	Bleomycin sulfate injection		K	0748		$35.52		$7.10
J9041	Bortezomib injection		K	9207		$32.37		$6.47
J9045	Carboplatin injection		K	0811		$8.38		$1.68
J9050	Carmus bischl nitro inj		K	0812		$138.52		$27.70
J9055	Cetuximab injection		K	9215		$49.34		$9.87
J9060	Cisplatin 10 MG injection		N					
J9062	Cisplatin 50 MG injection	CH	N					
J9065	Inj cladribine per 1 MG		K	0858		$35.78		$7.16
J9070	Cyclophosphamide 100 MG inj		N					
J9080	Cyclophosphamide 200 MG inj	CH	N					
J9090	Cyclophosphamide 500 MG inj	CH	N					
J9091	Cyclophosphamide 1.0 grm inj	CH	N					
J9092	Cyclophosphamide 2.0 grm inj	CH	N					
J9093	Cyclophosphamide lyophilized	CH	N					
J9094	Cyclophosphamide lyophilized	CH	N					
J9095	Cyclophosphamide lyophilized	CH	N					
J9096	Cyclophosphamide lyophilized	CH	N					
J9097	Cyclophosphamide lyophilized	CH	N					
J9098	Cytarabine liposome		K	1166		$391.31		$78.26
J9100	Cytarabine hcl 100 MG inj		N					
J9110	Cytarabine hcl 500 MG inj	CH	N					
J9120	Dactinomycin actinomycin d		K	0752		$488.78		$97.76
J9130	Dacarbazine 100 mg inj	CH	N					
J9140	Dacarbazine 200 MG inj	CH	N					
J9150	Daunorubicin		K	0820		$20.28		$4.06
J9151	Daunorubicin citrate liposom		K	0821		$55.40		$11.08
J9160	Denileukin diftitox, 300 mcg		K	1084		$1,393.32		$278.66
J9165	Diethylstilbestrol injection		N					
J9170	Docetaxel		K	0823		$303.92		$60.78
J9175	Elliotts b solution per ml		N					
J9178	Inj, epirubicin hcl, 2 mg		K	1167		$21.01		$4.20
J9181	Etoposide 10 MG inj		N					
J9182	Etoposide 100 MG inj	CH	N					
J9185	Fludarabine phosphate inj		K	0842		$234.21		$46.84
J9190	Fluorouracil injection		N					
J9200	Floxuridine injection		K	0827		$50.82		$10.16
J9201	Gemcitabine HCl		K	0828		$123.98		$24.80
J9202	Goserelin acetate implant		K	0810		$196.81		$39.36
J9206	Irinotecan injection		K	0830		$124.81		$24.96
J9208	Ifosfomide injection		K	0831		$46.15		$9.23
J9209	Mesna injection		K	0732		$8.89		$1.78
J9211	Idarubicin hcl injection		K	0832		$301.74		$60.35
J9212	Interferon alfacon-1		K	0912		$4.60		$0.92

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
J9213	Interferon alfa-2a inj		K	0834		$37.53		$7.51
J9214	Interferon alfa-2b inj		K	0836		$13.75		$2.75
J9215	Interferon alfa-n3 inj		K	0865		$9.03		$1.81
J9216	Interferon gamma 1-b inj		K	0838		$287.13		$57.43
J9217	Leuprolide acetate suspnsion		K	9217		$227.34		$45.47
J9218	Leuprolide acetate injeciton		K	0861		$8.79		$1.76
J9219	Leuprolide acetate implant		K	7051		$1,696.96		$339.39
J9225	Histrelin implant		K	1711		$1,446.98		$289.40
J9230	Mechlorethamine hcl inj		K	0751		$140.27		$28.05
J9245	Inj melphalan hydrochl 50 MG		K	0840		$1,272.00		$254.40
J9250	Methotrexate sodium inj		N					
J9260	Methotrexate sodium inj	CH	N					
J9261	Nelarabine injection		K	0825		$82.54		$16.51
J9263	Oxaliplatin		K	1738		$8.89		$1.78
J9264	Paclitaxel protein bound	CH	K	1712		$7.03		$1.41
J9265	Paclitaxel injection		K	0863		$12.47		$2.49
J9266	Pegaspargase/singl dose vial		K	0843		$1,667.61		$333.52
J9268	Pentostatin injection		K	0844		$1,916.66		$383.33
J9270	Plicamycin (mithramycin) inj	CH	N					
J9280	Mitomycin 5 MG inj		K	0862		$15.98		$3.20
J9290	Mitomycin 20 MG inj	CH	K	0941		$63.93		$12.79
J9291	Mitomycin 40 MG inj	CH	K	0942		$127.85		$25.57
J9293	Mitoxantrone hydrochl / 5 MG		K	0864		$166.64		$33.33
J9300	Gemtuzumab ozogamicin		K	9004		$2,334.75		$466.95
J9305	Pemetrexed injection		K	9213		$43.38		$8.68
J9310	Rituximab cancer treatment		K	0849		$491.54		$98.31
J9320	Streptozocin injection		K	0850		$152.28		$30.46
J9340	Thiotepa injection		K	0851		$40.32		$8.06
J9350	Topotecan		K	0852		$822.90		$164.58
J9355	Trastuzumab		K	1613		$57.33		$11.47
J9357	Valrubicin, 200 mg		K	9167	3.4445	$219.39		$43.88
J9360	Vinblastine sulfate inj		N					
J9370	Vincristine sulfate 1 MG inj		N					
J9375	Vincristine sulfate 2 MG inj	CH	N					
J9380	Vincristine sulfate 5 MG inj	CH	N					
J9390	Vinorelbine tartrate/10 mg		K	0855		$19.88		$3.98
J9395	Injection, Fulvestrant		K	9120		$79.80		$15.96
J9600	Porfimer sodium		K	0856		$2,539.13		$507.83
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					
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 ftrst/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					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
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 sadmerc ver		Y					
K0730	Ctrl dose inh drug deliv sys		Y					
K0733	12-24hr sealed lead acid		Y					
K0734	Adj skin pro w/c cus wd<22in		Y					
K0735	Adj skin pro wc cus wd≧22in		Y					
K0736	Adj skin pro/pos wc cus<22in		Y					
K0737	Adj skin pro/pos wc cus≧22≧		Y					
K0738	Portable gas oxygen system		Y					
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					
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					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
K0877	PWC gp4 std sing pow opt s/b		Y					
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 SADMERC		Y					
L0112	Cranial cervical orthosis		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					
L0210	Thoracic rib belt		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					
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					
L0960	Post surgical support pads		A					
L0970	Tlso corset front		A					
L0972	Lso corset front		A					
L0974	Tlso full corset		A					
L0976	Lso full corset		A					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
L0978	Axillary crutch extension		A					
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					
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					
L1800	Knee orthoses elas w stays		A					
L1810	Ko elastic with joints		A					
L1815	Elastic with condylar pads		A					
L1820	Ko elas w/ condyle pads & jo		A					
L1825	Ko elastic knee cap		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					
L1855	Ko plas doub upright jnt mol		A					
L1858	Ko polycentric pneumatic pad		A					
L1860	Ko supracondylar socket mold		A					
L1870	Ko doub upright lacers molde		A					
L1880	Ko doub upright cuffs/lacers		A					
L1900	Afo sprng wir drsflx calf bd		A					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
L1901	Prefab ankle orthosis		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					
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 multi-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					
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					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
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					
L2770	Low ext orthosis per bar/jnt		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					
L2860	Torsion mechanism knee/ankle		A					
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					
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		A					
L3216	Orthoped ladies shoes dpth i		A					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
L3217	Ladies shoes hightop depth i		A					
L3219	Orthopedic mens shoes oxford		A					
L3221	Orthopedic mens shoes dpth i		A					
L3222	Mens shoes hightop depth inl		A					
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					
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					
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					
L3651	Prefab shoulder orthosis		A					
L3652	Prefab dbl shoulder orthosis		A					
L3660	Abduct restrainer canvas&web		A					
L3670	Acromio/clavicular canvas&we		A					
L3671	SO cap design w/o jnts CF		A					
L3672	SO airplane w/o jnts CF		A					
L3673	SO airplane w/joint CF		A					
L3675	Canvas vest SO		A					
L3677	SO hard plastic stabilizer		E					
L3700	Elbow orthoses elas w stays		A					
L3701	Prefab elbow orthosis		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					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
L3765	EWHFO rigid w/o jnts CF		A					
L3766	EWHFO w/joint(s) CF		A					
L3800	Whfo short opponen no attach		A					
L3805	Whfo long opponens no attach		A					
L3806	WHFO w/joint(s) custom fab		A					
L3807	WHFO,no joint, prefabricated		A					
L3808	WHFO, rigid w/o joints		A					
L3810	Whfo thumb abduction bar		A					
L3815	Whfo second m.p. abduction a		A					
L3820	Whfo ip ext asst w/ mp ext s		A					
L3825	Whfo m.p. extension stop		A					
L3830	Whfo m.p. extension assist		A					
L3835	Whfo m.p. spring extension a		A					
L3840	Whfo spring swivel thumb		A					
L3845	Whfo thumb ip ext ass w/ mp		A					
L3850	Action wrist w/ dorsiflex as		A					
L3855	Whfo adj m.p. flexion contro		A					
L3860	Whfo adj m.p. flex ctrl & i.		A					
L3890	Torsion mechanism wrist/elbo		B					
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					
L3907	Whfo wrst gauntlt thmb spica		A					
L3908	Wrist cock-up non-molded		A					
L3909	Prefab wrist orthosis		A					
L3910	Whfo swanson design		A					
L3911	Prefab hand finger orthosis		A					
L3912	Flex glove w/elastic finger		A					
L3913	HFO w/o joints CF		A					
L3915	WHO w nontor jnt(s) prefab		A					
L3916	Whfo wrist extens w/ outrigg		A					
L3917	Prefab metacarpl fx orthosis		A					
L3918	HFO knuckle bender		A					
L3919	HO w/o joints CF		A					
L3920	Knuckle bender with outrigge		A					
L3921	HFO w/joint(s) CF		A					
L3922	Knuckle bend 2 seg to flex j		A					
L3923	HFO w/o joints PF		A					
L3924	Oppenheimer		A					
L3926	Thomas suspension		A					
L3928	Finger extension w/ clock sp		A					
L3930	Finger extension with wrist		A					
L3932	Safety pin spring wire		A					
L3933	FO w/o joints CF		A					
L3934	Safety pin modified		A					
L3935	FO nontorsion joint CF		A					
L3936	Palmer		A					
L3938	Dorsal wrist		A					
L3940	Dorsal wrist w/ outrigger at		A					
L3942	Reverse knuckle bender		A					
L3944	Reverse knuckle bend w/ outr		A					
L3946	HFO composite elastic		A					
L3948	Finger knuckle bender		A					
L3950	Oppenheimer w/ knuckle bend		A					
L3952	Oppenheimer w/ rev knuckle 2		A					
L3954	Spreading hand		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					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
L3982	Upper ext fx orthosis rad/ul		A					
L3984	Upper ext fx orthosis wrist		A					
L3985	Forearm hand fx orth w/ wr h		A					
L3986	Humeral rad/ulna wrist fx or		A					
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					
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					
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					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
L5616	Ak univ multiplex sys frict		A					
L5617	AK/BK self-aligning unit ea		A					
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					
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					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
L5726	Knee-shin ext jnts fld swg e		A					
L5728	Knee-shin fluid swg & stance		A					
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					
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					
L5970	Foot external keel sach foot		A					
L5971	SACH foot, replacement		A					
L5972	Flexible keel foot		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					
L5993	Heavy duty feature, foot		A					
L5994	Heavy duty feature, knee		A					
L5995	Lower ext pros heavyduty fea		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 splt 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					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
L6380	Postop dsg cast chg wrst/elb		A					
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					
L6639	Heavy duty elbow feature		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					
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					
L6805	Term dev modifier wrist unit		A					
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					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
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		A					
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 prosthesis silicone/e		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					
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					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
L8606	Synthetic implnt urinary 1ml		N					
L8609	Artificial cornea		N					
L8610	Ocular implant		N					
L8612	Aqueous shunt prosthesis		N					
L8613	Ossicular implant		N					
L8614	Cochlear device		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	Replace cochlear processor		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					
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		B					
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		B					
L8686	Implt nrostm pls gen sng non		B					
L8687	Implt nrostm pls gen dua rec		B					
L8688	Implt nrostm pls gen dua non		B					
L8689	External recharg sys intern		A					
L8690	Aud osseo dev, int/ext comp		H	1032				
L8691	Aud osseo dev ext snd proces		A					
L8695	External recharg sys extern		A					
L8699	Prosthetic implant NOS		N					
L9900	O&P supply/accessory/service		A					
M0064	Visit for drug monitoring	CH	Q	0605	1.0016	$63.79		$12.76
M0075	Cellular therapy		E					
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					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
P9010	Whole blood for transfusion		K	0950	4.4374	$282.63		$56.53
P9011	Blood split unit		K	0967	2.1237	$135.26		$27.05
P9012	Cryoprecipitate each unit		K	0952	0.6843	$43.59		$8.72
P9016	RBC leukocytes reduced		K	0954	2.959	$188.47		$37.69
P9017	Plasma 1 donor frz w/in 8 hr		K	9508	1.0902	$69.44		$13.89
P9019	Platelets, each unit		K	0957	1.0834	$69.00		$13.80
P9020	Plaelet rich plasma unit		K	0958	5.3744	$342.31		$68.46
P9021	Red blood cells unit		K	0959	2.0343	$129.57		$25.91
P9022	Washed red blood cells unit		K	0960	4.2092	$268.10		$53.62
P9023	Frozen plasma, pooled, sd		K	0949	1.1981	$76.31		$15.26
P9031	Platelets leukocytes reduced		K	1013	1.7207	$109.60		$21.92
P9032	Platelets, irradiated		K	9500	2.0742	$132.11		$26.42
P9033	Platelets leukoreduced irrad		K	0968	2.028	$129.17		$25.83
P9034	Platelets, pheresis		K	9507	7.0406	$448.44		$89.69
P9035	Platelet pheres leukoreduced		K	9501	7.9954	$509.25		$101.85
P9036	Platelet pheresis irradiated		K	9502	7.0075	$446.33		$89.27
P9037	Plate pheres leukoredu irrad		K	1019	10.0408	$639.53		$127.91
P9038	RBC irradiated		K	9505	3.3259	$211.84		$42.37
P9039	RBC deglycerolized		K	9504	5.7938	$369.02		$73.80
P9040	RBC leukoreduced irradiated		K	0969	3.8191	$243.25		$48.65
P9041	Albumin (human),5%, 50ml		K	0961	0.3757	$23.93		$4.79
P9043	Plasma protein fract,5%,50ml		K	0956	1.4392	$91.67		$18.33
P9044	Cryoprecipitatereducedplasma		K	1009	1.3131	$83.64		$16.73
P9045	Albumin (human), 5%, 250 ml		K	0963	1.1351	$72.30		$14.46
P9046	Albumin (human), 25%, 20 ml		K	0964	0.4448	$28.33		$5.67
P9047	Albumin (human), 25%, 50ml		K	0965	1.1679	$74.39		$14.88
P9048	Plasmaprotein fract,5%,250ml		K	0966	3.9009	$248.46		$49.69
P9050	Granulocytes, pheresis unit		K	9506	15.5519	$990.55		$198.11
P9051	Blood, l/r, cmv-neg		K	1010	2.3865	$152.00		$30.40
P9052	Platelets, hla-m, l/r, unit		K	1011	9.6766	$616.33		$123.27
P9053	Plt, pher, l/r cmv-neg, irr		K	1020	10.7802	$686.62		$137.32
P9054	Blood, l/r, froz/degly/wash		K	1016	3.352	$213.50		$42.70
P9055	Plt, aph/pher, l/r, cmv-neg		K	1017	7.7915	$496.26		$99.25
P9056	Blood, l/r, irradiated		K	1018	2.4372	$155.23		$31.05
P9057	RBC, frz/deg/wsh, l/r, irrad		K	1021	6.4694	$412.06		$82.41
P9058	RBC, l/r, cmv-neg, irrad		K	1022	4.6286	$294.81		$58.96
P9059	Plasma, frz between 8-24hour		K	0955	1.2456	$79.34		$15.87
P9060	Fr frz plasma donor retested		K	9503	1.1632	$74.09		$14.82
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	2.8631	$182.36	$41.40	$36.47
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	0.1414	$9.01	$2.50	$1.80
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					
Q0144	Azithromycin dihydrate, oral		E					
Q0163	Diphenhydramine HCl 50mg		N					
Q0164	Prochlorperazine maleate 5mg		N					
Q0165	Prochlorperazine maleate10mg		B					
Q0166	Granisetron HCl 1 mg oral		K	0765		$44.44		$8.89
Q0167	Dronabinol 2.5mg oral		N					
Q0168	Dronabinol 5mg oral		B					
Q0169	Promethazine HCl 12.5mg oral		N					
Q0170	Promethazine HCl 25 mg oral		B					
Q0171	Chlorpromazine HCl 10mg oral		N					
Q0172	Chlorpromazine HCl 25mg oral		B					
Q0173	Trimethobenzamide HCl 250mg		N					
Q0174	Thiethylperazine maleate10mg		N					
Q0175	Perphenazine 4mg oral		N					
Q0176	Perphenazine 8mg oral		B					
Q0177	Hydroxyzine pamoate 25mg		N					
Q0178	Hydroxyzine pamoate 50mg		B					
Q0179	Ondansetron HCl 8mg oral		K	0769		$36.21		$7.24
Q0180	Dolasetron mesylate oral		K	0763		$47.07		$9.41
Q0181	Unspecified oral anti-emetic		E					
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					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
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		$1.74		$0.35
Q1003	NTIOL category 3		N					
Q1004	Ntiol category 4		N					
Q1005	Ntiol category 5		N					
Q2004	Bladder calculi irrig sol		N					
Q2009	Fosphenytoin, 50 mg		K	7028		$5.50		$1.10
Q2017	Teniposide, 50 mg		K	7035		$261.93		$52.39
Q3001	Brachytherapy Radioelements		B					
Q3014	Telehealth facility fee		A					
Q3025	IM inj interferon beta 1-a		K	9022		$113.49		$22.70
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					
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					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
Q4079	Natalizumab injection	CH	K	9126		$7.45		$1.49
Q4080	Iloprost inhalation solution		Y					
Q4081	Epoetin alfa, 100 units ESRD		A					
Q4082	Drug/bio NOC part B drug CAP		B					
Q4083	Hyalgan/supartz inj per dose		K	0873		$103.86		$20.77
Q4084	Synvisc inj per dose		K	0874		$184.89		$36.98
Q4085	Euflexxa inj per dose		K	0875		$115.19		$23.04
Q4086	Orthovisc inj per dose		K	0877		$196.47		$39.29
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					
Q9945	LOCM ≦149 mg/ml iodine, 1ml	CH	N					
Q9946	LOCM 150-199mg/ml iodine,1ml	CH	N					
Q9947	LOCM 200-249mg/ml iodine,1ml	CH	N					
Q9948	LOCM 250-299mg/ml iodine,1ml	CH	N					
Q9949	LOCM 300-349mg/ml iodine,1ml	CH	N					
Q9950	LOCM 350-399mg/ml iodine,1ml	CH	N					
Q9951	LOCM ≧ 400 mg/ml iodine,1ml	CH	N					
Q9952	Inj Gad-base MR contrast,1ml	CH	N					
Q9953	Inj Fe-based MR contrast,1ml	CH	N					
Q9954	Oral MR contrast, 100 ml	CH	N					
Q9955	Inj perflexane lip micros,ml	CH	N					
Q9956	Inj octafluoropropane mic,ml	CH	N					
Q9957	Inj perflutren lip micros,ml	CH	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					
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					
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					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
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					
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					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
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					
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					
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					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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.—PROPOSED ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)

HCPCS code	Short descriptor	Comment indicator	Payment indicator	Proposed CY 2008 payment weight	Proposed CY 2008 payment
0028T	Dexa body composition study		N1		
0042T	Ct perfusion w/contrast, cbf		N1		
054T	Bone surgery using computer	CH	N1		
0055T	Bone surgery using computer	CH	N1		
0056T	Bone surgery using computer	CH	N1		
0067T	Ct colonography;dx		Z2	3.1487	$130.36
0071T	U/s leiomyomata ablate <200		Z2	61.5205	$2,546.95
0072T	U/s leiomyomata ablate >200		Z2	61.5205	$2,546.95
0073T	Delivery, comp imrt		Z2	5.7275	$237.12
0126T	Chd risk imt study		N1		
0144T	CT heart wo dye; qual calc		Z2	1.6768	$69.42
0145T	CT heart w/wo dye funct		Z2	4.9887	$206.53
0146T	CCTA w/wo dye		Z2	4.9887	$206.53
0147T	CCTA w/wo, quan calcium		Z2	4.9887	$206.53
0148T	CCTA w/wo, strxr		Z2	4.9887	$206.53
0149T	CCTA w/wo, strxr quan calc		Z2	4.9887	$206.53
0150T	CCTA w/wo, disease strxr		Z2	4.9887	$206.53
0151T	CT heart funct add-on		Z2	1.6768	$69.42
0159T	Cad breast mri		N1		
0174T	Cad cxr with interp		N1		
0175T	Cad cxr remote		N1		
70010	Contrast x-ray of brain	CH	N1		
70015	Contrast x-ray of brain	CH	N1		
70030	X-ray eye for foreign body		Z3	0.3957	$16.38
70100	X-ray exam of jaw		Z3	0.4534	$18.77
70110	X-ray exam of jaw		Z3	0.5442	$22.53
70120	X-ray exam of mastoids		Z3	0.5111	$21.16
70130	X-ray exam of mastoids		Z2	0.7259	$30.05
70134	X-ray exam of middle ear		Z3	0.6266	$25.94
70140	X-ray exam of facial bones		Z3	0.4534	$18.77
70150	X-ray exam of facial bones		Z3	0.6348	$26.28
70160	X-ray exam of nasal bones		Z3	0.4700	$19.46
70170	X-ray exam of tear duct	CH	N1		
70190	X-ray exam of eye sockets		Z3	0.5196	$21.51
70200	X-ray exam of eye sockets		Z3	0.6348	$26.28
70210	X-ray exam of sinuses		Z3	0.4700	$19.46
70220	X-ray exam of sinuses		Z3	0.5855	$24.24
70240	X-ray exam, pituitary saddle		Z3	0.3957	$16.38
70250	X-ray exam of skull		Z3	0.5111	$21.16
70260	X-ray exam of skull		Z3	0.6761	$27.99
70300	X-ray exam of teeth		Z3	0.1978	$8.19
70310	X-ray exam of teeth		Z3	0.4865	$20.14
70320	Full mouth x-ray of teeth		Z2	0.5739	$23.76
70328	X-ray exam of jaw joint		Z3	0.4287	$17.75
70330	X-ray exam of jaw joints		Z3	0.7174	$29.70
70332	X-ray exam of jaw joint	CH	N1		
70336	Magnetic image, jaw joint		Z2	5.0067	$207.28
70350	X-ray head for orthodontia		Z3	0.2638	$10.92
70355	Panoramic x-ray of jaws		Z3	0.3297	$13.65
70360	X-ray exam of neck		Z3	0.3792	$15.70
70370	Throat x-ray & fluoroscopy		Z3	1.1708	$48.47
70371	Speech evaluation, complex		Z2	1.3270	$54.94
70373	Contrast x-ray of larynx	CH	N1		
70380	X-ray exam of salivary gland		Z3	0.5855	$24.24
70390	X-ray exam of salivary duct	CH	N1		
70450	Ct head/brain w/o dye		Z2	3.1487	$130.36
70460	Ct head/brain w/dye		Z2	4.5485	$188.31
70470	Ct head/brain w/o & w/dye		Z2	5.3374	$220.97
70480	Ct orbit/ear/fossa w/o dye		Z2	3.1487	$130.36
70481	Ct orbit/ear/fossa w/dye		Z2	4.5485	$188.31
70482	Ct orbit/ear/fossa w/o&w/dye		Z2	5.3374	$220.97
70486	Ct maxillofacial w/o dye		Z2	3.1487	$130.36
70487	Ct maxillofacial w/dye		Z2	4.5485	$188.31
70488	Ct maxillofacial w/o & w/dye		Z2	5.3374	$220.97
70490	Ct soft tissue neck w/o dye		Z2	3.1487	$130.36
70491	Ct soft tissue neck w/dye		Z2	4.5485	$188.31
70492	Ct sft tsue nck w/o & w/dye		Z2	5.3374	$220.97
70496	Ct angiography, head		Z2	5.2818	$218.67

ADDENDUM BB.—PROPOSED ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS code	Short descriptor	Comment indicator	Payment indicator	Proposed CY 2008 payment weight	Proposed CY 2008 payment
70498	Ct angiography, neck		Z2	5.2818	$218.67
70540	Mri orbit/face/neck w/o dye		Z2	5.7101	$236.40
70542	Mri orbit/face/neck w/dye		Z2	6.7963	$281.37
70543	Mri orbt/fac/nck w/o & w/dye		Z2	8.6689	$358.89
70544	Mr angiography head w/o dye		Z2	5.7101	$236.40
70545	Mr angiography head w/dye		Z2	6.7963	$281.37
70546	Mr angiograph head w/o&w/dye		Z2	8.6689	$358.89
70547	Mr angiography neck w/o dye		Z2	5.7101	$236.40
70548	Mr angiography neck w/dye		Z2	6.7963	$281.37
70549	Mr angiograph neck w/o&w/dye		Z2	8.6689	$358.89
70551	Mri brain w/o dye		Z2	5.7101	$236.40
70552	Mri brain w/dye		Z2	6.7963	$281.37
70553	Mri brain w/o & w/dye		Z2	8.6689	$358.89
70554	Fmri brain by tech		Z2	5.7101	$236.40
70555	Fmri brain by phys/psych		Z2	5.7101	$236.40
70557	Mri brain w/o dye		Z2	5.7101	$236.40
70558	Mri brain w/dye		Z2	6.7963	$281.37
70559	Mri brain w/o & w/dye		Z2	8.6689	$358.89
71010	Chest x-ray		Z3	0.3464	$14.34
71015	Chest x-ray		Z3	0.4205	$17.41
71020	Chest x-ray		Z3	0.4618	$19.12
71021	Chest x-ray		Z3	0.5524	$22.87
71022	Chest x-ray		Z3	0.6266	$25.94
71023	Chest x-ray and fluoroscopy		Z3	0.8906	$36.87
71030	Chest x-ray		Z3	0.6514	$26.97
71034	Chest x-ray and fluoroscopy		Z2	1.3270	$54.94
71035	Chest x-ray		Z3	0.5029	$20.82
71040	Contrast x-ray of bronchi	CH	N1		
71060	Contrast x-ray of bronchi	CH	N1		
71090	X-ray & pacemaker insertion	CH	N1		
71100	X-ray exam of ribs		Z3	0.4534	$18.77
71101	X-ray exam of ribs/chest		Z3	0.5442	$22.53
71110	X-ray exam of ribs		Z3	0.6019	$24.92
71111	X-ray exam of ribs/chest		Z3	0.7585	$31.40
71120	X-ray exam of breastbone		Z3	0.4947	$20.48
71130	X-ray exam of breastbone		Z3	0.5688	$23.55
71250	Ct thorax w/o dye		Z2	3.1487	$130.36
71260	Ct thorax w/dye		Z2	4.5485	$188.31
71270	Ct thorax w/o & w/dye		Z2	5.3374	$220.97
71275	Ct angiography, chest		Z2	5.2818	$218.67
71550	Mri chest w/o dye		Z2	5.7101	$236.40
71551	Mri chest w/dye		Z2	6.7963	$281.37
71552	Mri chest w/o & w/dye		Z2	8.6689	$358.89
72010	X-ray exam of spine		Z2	0.7259	$30.05
72020	X-ray exam of spine		Z3	0.3382	$14.00
72040	X-ray exam of neck spine		Z3	0.5278	$21.85
72050	X-ray exam of neck spine		Z3	0.7585	$31.40
72052	X-ray exam of neck spine		Z3	0.9812	$40.62
72069	X-ray exam of trunk spine		Z3	0.4783	$19.80
72070	X-ray exam of thoracic spine		Z3	0.4947	$20.48
72072	X-ray exam of thoracic spine		Z3	0.5771	$23.89
72074	X-ray exam of thoracic spine		Z3	0.7256	$30.04
72080	X-ray exam of trunk spine		Z3	0.5278	$21.85
72090	X-ray exam of trunk spine		Z3	0.6432	$26.63
72100	X-ray exam of lower spine		Z3	0.5771	$23.89
72110	X-ray exam of lower spine		Z3	0.7915	$32.77
72114	X-ray exam of lower spine		Z3	1.0720	$44.38
72120	X-ray exam of lower spine		Z3	0.7751	$32.09
72125	Ct neck spine w/o dye		Z2	3.1487	$130.36
72126	Ct neck spine w/dye	CH	Z3	5.9614	$246.80
72127	Ct neck spine w/o & w/dye		Z2	5.3374	$220.97
72128	Ct chest spine w/o dye		Z2	3.1487	$130.36
72129	Ct chest spine w/dye		Z2	4.5485	$188.31
72130	Ct chest spine w/o & w/dye		Z2	5.3374	$220.97
72131	Ct lumbar spine w/o dye		Z2	3.1487	$130.36
72132	Ct lumbar spine w/dye	CH	Z3	5.9529	$246.45
72133	Ct lumbar spine w/o & w/dye		Z2	5.3374	$220.97
72141	Mri neck spine w/o dye		Z2	5.7101	$236.40

ADDENDUM BB.—PROPOSED ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS code	Short descriptor	Comment indicator	Payment indicator	Proposed CY 2008 payment weight	Proposed CY 2008 payment
72142	Mri neck spine w/dye		Z2	6.7963	$281.37
72146	Mri chest spine w/o dye		Z2	5.7101	$236.40
72147	Mri chest spine w/dye		Z2	6.7963	$281.37
72148	Mri lumbar spine w/o dye		Z2	5.7101	$236.40
72149	Mri lumbar spine w/dye		Z2	6.7963	$281.37
72156	Mri neck spine w/o & w/dye		Z2	8.6689	$358.89
72157	Mri chest spine w/o & w/dye		Z2	8.6689	$358.89
72158	Mri lumbar spine w/o & w/dye		Z2	8.6689	$358.89
72170	X-ray exam of pelvis		Z3	0.3957	$16.38
72190	X-ray exam of pelvis		Z3	0.5937	$24.58
72191	Ct angiograph pelv w/o&w/dye		Z2	5.2818	$218.67
72192	Ct pelvis w/o dye		Z2	3.1487	$130.36
72193	Ct pelvis w/dye		Z2	4.5485	$188.31
72194	Ct pelvis w/o & w/dye		Z2	5.3374	$220.97
72195	Mri pelvis w/o dye		Z2	5.7101	$236.40
72196	Mri pelvis w/dye		Z2	6.7963	$281.37
72197	Mri pelvis w/o & w/dye		Z2	8.6689	$358.89
72200	X-ray exam sacroiliac joints		Z3	0.4370	$18.09
72202	X-ray exam sacroiliac joints		Z3	0.5278	$21.85
72220	X-ray exam of tailbone		Z3	0.4452	$18.43
72240	Contrast x-ray of neck spine	CH	N1		
72255	Contrast x-ray, thorax spine	CH	N1		
72265	Contrast x-ray, lower spine	CH	N1		
72270	Contrast x-ray, spine	CH	N1		
72275	Epidurography	CH	N1		
72285	X-ray c/t spine disk	CH	N1		
72291	Perq vertebroplasty, fluor	CH	N1		
72292	Perq vertebroplasty, ct	CH	N1		
72295	X-ray of lower spine disk	CH	N1		
73000	X-ray exam of collar bone		Z3	0.4205	$17.41
73010	X-ray exam of shoulder blade		Z3	0.4287	$17.75
73020	X-ray exam of shoulder		Z3	0.3546	$14.68
73030	X-ray exam of shoulder		Z3	0.4370	$18.09
73040	Contrast x-ray of shoulder	CH	N1		
73050	X-ray exam of shoulders		Z3	0.5442	$22.53
73060	X-ray exam of humerus		Z3	0.4452	$18.43
73070	X-ray exam of elbow		Z3	0.4205	$17.41
73080	X-ray exam of elbow		Z3	0.5196	$21.51
73085	Contrast x-ray of elbow	CH	N1		
73090	X-ray exam of forearm		Z3	0.4205	$17.41
73092	X-ray exam of arm, infant		Z3	0.4205	$17.41
73100	X-ray exam of wrist		Z3	0.4205	$17.41
73110	X-ray exam of wrist		Z3	0.5111	$21.16
73115	Contrast x-ray of wrist	CH	N1		
73120	X-ray exam of hand		Z3	0.4041	$16.73
73130	X-ray exam of hand		Z3	0.4618	$19.12
73140	X-ray exam of finger(s)		Z3	0.4287	$17.75
73200	Ct upper extremity w/o dye		Z2	3.1487	$130.36
73201	Ct upper extremity w/dye		Z2	4.5485	$188.31
73202	Ct uppr extremity w/o&w/dye		Z2	5.3374	$220.97
73206	Ct angio upr extrm w/o&w/dye		Z2	5.2818	$218.67
73218	Mri upper extremity w/o dye		Z2	5.7101	$236.40
73219	Mri upper extremity w/dye		Z2	6.7963	$281.37
73220	Mri uppr extremity w/o&w/dye		Z2	8.6689	$358.89
73221	Mri joint upr extrem w/o dye		Z2	5.7101	$236.40
73222	Mri joint upr extrem w/dye		Z2	6.7963	$281.37
73223	Mri joint upr extr w/o&w/dye		Z2	8.6689	$358.89
73500	X-ray exam of hip		Z3	0.3710	$15.36
73510	X-ray exam of hip		Z3	0.5196	$21.51
73520	X-ray exam of hips		Z3	0.5606	$23.21
73525	Contrast x-ray of hip	CH	N1		
73530	X-ray exam of hip	CH	N1		
73540	X-ray exam of pelvis & hips		Z3	0.5360	$22.19
73542	X-ray exam, sacroiliac joint	CH	N1		
73550	X-ray exam of thigh		Z3	0.4370	$18.09
73560	X-ray exam of knee, 1 or 2		Z3	0.4287	$17.75
73562	X-ray exam of knee, 3		Z3	0.5029	$20.82
73564	X-ray exam, knee, 4 or more		Z3	0.5771	$23.89

ADDENDUM BB.—PROPOSED ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS code	Short descriptor	Comment indicator	Payment indicator	Proposed CY 2008 payment weight	Proposed CY 2008 payment
73565	X-ray exam of knees		Z3	0.4370	$18.09
73580	Contrast x-ray of knee joint	CH	N1		
73590	X-ray exam of lower leg		Z3	0.4123	$17.07
73592	X-ray exam of leg, infant		Z3	0.4205	$17.41
73600	X-ray exam of ankle		Z3	0.4041	$16.73
73610	X-ray exam of ankle		Z3	0.4700	$19.46
73615	Contrast x-ray of ankle	CH	N1		
73620	X-ray exam of foot		Z3	0.3957	$16.38
73630	X-ray exam of foot		Z3	0.4618	$19.12
73650	X-ray exam of heel		Z3	0.3957	$16.38
73660	X-ray exam of toe(s)		Z3	0.4123	$17.07
73700	Ct lower extremity w/o dye		Z2	3.1487	$130.36
73701	Ct lower extremity w/dye		Z2	4.5485	$188.31
73702	Ct lwr extremity w/o&w/dye		Z2	5.3374	$220.97
73706	Ct angio lwr extr w/o&w/dye		Z2	5.2818	$218.67
73718	Mri lower extremity w/o dye		Z2	5.7101	$236.40
73719	Mri lower extremity w/dye		Z2	6.7963	$281.37
73720	Mri lwr extremity w/o&w/dye		Z2	8.6689	$358.89
73721	Mri jnt of lwr extre w/o dye		Z2	5.7101	$236.40
73722	Mri joint of lwr extr w/dye		Z2	6.7963	$281.37
73723	Mri joint lwr extr w/o&w/dye		Z2	8.6689	$358.89
74000	X-ray exam of abdomen		Z3	0.3792	$15.70
74010	X-ray exam of abdomen		Z3	0.5278	$21.85
74020	X-ray exam of abdomen		Z3	0.5442	$22.53
74022	X-ray exam series, abdomen		Z3	0.6514	$26.97
74150	Ct abdomen w/o dye		Z2	3.1487	$130.36
74160	Ct abdomen w/dye		Z2	4.5485	$188.31
74170	Ct abdomen w/o & w/dye		Z2	5.3374	$220.97
74175	Ct angio abdom w/o & w/dye		Z2	5.2818	$218.67
74181	Mri abdomen w/o dye		Z2	5.7101	$236.40
74182	Mri abdomen w/dye		Z2	6.7963	$281.37
74183	Mri abdomen w/o & w/dye		Z2	8.6689	$358.89
74190	X-ray exam of peritoneum	CH	N1		
74210	Contrst x-ray exam of throat		Z3	1.1543	$47.79
74220	Contrast x-ray, esophagus		Z3	1.2367	$51.20
74230	Cine/vid x-ray, throat/esoph		Z3	1.2534	$51.89
74235	Remove esophagus obstruction	CH	N1		
74240	X-ray exam, upper gi tract		Z3	1.4263	$59.05
74241	X-ray exam, upper gi tract		Z2	1.4387	$59.56
74245	X-ray exam, upper gi tract		Z2	2.2875	$94.70
74246	Contrst x-ray uppr gi tract		Z2	1.4387	$59.56
74247	Contrst x-ray uppr gi tract		Z2	1.4387	$59.56
74249	Contrst x-ray uppr gi tract		Z2	2.2875	$94.70
74250	X-ray exam of small bowel	CH	Z2	1.4387	$59.56
74251	X-ray exam of small bowel		Z2	2.2875	$94.70
74260	X-ray exam of small bowel		Z2	1.4387	$59.56
74270	Contrast x-ray exam of colon		Z2	1.4387	$59.56
74280	Contrast x-ray exam of colon		Z2	2.2875	$94.70
74283	Contrast x-ray exam of colon		Z2	1.4387	$59.56
74290	Contrast x-ray, gallbladder		Z3	0.8906	$36.87
74291	Contrast x-rays, gallbladder		Z3	0.7833	$32.43
74300	X-ray bile ducts/pancreas	CH	N1		
74301	X-rays at surgery add-on	CH	N1		
74305	X-ray bile ducts/pancreas	CH	N1		
74320	Contrast x-ray of bile ducts	CH	N1		
74327	X-ray bile stone removal	CH	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	CH	N1		
74350	X-ray guide, stomach tube	CH	N1		
74355	X-ray guide, intestinal tube	CH	N1		
74360	X-ray guide, GI dilation	CH	N1		
74363	X-ray, bile duct dilation	CH	N1		
74400	Contrst x-ray, urinary tract		Z3	1.6737	$69.29
74410	Contrst x-ray, urinary tract		Z3	1.8222	$75.44
74415	Contrst x-ray, urinary tract		Z3	2.1273	$88.07
74420	Contrst x-ray, urinary tract		Z2	2.6114	$108.11

ADDENDUM BB.—PROPOSED ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS code	Short descriptor	Comment indicator	Payment indicator	Proposed CY 2008 payment weight	Proposed CY 2008 payment
74425	Contrst x-ray, urinary tract	CH	N1		
74430	Contrast x-ray, bladder	CH	N1		
74440	X-ray, male genital tract	CH	N1		
74445	X-ray exam of penis	CH	N1		
74450	X-ray, urethra/bladder	CH	N1		
74455	X-ray, urethra/bladder	CH	N1		
74470	X-ray exam of kidney lesion	CH	N1		
74475	X-ray control, cath insert	CH	N1		
74480	X-ray control, cath insert	CH	N1		
74485	X-ray guide, GU dilation	CH	N1		
74710	X-ray measurement of pelvis		Z3	0.6514	$26.97
74740	X-ray, female genital tract	CH	N1		
74742	X-ray, fallopian tube	CH	N1		
74775	X-ray exam of perineum	CH	Z3	0.7998	$33.11
75552	Heart mri for morph w/o dye		Z2	5.7101	$236.40
75553	Heart mri for morph w/dye		Z2	6.7963	$281.37
75554	Cardiac MRI/function		Z2	5.7101	$236.40
75555	Cardiac MRI/limited study		Z2	5.7101	$236.40
75600	Contrast x-ray exam of aorta	CH	N1		
75605	Contrast x-ray exam of aorta	CH	N1		
75625	Contrast x-ray exam of aorta	CH	N1		
75630	X-ray aorta, leg arteries	CH	N1		
75635	Ct angio abdominal arteries	CH	N1		
75650	Artery x-rays, head & neck	CH	N1		
75658	Artery x-rays, arm	CH	N1		
75660	Artery x-rays, head & neck	CH	N1		
75662	Artery x-rays, head & neck	CH	N1		
75665	Artery x-rays, head & neck	CH	N1		
75671	Artery x-rays, head & neck	CH	N1		
75676	Artery x-rays, neck	CH	N1		
75680	Artery x-rays, neck	CH	N1		
75685	Artery x-rays, spine	CH	N1		
75705	Artery x-rays, spine	CH	N1		
75710	Artery x-rays, arm/leg	CH	N1		
75716	Artery x-rays, arms/legs	CH	N1		
75722	Artery x-rays, kidney	CH	N1		
75724	Artery x-rays, kidneys	CH	N1		
75726	Artery x-rays, abdomen	CH	N1		
75731	Artery x-rays, adrenal gland	CH	N1		
75733	Artery x-rays, adrenals	CH	N1		
75736	Artery x-rays, pelvis	CH	N1		
75741	Artery x-rays, lung	CH	N1		
75743	Artery x-rays, lungs	CH	N1		
75746	Artery x-rays, lung	CH	N1		
75756	Artery x-rays, chest	CH	N1		
75774	Artery x-ray, each vessel	CH	N1		
75790	Visualize A-V shunt	CH	N1		
75801	Lymph vessel x-ray, arm/leg	CH	N1		
75803	Lymph vessel x-ray,arms/legs	CH	N1		
75805	Lymph vessel x-ray, trunk	CH	N1		
75807	Lymph vessel x-ray, trunk	CH	N1		
75809	Nonvascular shunt, x-ray	CH	N1		
75810	Vein x-ray, spleen/liver	CH	N1		
75820	Vein x-ray, arm/leg	CH	N1		
75822	Vein x-ray, arms/legs	CH	N1		
75825	Vein x-ray, trunk	CH	N1		
75827	Vein x-ray, chest	CH	N1		
75831	Vein x-ray, kidney	CH	N1		
75833	Vein x-ray, kidneys	CH	N1		
75840	Vein x-ray, adrenal gland	CH	N1		
75842	Vein x-ray, adrenal glands	CH	N1		
75860	Vein x-ray, neck	CH	N1		
75870	Vein x-ray, skull	CH	N1		
75872	Vein x-ray, skull	CH	N1		
75880	Vein x-ray, eye socket	CH	N1		
75885	Vein x-ray, liver	CH	N1		
75887	Vein x-ray, liver	CH	N1		
75889	Vein x-ray, liver	CH	N1		

ADDENDUM BB.—PROPOSED ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS code	Short descriptor	Comment indicator	Payment indicator	Proposed CY 2008 payment weight	Proposed CY 2008 payment
75891	Vein x-ray, liver	CH	N1		
75893	Venous sampling by catheter		N1		
75894	X-rays, transcath therapy	CH	N1		
75896	X-rays, transcath therapy	CH	N1		
75898	Follow-up angiography	CH	N1		
75901	Remove cva device obstruct	CH	N1		
75902	Remove cva lumen obstruct	CH	N1		
75940	X-ray placement, vein filter	CH	N1		
75945	Intravascular us	CH	N1		
75946	Intravascular us add-on	CH	N1		
75960	Transcath iv stent rs&i	CH	N1		
75961	Retrieval, broken catheter	CH	N1		
75962	Repair arterial blockage	CH	N1		
75964	Repair artery blockage, each	CH	N1		
75966	Repair arterial blockage	CH	N1		
75968	Repair artery blockage, each	CH	N1		
75970	Vascular biopsy	CH	N1		
75978	Repair venous blockage	CH	N1		
75980	Contrast xray exam bile duct	CH	N1		
75982	Contrast xray exam bile duct	CH	N1		
75984	Xray control catheter change	CH	N1		
75989	Abscess drainage under x-ray		N1		
75992	Atherectomy, x-ray exam	CH	N1		
75993	Atherectomy, x-ray exam	CH	N1		
75994	Atherectomy, x-ray exam	CH	N1		
75995	Atherectomy, x-ray exam	CH	N1		
75996	Atherectomy, x-ray exam	CH	N1		
76000	Fluoroscope examination	CH	N1		
76001	Fluoroscope exam, extensive		N1		
76010	X-ray, nose to rectum		Z3	0.4123	$17.07
76080	X-ray exam of fistula	CH	N1		
76098	X-ray exam, breast specimen		Z3	0.2804	$11.61
76100	X-ray exam of body section		Z2	1.2024	$49.78
76101	Complex body section x-ray		Z2	1.4802	$61.28
76102	Complex body section x-rays		Z2	1.4802	$61.28
76120	Cine/video x-rays		Z3	1.1379	$47.11
76125	Cine/video x-rays add-on	CH	N1		
76150	X-ray exam, dry process		Z3	0.4452	$18.43
76350	Special x-ray contrast study		N1		
76376	3d render w/o postprocess	CH	N1		
76377	3d rendering w/postprocess	CH	N1		
76380	CAT scan follow-up study		Z2	1.6768	$69.42
76496	Fluoroscopic procedure		Z2	1.3270	$54.94
76497	Ct procedure		Z2	1.6768	$69.42
76498	Mri procedure		Z2	5.0067	$207.28
76499	Radiographic procedure		Z2	0.7259	$30.05
76506	Echo exam of head		Z2	0.9925	$41.09
76510	Ophth us, b & quant a	CH	Z3	1.5995	$66.22
76511	Ophth us, quant a only		Z3	1.2534	$51.89
76512	Ophth us, b w/non-quant a		Z3	1.0884	$45.06
76513	Echo exam of eye, water bath		Z3	1.1626	$48.13
76514	Echo exam of eye, thickness		Z3	0.0659	$2.73
76516	Echo exam of eye		Z3	0.9070	$37.55
76519	Echo exam of eye		Z3	0.9894	$40.96
76529	Echo exam of eye		Z3	0.8575	$35.50
76536	Us exam of head and neck	CH	Z2	1.5657	$64.82
76604	Us exam, chest		Z2	0.9925	$41.09
76645	Us exam, breast(s)		Z2	0.9925	$41.09
76700	Us exam, abdom, complete		Z2	1.5657	$64.82
76705	Echo exam of abdomen		Z3	1.4512	$60.08
76770	Us exam abdo back wall, comp		Z2	1.5657	$64.82
76775	Us exam abdo back wall, lim		Z3	1.4676	$60.76
76776	Us exam k transpl w/doppler		Z2	1.5657	$64.82
76800	Us exam, spinal canal		Z3	1.4099	$58.37
76801	Ob us < 14 wks, single fetus		Z2	1.5657	$64.82
76802	Ob us < 14 wks, add l fetus		Z3	0.7174	$29.70
76805	Ob us >/= 14 wks, sngl fetus		Z2	1.5657	$64.82
76810	Ob us >/= 14 wks, addl fetus		Z3	0.9812	$40.62

ADDENDUM BB.—PROPOSED ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS code	Short descriptor	Comment indicator	Payment indicator	Proposed CY 2008 payment weight	Proposed CY 2008 payment
76811	Ob us, detailed, sngl fetus		Z3	2.4737	$102.41
76812	Ob us, detailed, addl fetus		Z2	0.9925	$41.09
76813	Ob us nuchal meas, 1 gest		Z3	1.4430	$59.74
76814	Ob us nuchal meas, add-on		Z3	0.6925	$28.67
76815	Ob us, limited, fetus(s)		Z2	0.9925	$41.09
76816	Ob us, follow-up, per fetus		Z2	0.9925	$41.09
76817	Transvaginal us, obstetric		Z2	0.9925	$41.09
76818	Fetal biophys profile w/nst		Z3	1.4430	$59.74
76819	Fetal biophys profil w/o nst		Z3	1.2367	$51.20
76820	Umbilical artery echo		Z3	0.8329	$34.48
76821	Middle cerebral artery echo		Z3	1.3440	$55.64
76825	Echo exam of fetal heart		Z2	1.5657	$64.82
76826	Echo exam of fetal heart	CH	Z2	0.9925	$41.09
76827	Echo exam of fetal heart	CH	Z2	0.9925	$41.09
76828	Echo exam of fetal heart		Z3	0.6514	$26.97
76830	Transvaginal us, non-ob		Z2	1.5657	$64.82
76831	Echo exam, uterus		Z3	1.6572	$68.61
76856	Us exam, pelvic, complete		Z2	1.5657	$64.82
76857	Us exam, pelvic, limited		Z2	0.9925	$41.09
76870	Us exam, scrotum		Z2	1.5657	$64.82
76872	Us, transrectal		Z2	1.5657	$64.82
76873	Echograp trans r, pros study		Z2	1.5657	$64.82
76880	Us exam, extremity		Z2	1.5657	$64.82
76885	Us exam infant hips, dynamic		Z2	0.9925	$41.09
76886	Us exam infant hips, static		Z2	0.9925	$41.09
76930	Echo guide, cardiocentesis	CH	N1		
76932	Echo guide for heart biopsy	CH	N1		
76936	Echo guide for artery repair	CH	N1		
76937	Us guide, vascular access		N1		
76940	Us guide, tissue ablation	CH	N1		
76941	Echo guide for transfusion	CH	N1		
76942	Echo guide for biopsy	CH	N1		
76945	Echo guide, villus sampling	CH	N1		
76946	Echo guide for amniocentesis	CH	N1		
76948	Echo guide, ova aspiration	CH	N1		
76950	Echo guidance radiotherapy	CH	N1		
76965	Echo guidance radiotherapy	CH	N1		
76970	Ultrasound exam follow-up		Z2	0.9925	$41.09
76975	GI endoscopic ultrasound	CH	N1		
76977	Us bone density measure		Z3	0.3792	$15.70
76998	Us guide, intraop	CH	N1		
76999	Echo examination procedure		Z2	0.9925	$41.09
77001	Fluoroguide for vein device		N1		
77002	Needle localization by xray		N1		
77003	Fluoroguide for spine inject		N1		
77011	Ct scan for localization	CH	N1		
77012	Ct scan for needle biopsy	CH	N1		
77013	Ct guide for tissue ablation	CH	N1		
77014	Ct scan for therapy guide	CH	N1		
77021	Mr guidance for needle place	CH	N1		
77022	Mri for tissue ablation	CH	N1		
77031	Stereotact guide for brst bx	CH	N1		
77032	Guidance for needle, breast	CH	N1		
77053	X-ray of mammary duct	CH	N1		
77054	X-ray of mammary ducts	CH	N1		
77071	X-ray stress view		Z3	0.3051	$12.63
77072	X-rays for bone age		Z3	0.2886	$11.95
77073	X-rays, bone length studies		Z3	0.5855	$24.24
77074	X-rays, bone survey, limited		Z3	0.8988	$37.21
77075	X-rays, bone survey complete		Z2	1.2024	$49.78
77076	X-rays, bone survey, infant		Z2	0.7259	$30.05
77077	Joint survey, single view	CH	Z2	0.7259	$30.05
77078	Ct bone density, axial		Z2	1.1920	$49.35
77079	Ct bone density, peripheral	CH	Z2	1.6768	$69.42
77080	Dxa bone density, axial		Z2	1.1920	$49.35
77081	Dxa bone density/peripheral	CH	Z3	0.5196	$21.51
77082	Dxa bone density, vert fx		Z3	0.5442	$22.53
77083	Radiographic absorptiometry		Z3	0.4947	$20.48

ADDENDUM BB.—PROPOSED ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS code	Short descriptor	Comment indicator	Payment indicator	Proposed CY 2008 payment weight	Proposed CY 2008 payment
77084	Magnetic image, bone marrow		Z2	5.0067	$207.28
77280	Sbrt management		Z2	1.6409	$67.93
77285	Set radiation therapy field		Z2	4.1775	$172.95
77290	Set radiation therapy field		Z2	4.1775	$172.95
77295	Set radiation therapy field		Z3	13.9592	$577.91
77299	Radiation therapy planning		Z2	1.6409	$67.93
77300	Radiation therapy dose plan		Z3	0.9565	$39.60
77301	Radiotherapy dose plan, imrt		Z2	14.0797	$582.90
77305	Teletx isodose plan simple		Z3	1.0389	$43.01
77310	Teletx isodose plan intermed		Z3	1.3357	$55.30
77315	Teletx isodose plan complex		Z3	1.7396	$72.02
77321	Special teletx port plan		Z3	2.1601	$89.43
77326	Brachytx isodose calc simp		Z2	1.6409	$67.93
77327	Brachytx isodose calc interm		Z3	2.9271	$121.18
77328	Brachytx isodose plan compl		Z3	3.9164	$162.14
77331	Special radiation dosimetry		Z3	0.4205	$17.41
77332	Radiation treatment aid(s)		Z3	1.1130	$46.08
77333	Radiation treatment aid(s)		Z3	0.8821	$36.52
77334	Radiation treatment aid(s)		Z3	2.2923	$94.90
77336	Radiation physics consult		Z2	1.6409	$67.93
77370	Radiation physics consult		Z2	1.6409	$67.93
77371	Srs, multisource		Z3	24.8261	$1,027.80
77399	External radiation dosimetry		Z2	1.6409	$67.93
77401	Radiation treatment delivery		Z3	0.9234	$38.23
77402	Radiation treatment delivery		Z2	1.5000	$62.10
77403	Radiation treatment delivery		Z2	1.5000	$62.10
77404	Radiation treatment delivery		Z2	1.5000	$62.10
77406	Radiation treatment delivery		Z2	1.5000	$62.10
77407	Radiation treatment delivery		Z2	1.5000	$62.10
77408	Radiation treatment delivery		Z2	1.5000	$62.10
77409	Radiation treatment delivery		Z2	1.5000	$62.10
77411	Radiation treatment delivery		Z2	2.2933	$94.94
77412	Radiation treatment delivery		Z2	2.2933	$94.94
77413	Radiation treatment delivery		Z2	2.2933	$94.94
77414	Radiation treatment delivery		Z2	2.2933	$94.94
77416	Radiation treatment delivery		Z2	2.2933	$94.94
77417	Radiology port film(s)	CH	N1		
77418	Radiation tx delivery, imrt		Z2	5.7275	$237.12
77421	Stereoscopic x-ray guidance	CH	N1		
77422	Neutron beam tx, simple		Z2	2.2933	$94.94
77423	Neutron beam tx, complex		Z2	2.2933	$94.94
77435	Sbrt management		N1		
77470	Special radiation treatment		Z3	5.1039	$211.30
77520	Proton trmt, simple w/o comp		Z2	13.2746	$549.57
77522	Proton trmt, simple w/comp		Z2	13.2746	$549.57
77523	Proton trmt, intermediate		Z2	15.8841	$657.60
77525	Proton treatment, complex		Z2	15.8841	$657.60
77600	Hyperthermia treatment	CH	Z3	5.1862	$214.71
77605	Hyperthermia treatment		Z2	6.0275	$249.54
77610	Hyperthermia treatment		Z2	6.0275	$249.54
77615	Hyperthermia treatment		Z2	6.0275	$249.54
77620	Hyperthermia treatment	CH	Z3	5.2440	$217.10
77750	Infuse radioactive materials		Z3	1.7481	$72.37
77761	Apply intrcav radiat simple		Z3	3.1167	$129.03
77762	Apply intrcav radiat interm		Z3	3.8505	$159.41
77763	Apply intrcav radiat compl		Z3	4.9389	$204.47
77776	Apply interstit radiat simpl		Z3	3.2816	$135.86
77777	Apply interstit radiat inter		Z3	3.9742	$164.53
77778	Apply interstit radiat compl		Z3	5.2440	$217.10
77781	High intensity brachytherapy		Z3	10.0097	$414.40
77782	High intensity brachytherapy		Z2	11.6098	$480.65
77783	High intensity brachytherapy		Z2	11.6098	$480.65
77784	High intensity brachytherapy		Z2	11.6098	$480.65
77789	Apply surface radiation		Z3	0.8657	$35.84
77790	Radiation handling		N1		
77799	Radium/radioisotope therapy		Z2	8.3915	$347.41
78000	Thyroid, single uptake		Z3	1.1213	$46.42
78001	Thyroid, multiple uptakes		Z3	1.4263	$59.05

ADDENDUM BB.—PROPOSED ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS code	Short descriptor	Comment indicator	Payment indicator	Proposed CY 2008 payment weight	Proposed CY 2008 payment
78003	Thyroid suppress/stimul		Z3	1.1295	$46.76
78006	Thyroid imaging with uptake		Z2	2.8272	$117.05
78007	Thyroid image, mult uptakes		Z3	2.2179	$91.82
78010	Thyroid imaging		Z3	2.3746	$98.31
78011	Thyroid imaging with flow	CH	Z3	2.7457	$113.67
78015	Thyroid met imaging		Z3	3.1249	$129.37
78016	Thyroid met imaging/studies		Z2	4.4988	$186.25
78018	Thyroid met imaging, body		Z2	4.4988	$186.25
78020	Thyroid met uptake	CH	N1		
78070	Parathyroid nuclear imaging	CH	Z3	3.0343	$125.62
78075	Adrenal nuclear imaging		Z2	3.6540	$151.28
78099	Endocrine nuclear procedure		Z2	2.8272	$117.05
78102	Bone marrow imaging, ltd		Z3	2.4406	$101.04
78103	Bone marrow imaging, mult		Z3	3.3804	$139.95
78104	Bone marrow imaging, body	CH	Z3	4.0732	$168.63
78110	Plasma volume, single		Z3	1.2285	$50.86
78111	Plasma volume, multiple		Z3	1.8882	$78.17
78120	Red cell mass, single		Z3	1.5171	$62.81
78121	Red cell mass, multiple		Z3	2.0447	$84.65
78122	Blood volume		Z3	2.7374	$113.33
78130	Red cell survival study		Z3	2.4983	$103.43
78135	Red cell survival kinetics	CH	Z3	5.3923	$223.24
78140	Red cell sequestration		Z3	2.7126	$112.30
78185	Spleen imaging		Z3	3.0012	$124.25
78190	Platelet survival, kinetics		Z2	3.2810	$135.83
78191	Platelet survival		Z2	3.2810	$135.83
78195	Lymph system imaging		Z2	4.1916	$173.53
78199	Blood/lymph nuclear exam		Z2	4.1916	$173.53
78201	Liver imaging		Z3	2.7870	$115.38
78202	Liver imaging with flow		Z3	3.2650	$135.17
78205	Liver imaging (3D)		Z3	4.4524	$184.33
78206	Liver image (3d) with flow		Z2	4.5297	$187.53
78215	Liver and spleen imaging		Z3	3.0754	$127.32
78216	Liver & spleen image/flow		Z3	2.4983	$103.43
78220	Liver function study		Z3	2.6961	$111.62
78223	Hepatobiliary imaging		Z2	4.5297	$187.53
78230	Salivary gland imaging		Z3	2.5065	$103.77
78231	Serial salivary imaging		Z3	2.3582	$97.63
78232	Salivary gland function exam		Z3	2.5065	$103.77
78258	Esophageal motility study		Z3	3.3476	$138.59
78261	Gastric mucosa imaging		Z2	3.8546	$159.58
78262	Gastroesophageal reflux exam		Z2	3.8546	$159.58
78264	Gastric emptying study		Z2	3.8546	$159.58
78270	Vit B-12 absorption exam		Z3	1.3853	$57.35
78271	Vit b-12 absrp exam, int fac		Z3	1.4181	$58.71
78272	Vit B-12 absorp, combined		Z3	1.7563	$72.71
78278	Acute GI blood loss imaging		Z2	3.8546	$159.58
78282	GI protein loss exam		Z2	3.8546	$159.58
78290	Meckel's divert exam		Z2	3.8546	$159.58
78291	Leveen/shunt patency exam		Z3	3.6196	$149.85
78299	GI nuclear procedure		Z2	3.8546	$159.58
78300	Bone imaging, limited area		Z3	2.6302	$108.89
78305	Bone imaging, multiple areas		Z3	3.5949	$148.83
78306	Bone imaging, whole body	CH	Z2	3.9566	$163.80
78315	Bone imaging, 3 phase		Z2	3.9566	$163.80
78320	Bone imaging (3D)		Z2	3.9566	$163.80
78399	Musculoskeletal nuclear exam		Z2	3.9566	$163.80
78414	Non-imaging heart function		Z2	5.4404	$225.23
78428	Cardiac shunt imaging		Z3	2.9106	$120.50
78445	Vascular flow imaging	CH	Z3	2.5065	$103.77
78456	Acute venous thrombus image		Z2	3.0424	$125.96
78457	Venous thrombosis imaging	CH	Z3	2.8857	$119.47
78458	Ven thrombosis images, bilat		Z2	3.0424	$125.96
78459	Heart muscle imaging (PET)		Z2	42.5674	$1,762.29
78460	Heart muscle blood, single		Z3	2.7210	$112.65
78461	Heart muscle blood, multiple		Z3	3.3886	$140.29
78464	Heart image (3d), single	CH	Z3	5.0708	$209.93
78465	Heart image (3d), multiple	CH	Z3	9.1935	$380.61

ADDENDUM BB.—PROPOSED ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS code	Short descriptor	Comment indicator	Payment indicator	Proposed CY 2008 payment weight	Proposed CY 2008 payment
78466	Heart infarct image		Z3	2.7952	$115.72
78468	Heart infarct image (ef)		Z3	3.7350	$154.63
78469	Heart infarct image (3D)	CH	Z3	4.5019	$186.38
78472	Gated heart, planar, single	CH	Z3	4.5430	$188.08
78473	Gated heart, multiple		Z2	5.4404	$225.23
78478	Heart wall motion add-on	CH	N1		
78480	Heart function add-on	CH	N1		
78481	Heart first pass, single		Z3	3.9988	$165.55
78483	Heart first pass, multiple		Z2	5.4404	$225.23
78491	Heart image (pet), single		Z2	42.5674	$1,762.29
78492	Heart image (pet), multiple		Z2	42.5674	$1,762.29
78494	Heart image, spect	CH	Z3	5.2109	$215.73
78496	Heart first pass add-on	CH	N1		
78499	Cardiovascular nuclear exam		Z2	5.4404	$225.23
78580	Lung perfusion imaging		Z2	3.2976	$136.52
78584	Lung V/Q image single breath		Z3	2.3911	$98.99
78585	Lung V/Q imaging		Z2	5.1617	$213.69
78586	Aerosol lung image, single		Z3	2.6879	$111.28
78587	Aerosol lung image, multiple		Z3	3.2734	$135.52
78588	Perfusion lung image		Z3	4.6420	$192.18
78591	Vent image, 1 breath, 1 proj		Z3	2.7870	$115.38
78593	Vent image, 1 proj, gas		Z3	3.2899	$136.20
78594	Vent image, mult proj, gas		Z2	3.2976	$136.52
78596	Lung differential function		Z2	5.1617	$213.69
78599	Respiratory nuclear exam		Z2	3.2976	$136.52
78600	Brain imaging, ltd static		Z3	3.2568	$134.83
78601	Brain imaging, ltd w/flow	CH	Z2	3.3325	$137.97
78605	Brain imaging, complete		Z3	3.2568	$134.83
78606	Brain imaging, compl w/flow	CH	Z3	4.9389	$204.47
78607	Brain imaging (3D)	CH	Z3	6.8599	$284.00
78608	Brain imaging (PET)		Z2	17.3837	$719.69
78610	Brain flow imaging only		Z3	2.3829	$98.65
78615	Cerebral vascular flow image		Z3	3.7186	$153.95
78630	Cerebrospinal fluid scan	CH	Z3	5.4582	$225.97
78635	CSF ventriculography	CH	Z3	4.4688	$185.01
78645	CSF shunt evaluation		Z2	3.3325	$137.97
78647	Cerebrospinal fluid scan	CH	Z3	6.5056	$269.33
78650	CSF leakage imaging	CH	Z3	5.2853	$218.81
78660	Nuclear exam of tear flow		Z3	2.5147	$104.11
78699	Nervous system nuclear exam		Z2	3.3325	$137.97
78700	Kidney imaging, morphol		Z3	2.9766	$123.23
78701	Kidney imaging with flow		Z3	3.5618	$147.46
78707	Kflow/funct image w/o drug	CH	Z3	3.9082	$161.80
78708	Kflow/funct image w/drug		Z3	3.0589	$126.64
78709	Kflow/funct image, multiple		Z2	5.0935	$210.87
78710	Kidney imaging (3D)	CH	Z3	4.4771	$185.35
78725	Kidney function study		Z2	1.5806	$65.44
78730	Urinary bladder retention		Z2	0.6416	$26.56
78740	Ureteral reflux study		Z3	3.0507	$126.30
78761	Testicular imaging w/flow		Z3	3.2321	$133.81
78799	Genitourinary nuclear exam		Z2	5.0935	$210.87
78800	Tumor imaging, limited area		Z3	3.0589	$126.64
78801	Tumor imaging, mult areas		Z3	4.0732	$168.63
78802	Tumor imaging, whole body	CH	Z3	5.4336	$224.95
78803	Tumor imaging (3D)	CH	Z3	6.8188	$282.30
78804	Tumor imaging, whole body	CH	Z3	10.3807	$429.76
78805	Abscess imaging, ltd area		Z3	3.0012	$124.25
78806	Abscess imaging, whole body	CH	Z3	5.8870	$243.72
78807	Nuclear localization/abscess	CH	Z3	6.7116	$277.86
78811	Tumor imaging (pet), limited		Z2	17.3837	$719.69
78812	Tumor image (pet)/skul-thigh		Z2	17.3837	$719.69
78813	Tumor image (pet) full body		Z2	17.3837	$719.69
78814	Tumor image pet/ct, limited		Z2	17.3837	$719.69
78815	Tumorimage pet/ct skul-thigh		Z2	17.3837	$719.69
78816	Tumor image pet/ct full body		Z2	17.3837	$719.69
78890	Nuclear medicine data proc		N1		
78891	Nuclear med data proc		N1		
78999	Nuclear diagnostic exam		Z2	1.5806	$65.44

ADDENDUM BB.—PROPOSED ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS code	Short descriptor	Comment indicator	Payment indicator	Proposed CY 2008 payment weight	Proposed CY 2008 payment
79005	Nuclear rx, oral admin		Z3	1.5913	$65.88
79101	Nuclear rx, iv admin		Z3	1.6572	$68.61
79200	Nuclear rx, intracav admin		Z3	1.7150	$71.00
79300	Nuclr rx, interstit colloid		Z2	3.4563	$143.09
79403	Hematopoietic nuclear tx		Z3	2.6384	$109.23
79440	Nuclear rx, intra-articular		Z3	1.5418	$63.83
79445	Nuclear rx, intra-arterial		Z2	3.4563	$143.09
79999	Nuclear medicine therapy		Z2	3.4563	$143.09
90371	Hep b ig, im		K2		$132.42
90375	Rabies ig, im/sc		K2		$64.82
90376	Rabies ig, heat treated		K2		$69.40
90396	Varicella-zoster ig, im		K2		$121.58
90585	Bcg vaccine, percut		K2		$112.56
90675	Rabies vaccine, im		K2		$145.53
90676	Rabies vaccine, id		K2		$124.09
90708	Measles-rubella vaccine, sc		K2		$61.10
90720	Dtp/hib vaccine, im	CH	N1		
90727	Plague vaccine, im	CH	N1		
90733	Meningococcal vaccine, sc		K2		$88.59
90734	Meningococcal vaccine, im		K2		$72.03
90735	Encephalitis vaccine, sc		K2		$98.17
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		
A9527	Iodine I-125 sodium iodide	CH	H2		$28.62
A9698	Non-rad contrast materialNOC		N1		
C1713	Anchor/screw bn/bn,tis/bn		N1		
C1714	Cath, trans atherectomy, dir		N1		
C1715	Brachytherapy needle		N1		
C1716	Brachytx source, Gold 198	CH	H2		$31.95
C1717	Brachytx source, HDR Ir-192	CH	H2		$173.40
C1719	Brachytx sour,Non-HDR Ir-192	CH	H2		$57.40
C1721	AICD, dual chamber		N1		
C1722	AICD, single chamber		N1		
C1724	Cath, trans atherec,rotation		N1		
C1725	Cath, translumin non-laser		N1		
C1726	Cath, bal dil, non-vascular		N1		
C1727	Cath, bal tis dis, non-vas		N1		
C1728	Cath, brachytx seed adm		N1		
C1729	Cath, drainage		N1		
C1730	Cath, EP, 19 or few elect		N1		
C1731	Cath, EP, 20 or more elec		N1		
C1732	Cath, EP, diag/abl, 3D/vect		N1		
C1733	Cath, EP, othr than cool-tip		N1		
C1750	Cath, hemodialysis,long-term		N1		
C1751	Cath, inf, per/cent/midline		N1		
C1752	Cath,hemodialysis,short-term		N1		
C1753	Cath, intravas ultrasound		N1		
C1754	Catheter, intradiscal		N1		
C1755	Catheter, intraspinal		N1		
C1756	Cath, pacing, transesoph		N1		
C1757	Cath, thrombectomy/embolect		N1		
C1758	Catheter, ureteral		N1		
C1759	Cath, intra echocardiography		N1		
C1760	Closure dev, vasc		N1		
C1762	Conn tiss, human(inc fascia)		N1		
C1763	Conn tiss, non-human		N1		
C1764	Event recorder, cardiac		N1		
C1765	Adhesion barrier		N1		
C1766	Intro/sheath,strble,non-peel		N1		
C1767	Generator, neuro non-recharg		N1		

ADDENDUM BB.—PROPOSED ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS code	Short descriptor	Comment indicator	Payment indicator	Proposed CY 2008 payment weight	Proposed CY 2008 payment
C1768	Graft, vascular		N1		
C1769	Guide wire		N1		
C1770	Imaging coil, MR, insertable		N1		
C1771	Rep dev, urinary, w/sling		N1		
C1772	Infusion pump, programmable		N1		
C1773	Ret dev, insertable		N1		
C1776	Joint device (implantable)		N1		
C1777	Lead, AICD, endo single coil		N1		
C1778	Lead, neurostimulator		N1		
C1779	Lead, pmkr, transvenous VDD		N1		
C1780	Lens, intraocular (new tech)		N1		
C1781	Mesh (implantable)		N1		
C1782	Morcellator		N1		
C1783	Ocular imp, aqueous drain de		N1		
C1784	Ocular dev, intraop, det ret		N1		
C1785	Pmkr, dual, rate-resp		N1		
C1786	Pmkr, single, rate-resp		N1		
C1787	Patient progr, neurostim		N1		
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	CH	N1		
C1821	Interspinous implant		J7		
C1874	Stent, coated/cov w/del sys		N1		
C1875	Stent, coated/cov w/o del sy		N1		
C1876	Stent, non-coa/non-cov w/del		N1		
C1877	Stent, non-coat/cov w/o del		N1		
C1878	Matrl for vocal cord		N1		
C1879	Tissue marker, implantable		N1		
C1880	Vena cava filter		N1		
C1881	Dialysis access system		N1		
C1882	AICD, other than sing/dual		N1		
C1883	Adapt/ext, pacing/neuro lead		N1		
C1884	Embolization Protect syst		N1		
C1885	Cath, translumin angio laser		N1		
C1887	Catheter, guiding		N1		
C1888	Endovas non-cardiac abl cath		N1		
C1891	Infusion pump,non-prog, perm		N1		
C1892	Intro/sheath,fixed,peel-away		N1		
C1893	Intro/sheath, fixed,non-peel		N1		
C1894	Intro/sheath, non-laser		N1		
C1895	Lead, AICD, endo dual coil		N1		
C1896	Lead, AICD, non sing/dual		N1		
C1897	Lead, neurostim test kit		N1		
C1898	Lead, pmkr, other than trans		N1		
C1899	Lead, pmkr/AICD combination		N1		
C1900	Lead, coronary venous		N1		
C2614	Probe, perc lumb disc		N1		
C2615	Sealant, pulmonary, liquid		N1		
C2616	Brachytx source, Yttrium-90	CH	H2		$11,943.79
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		

ADDENDUM BB.—PROPOSED ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS code	Short descriptor	Comment indicator	Payment indicator	Proposed CY 2008 payment weight	Proposed CY 2008 payment
C2631	Rep dev, urinary, w/o sling		N1		
C2634	Brachytx source, HA, I-125	CH	H2		$29.93
C2635	Brachytx source, HA, P-103	CH	H2		$47.06
C2636	Brachytx linear source,P-103	CH	H2		$37.09
C8900	MRA w/cont, abd		Z2	6.7963	$281.37
C8901	MRA w/o cont, abd		Z2	5.7101	$236.40
C8902	MRA w/o fol w/cont, abd		Z2	8.6689	$358.89
C8903	MRI w/cont, breast, uni		Z2	6.7963	$281.37
C8904	MRI w/o cont, breast, uni		Z2	5.7101	$236.40
C8905	MRI w/o fol w/cont, brst, un		Z2	8.6689	$358.89
C8906	MRI w/cont, breast, bi		Z2	6.7963	$281.37
C8907	MRI w/o cont, breast, bi		Z2	5.7101	$236.40
C8908	MRI w/o fol w/cont, breast,		Z2	8.6689	$358.89
C8909	MRA w/cont, chest		Z2	6.7963	$281.37
C8910	MRA w/o cont, chest		Z2	5.7101	$236.40
C8911	MRA w/o fol w/cont, chest		Z2	8.6689	$358.89
C8912	MRA w/cont, lwr ext		Z2	6.7963	$281.37
C8913	MRA w/o cont, lwr ext		Z2	5.7101	$236.40
C8914	MRA w/o fol w/cont, lwr ext		Z2	8.6689	$358.89
C8918	MRA w/cont, pelvis		Z2	6.7963	$281.37
C8919	MRA w/o cont, pelvis		Z2	5.7101	$236.40
C8920	MRA w/o fol w/cont, pelvis		Z2	8.6689	$358.89
C9003	Palivizumab, per 50 mg		K2		$677.97
C9113	Inj pantoprazole sodium, via		N1		
C9121	Injection, argatroban		K2		$17.87
C9232	Injection, idursulfase		K2		$455.03
C9233	Injection, ranibizumab		K2		$2,030.92
C9234	Inj, alglucosidase alfa		K2		$1.26
C9235	Injection, panitumumab		K2		$84.80
C9350	Porous collagen tube per cm		K2		$485.91
C9351	Acellular derm tissue percm2		K2		$41.59
C9399	Unclassified drugs or biolog		K7		
E0616	Cardiac event recorder		N1		
E0749	Elec osteogen stim implanted		N1		
E0782	Non-programble infusion pump		N1		
E0783	Programmable infusion pump		N1		
E0785	Replacement impl pump cathet		N1		
E0786	Implantable pump replacement		N1		
G0130	Single energy x-ray study		Z3	0.5278	$21.85
G0173	Linear acc stereo radsur com		Z2	61.5205	$2,546.95
G0251	Linear acc based stero radio		Z2	17.1992	$712.05
G0259	Inject for sacroiliac joint		N1		
G0269	Occlusive device in vein art		N1		
G0288	Recon, CTA for surg plan	CH	N1		
G0289	Arthro, loose body + chondro		N1		
G0339	Robot lin-radsurg com, first		Z2	61.5205	$2,546.95
G0340	Robt lin-radsurg fractx 2-5		Z2	47.3767	$1,961.40
J0120	Tetracyclin injection		N1		
J0128	Abarelix injection		K2		$67.97
J0129	Abatacept injection		K2		$18.69
J0130	Abciximab injection		K2		$409.26
J0132	Acetylcysteine injection	CH	N1		
J0133	Acyclovir injection		N1		
J0135	Adalimumab injection		K2		$316.02
J0150	Injection adenosine 6 MG		K2		$22.65
J0152	Adenosine injection		K2		$68.50
J0170	Adrenalin epinephrin inject		N1		
J0180	Agalsidase beta injection		K2		$1.26
J0190	Inj biperiden lactate/5 mg	CH	N1		
J0200	Alatrofloxacin mesylate		N1		
J0205	Alglucerase injection		K2		$38.85
J0207	Amifostine		K2		$476.10
J0210	Methyldopate hcl injection		K2		$10.01
J0215	Alefacept		K2		$25.82
J0256	Alpha 1 proteinase inhibitor		K2		$3.24
J0278	Amikacin sulfate injection		N1		
J0280	Aminophyllin 250 MG inj		N1		
J0282	Amiodarone HCl		N1		

ADDENDUM BB.—PROPOSED ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS code	Short descriptor	Comment indicator	Payment indicator	Proposed CY 2008 payment weight	Proposed CY 2008 payment
J0285	Amphotericin B		N1		
J0287	Amphotericin b lipid complex		K2		$10.28
J0288	Ampho b cholesteryl sulfate		K2		$11.89
J0289	Amphotericin b liposome inj		K2		$17.07
J0290	Ampicillin 500 MG inj		N1		
J0295	Ampicillin sodium per 1.5 gm		N1		
J0300	Amobarbital 125 MG inj		N1		
J0330	Succinycholine chloride inj		N1		
J0348	Anadulafungin injection		K2		$1.91
J0350	Injection anistreplase 30 u		K2		$2,693.80
J0360	Hydralazine hcl injection		N1		
J0364	Apomorphine hydrochloride	CH	N1		
J0365	Aprotonin, 10,000 kiu		K2		$2.50
J0380	Inj metaraminol bitartrate	CH	N1		
J0390	Chloroquine injection		N1		
J0395	Arbutamine HCl injection	CH	N1		
J0456	Azithromycin		N1		
J0460	Atropine sulfate injection		N1		
J0470	Dimecaprol injection		N1		
J0475	Baclofen 10 MG injection		K2		$195.18
J0476	Baclofen intrathecal trial		K2		$70.92
J0480	Basiliximab		K2		$1,347.14
J0500	Dicyclomine injection		N1		
J0515	Inj benztropine mesylate		N1		
J0520	Bethanechol chloride inject	CH	K2		$32.66
J0530	Penicillin g benzathine inj		N1		
J0540	Penicillin g benzathine inj		N1		
J0550	Penicillin g benzathine inj		N1		
J0560	Penicillin g benzathine inj		N1		
J0570	Penicillin g benzathine inj		N1		
J0580	Penicillin g benzathine inj		N1		
J0583	Bivalirudin		K2		$1.72
J0585	Botulinum toxin a per unit		K2		$5.05
J0587	Botulinum toxin type B		K2		$8.30
J0592	Buprenorphine hydrochloride		N1		
J0594	Busulfan injection		K2		$8.80
J0595	Butorphanol tartrate 1 mg		N1		
J0600	Edetate calcium disodium inj	CH	N1		
J0610	Calcium gluconate injection		N1		
J0620	Calcium glycer & lact/10 ML		N1		
J0630	Calcitonin salmon injection		N1		
J0636	Inj calcitriol per 0.1 mcg		N1		
J0637	Caspofungin acetate		K2		$30.07
J0640	Leucovorin calcium injection		N1		
J0670	Inj mepivacaine HCL/10 ml		N1		
J0690	Cefazolin sodium injection		N1		
J0692	Cefepime HCl for injection		N1		
J0694	Cefoxitin sodium injection		N1		
J0696	Ceftriaxone sodium injection		N1		
J0697	Sterile cefuroxime injection		N1		
J0698	Cefotaxime sodium injection		N1		
J0702	Betamethasone acet&sod phosp		N1		
J0704	Betamethasone sod phosp/4 MG		N1		
J0706	Caffeine citrate injection	CH	N1		
J0710	Cephapirin sodium injection		N1		
J0713	Inj ceftazidime per 500 mg		N1		
J0715	Ceftizoxime sodium / 500 MG		N1		
J0720	Chloramphenicol sodium injec		N1		
J0725	Chorionic gonadotropin/1000u		N1		
J0735	Clonidine hydrochloride		K2		$62.86
J0740	Cidofovir injection		K2		$754.62
J0743	Cilastatin sodium injection		N1		
J0744	Ciprofloxacin iv		N1		
J0745	Inj codeine phosphate /30 MG		N1		
J0760	Colchicine injection		N1		
J0770	Colistimethate sodium inj		N1		
J0780	Prochlorperazine injection		N1		
J0795	Corticorelin ovine triflutal		K2		$4.26

ADDENDUM BB.—PROPOSED ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS code	Short descriptor	Comment indicator	Payment indicator	Proposed CY 2008 payment weight	Proposed CY 2008 payment
J0800	Corticotropin injection		K2		$126.52
J0835	Inj cosyntropin per 0.25 MG		K2		$63.25
J0850	Cytomegalovirus imm IV /vial		K2		$859.86
J0878	Daptomycin injection		K2		$0.33
J0881	Darbepoetin alfa, non-esrd		K2		$3.11
J0885	Epoetin alfa, non-esrd		K2		$9.36
J0894	Decitabine injection		K2		$26.48
J0895	Deferoxamine mesylate inj	CH	N1		
J0900	Testosterone enanthate inj		N1		
J0945	Brompheniramine maleate inj		N1		
J0970	Estradiol valerate injection		N1		
J1000	Depo-estradiol cypionate inj		N1		
J1020	Methylprednisolone 20 MG inj		N1		
J1030	Methylprednisolone 40 MG inj		N1		
J1040	Methylprednisolone 80 MG inj		N1		
J1051	Medroxyprogesterone inj		N1		
J1060	Testosterone cypionate 1 ML		N1		
J1070	Testosterone cypionat 100 MG		N1		
J1080	Testosterone cypionat 200 MG		N1		
J1094	Inj dexamethasone acetate		N1		
J1100	Dexamethasone sodium phos		N1		
J1110	Inj dihydroergotamine mesylt		N1		
J1120	Acetazolamid sodium injectio		N1		
J1160	Digoxin injection		N1		
J1162	Digoxin immune fab (ovine)		K2		$511.48
J1165	Phenytoin sodium injection		N1		
J1170	Hydromorphone injection		N1		
J1180	Dyphylline injection		N1		
J1190	Dexrazoxane HCl injection		K2		$172.43
J1200	Diphenhydramine hcl injectio		N1		
J1205	Chlorothiazide sodium inj		K2		$122.67
J1212	Dimethyl sulfoxide 50% 50 ML		N1		
J1230	Methadone injection		N1		
J1240	Dimenhydrinate injection		N1		
J1245	Dipyridamole injection		N1		
J1250	Inj dobutamine HCL/250 mg		N1		
J1260	Dolasetron mesylate		K2		$6.05
J1265	Dopamine injection		N1		
J1270	Injection, doxercalciferol		N1		
J1320	Amitriptyline injection		N1		
J1324	Enfuvirtide injection		K2		$22.69
J1325	Epoprostenol injection		N1		
J1327	Eptifibatide injection		K2		$15.90
J1330	Ergonovine maleate injection	CH	N1		
J1335	Ertapenem injection		N1		
J1364	Erythro lactobionate /500 MG		N1		
J1380	Estradiol valerate 10 MG inj		N1		
J1390	Estradiol valerate 20 MG inj		N1		
J1410	Inj estrogen conjugate 25 MG		K2		$60.32
J1430	Ethanolamine oleate 100 mg		K2		$78.26
J1435	Injection estrone per 1 MG		N1		
J1436	Etidronate disodium inj		K2		$70.73
J1438	Etanercept injection		K2		$160.03
J1440	Filgrastim 300 mcg injection		K2		$187.68
J1441	Filgrastim 480 mcg injection		K2		$297.75
J1450	Fluconazole		N1		
J1451	Fomepizole, 15 mg		K2		$12.28
J1452	Intraocular Fomivirsen na	CH	N1		
J1455	Foscarnet sodium injection	CH	N1		
J1457	Gallium nitrate injection	CH	K2		$1.47
J1458	Galsulfase injection		K2		$297.09
J1460	Gamma globulin 1 CC inj		K2		$11.31
J1470	Gamma globulin 2 CC inj	CH	K2		$22.63
J1480	Gamma globulin 3 CC inj	CH	K2		$33.93
J1490	Gamma globulin 4 CC inj	CH	K2		$45.25
J1500	Gamma globulin 5 CC inj	CH	K2		$56.56
J1510	Gamma globulin 6 CC inj	CH	K2		$67.91
J1520	Gamma globulin 7 CC inj	CH	K2		$79.14

ADDENDUM BB.—PROPOSED ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS code	Short descriptor	Comment indicator	Payment indicator	Proposed CY 2008 payment weight	Proposed CY 2008 payment
J1530	Gamma globulin 8 CC inj	CH	K2		$90.50
J1540	Gamma globulin 9 CC inj	CH	K2		$101.88
J1550	Gamma globulin 10 CC inj	CH	K2		$113.13
J1560	Gamma globulin > 10 CC inj	CH	K2		$113.13
J1562	Immune globulin subcutaneous		K2		$12.60
J1565	RSV-ivig		K2		$16.02
J1566	Immune globulin, powder		K2		$25.48
J1567	Immune globulin, liquid		K2		$30.28
J1570	Ganciclovir sodium injection		N1		
J1580	Garamycin gentamicin inj		N1		
J1590	Gatifloxacin injection		N1		
J1595	Injection glatiramer acetate		N1		
J1600	Gold sodium thiomaleate inj		N1		
J1610	Glucagon hydrochloride/1 MG		K2		$65.64
J1620	Gonadorelin hydroch/ 100 mcg		K2		$178.59
J1626	Granisetron HCl injection		K2		$7.43
J1630	Haloperidol injection		N1		
J1631	Haloperidol decanoate inj		N1		
J1640	Hemin, 1 mg		K2		$6.74
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	K2		$5.82
J1655	Tinzaparin sodium injection	CH	N1		
J1670	Tetanus immune globulin inj		K2		$96.35
J1700	Hydrocortisone acetate inj		N1		
J1710	Hydrocortisone sodium ph inj		N1		
J1720	Hydrocortisone sodium succ i		N1		
J1730	Diazoxide injection		K2		$113.24
J1740	Ibandronate sodium injection		K2		$138.71
J1742	Ibutilide fumarate injection		K2		$264.40
J1745	Infliximab injection		K2		$53.25
J1751	Iron dextran 165 injection		K2		$11.61
J1752	Iron dextran 267 injection		K2		$10.32
J1756	Iron sucrose injection		K2		$0.37
J1785	Injection imiglucerase /unit		K2		$3.89
J1790	Droperidol injection		N1		
J1800	Propranolol injection		N1		
J1815	Insulin injection		N1		
J1817	Insulin for insulin pump use		N1		
J1830	Interferon beta-1b / .25 MG		K2		$84.12
J1835	Itraconazole injection		K2		$38.05
J1840	Kanamycin sulfate 500 MG inj		N1		
J1850	Kanamycin sulfate 75 MG inj		N1		
J1885	Ketorolac tromethamine inj		N1		
J1890	Cephalothin sodium injection		N1		
J1931	Laronidase injection		K2		$23.64
J1940	Furosemide injection		N1		
J1945	Lepirudin		K2		$153.42
J1950	Leuprolide acetate /3.75 MG		K2		$429.83
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		$24.93
J2060	Lorazepam injection		N1		
J2150	Mannitol injection		N1		
J2170	Mecasermin injection		K2		$11.81
J2175	Meperidine hydrochl /100 MG		N1		
J2180	Meperidine/promethazine inj		N1		
J2185	Meropenem	CH	N1		
J2210	Methylergonovin maleate inj		N1		
J2248	Micafungin sodium injection		K2		$1.71
J2250	Inj midazolam hydrochloride		N1		
J2260	Inj milrinone lactate / 5 MG		N1		

ADDENDUM BB.—PROPOSED ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS code	Short descriptor	Comment indicator	Payment indicator	Proposed CY 2008 payment weight	Proposed CY 2008 payment
J2270	Morphine sulfate injection		N1		
J2271	Morphine so4 injection 100mg		N1		
J2275	Morphine sulfate injection		N1		
J2278	Ziconotide injection		K2		$6.46
J2280	Inj, moxifloxacin 100 mg		N1		
J2300	Inj nalbuphine hydrochloride		N1		
J2310	Inj naloxone hydrochloride		N1		
J2315	Naltrexone, depot form		K2		$1.88
J2320	Nandrolone decanoate 50 MG		N1		
J2321	Nandrolone decanoate 100 MG		N1		
J2322	Nandrolone decanoate 200 MG		N1		
J2325	Nesiritide injection		K2		$31.36
J2353	Octreotide injection, depot		K2		$95.86
J2354	Octreotide inj, non-depot		N1		
J2355	Oprelvekin injection		K2		$244.98
J2357	Omalizumab injection		K2		$16.79
J2360	Orphenadrine injection		N1		
J2370	Phenylephrine hcl injection		N1		
J2400	Chloroprocaine hcl injection		N1		
J2405	Ondansetron hcl injection		K2		$3.37
J2410	Oxymorphone hcl injection		N1		
J2425	Palifermin injection		K2		$11.32
J2430	Pamidronate disodium /30 MG		K2		$30.49
J2440	Papaverin hcl injection		N1		
J2460	Oxytetracycline injection		N1		
J2469	Palonosetron HCl		K2		$15.85
J2501	Paricalcitol		N1		
J2503	Pegaptanib sodium injection		K2		$1,054.70
J2504	Pegademase bovine, 25 iu		K2		$176.16
J2505	Injection, pegfilgrastim 6mg		K2		$2,142.92
J2510	Penicillin g procaine inj		N1		
J2513	Pentastarch 10% solution	CH	K2		$23.61
J2515	Pentobarbital sodium inj		N1		
J2540	Penicillin g potassium inj		N1		
J2543	Piperacillin/tazobactam		N1		
J2550	Promethazine hcl injection		N1		
J2560	Phenobarbital sodium inj		N1		
J2590	Oxytocin injection		N1		
J2597	Inj desmopressin acetate		N1		
J2650	Prednisolone acetate inj		N1		
J2670	Totazoline hcl injection		N1		
J2675	Inj progesterone per 50 MG		N1		
J2680	Fluphenazine decanoate 25 MG		N1		
J2690	Procainamide hcl injection		N1		
J2700	Oxacillin sodium injeciton		N1		
J2710	Neostigmine methylslfte inj		N1		
J2720	Inj protamine sulfate/10 MG		N1		
J2725	Inj protirelin per 250 mcg		N1		
J2730	Pralidoxime chloride inj		N1		
J2760	Phentolaine mesylate inj		N1		
J2765	Metoclopramide hcl injection		N1		
J2770	Quinupristin/dalfopristin		K2		$116.70
J2780	Ranitidine hydrochloride inj		N1		
J2783	Rasburicase		K2		$131.28
J2788	Rho d immune globulin 50 mcg		K2		$26.41
J2790	Rho d immune globulin inj		K2		$80.71
J2792	Rho(D) immune globulin h, sd		K2		$15.76
J2794	Risperidone, long acting		K2		$4.80
J2795	Ropivacaine HCl injection		N1		
J2800	Methocarbamol injection		N1		
J2805	Sincalide injection		N1		
J2810	Inj theophylline per 40 MG		N1		
J2820	Sargramostim injection		K2		$25.08
J2850	Inj secretin synthetic human		K2		$20.12
J2910	Aurothioglucose injeciton		N1		
J2916	Na ferric gluconate complex		N1		
J2920	Methylprednisolone injection		N1		
J2930	Methylprednisolone injection		N1		

ADDENDUM BB.—PROPOSED ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS code	Short descriptor	Comment indicator	Payment indicator	Proposed CY 2008 payment weight	Proposed CY 2008 payment
J2940	Somatrem injection		K2		$69.53
J2941	Somatropin injection		K2		$46.75
J2950	Promazine hcl injection		N1		
J2993	Reteplase injection		K2		$891.03
J2995	Inj streptokinase /250000 IU		K2		$75.48
J2997	Alteplase recombinant		K2		$32.48
J3000	Streptomycin injection		N1		
J3010	Fentanyl citrate injeciton		N1		
J3030	Sumatriptan succinate / 6 MG		K2		$58.82
J3070	Pentazocine injection		N1		
J3100	Tenecteplase injection		K2		$2,024.13
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		$758.16
J3243	Tigecycline injection		K2		$0.91
J3246	Tirofiban HCl		K2		$7.66
J3250	Trimethobenzamide hcl inj		N1		
J3260	Tobramycin sulfate injection		N1		
J3265	Injection torsemide 10 mg/ml		N1		
J3280	Thiethylperazine maleate inj		N1		
J3285	Treprostinil injection		K2		$55.36
J3301	Triamcinolone acetonide inj		N1		
J3302	Triamcinolone diacetate inj		N1		
J3303	Triamcinolone hexacetonl inj		N1		
J3305	Inj trimetrexate glucoronate		K2		$143.89
J3310	Perphenazine injeciton		N1		
J3315	Triptorelin pamoate		K2		$153.97
J3320	Spectinomycn di-hcl inj	CH	N1		
J3350	Urea injection		K2		$73.46
J3355	Urofollitropin, 75 iu		K2		$50.22
J3360	Diazepam injection		N1		
J3364	Urokinase 5000 IU injection	CH	K2		$9.07
J3365	Urokinase 250,000 IU inj		K2		$453.41
J3370	Vancomycin hcl injection		N1		
J3396	Verteporfin injection		K2		$8.84
J3400	Triflupromazine hcl inj		N1		
J3410	Hydroxyzine hcl injection		N1		
J3411	Thiamine hcl 100 mg		N1		
J3415	Pyridoxine hcl 100 mg		N1		
J3420	Vitamin b12 injection		N1		
J3430	Vitamin k phytonadione inj		N1		
J3465	Injection, voriconazole		K2		$4.94
J3470	Hyaluronidase injection		N1		
J3471	Ovine, up to 999 USP units		N1		
J3472	Ovine, 1000 USP units		K2		$133.77
J3473	Hyaluronidase recombinant		K2		$0.40
J3475	Inj magnesium sulfate		N1		
J3480	Inj potassium chloride		N1		
J3485	Zidovudine		N1		
J3486	Ziprasidone mesylate		N1		
J3487	Zoledronic acid		K2		$204.09
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		

ADDENDUM BB.—PROPOSED ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS code	Short descriptor	Comment indicator	Payment indicator	Proposed CY 2008 payment weight	Proposed CY 2008 payment
J7187	Inj Vonwillebrand factor IU		K2		$0.88
J7189	Factor viia		K2		$1.11
J7190	Factor viii		K2		$0.70
J7191	Factor VIII (porcine)	CH	N1		
J7192	Factor viii recombinant		K2		$1.07
J7193	Factor IX non-recombinant		K2		$0.89
J7194	Factor ix complex		K2		$0.75
J7195	Factor IX recombinant		K2		$0.99
J7197	Antithrombin iii injection		K2		$1.62
J7198	Anti-inhibitor		K2		$1.35
J7308	Aminolevulinic acid hcl top		K2		$104.43
J7310	Ganciclovir long act implant		K2		$4,707.42
J7311	Fluocinolone acetonide implt		K2		$19,162.50
J7340	Metabolic active D/E tissue		K2		$28.51
J7341	Non-human, metabolic tissue	CH	N1		
J7342	Metabolically active tissue		K2		$31.36
J7343	Nonmetabolic act d/e tissue		K2		$18.13
J7344	Nonmetabolic active tissue		K2		$88.37
J7345	Non-human, non-metab tissue		K2		$35.76
J7346	Injectable human tissue		K2		$728.44
J7500	Azathioprine oral 50mg		N1		
J7501	Azathioprine parenteral		K2		$47.99
J7502	Cyclosporine oral 100 mg		K2		$3.57
J7504	Lymphocyte immune globulin		K2		$314.19
J7505	Monoclonal antibodies		K2		$886.70
J7506	Prednisone oral		N1		
J7507	Tacrolimus oral per 1 MG		K2		$3.63
J7509	Methylprednisolone oral		N1		
J7510	Prednisolone oral per 5 mg		N1		
J7511	Antithymocyte globuln rabbit		K2		$324.66
J7513	Daclizumab, parenteral		K2		$297.03
J7515	Cyclosporine oral 25 mg		N1		
J7516	Cyclosporin parenteral 250mg		N1		
J7517	Mycophenolate mofetil oral		K2		$2.60
J7518	Mycophenolic acid		K2		$2.25
J7520	Sirolimus, oral		K2		$7.15
J7525	Tacrolimus injection		K2		$139.11
J7599	Immunosuppressive drug noc		N1		
J7674	Methacholine chloride, neb		N1		
J7799	Non-inhalation drug for DME		N1		
J8501	Oral aprepitant		K2		$5.02
J8510	Oral busulfan		K2		$2.12
J8520	Capecitabine, oral, 150 mg		K2		$3.94
J8521	Capecitabine, oral, 500 mg	CH	K2		$13.12
J8530	Cyclophosphamide oral 25 MG		N1		
J8540	Oral dexamethasone		N1		
J8560	Etoposide oral 50 MG		K2		$29.32
J8597	Antiemetic drug oral NOS		N1		
J8600	Melphalan oral 2 MG	CH	K2		$4.34
J8610	Methotrexate oral 2.5 MG		N1		
J8650	Nabilone oral		K2		$16.80
J8700	Temozolomide		K2		$7.34
J9000	Doxorubic hcl 10 MG vl chemo	CH	N1		
J9001	Doxorubicin hcl liposome inj		K2		$385.81
J9010	Alemtuzumab injection		K2		$536.10
J9015	Aldesleukin/single use vial		K2		$755.78
J9017	Arsenic trioxide		K2		$33.84
J9020	Asparaginase injection		K2		$54.20
J9025	Azacitidine injection		K2		$4.26
J9027	Clofarabine injection		K2		$115.64
J9031	Bcg live intravesical vac		K2		$109.63
J9035	Bevacizumab injection		K2		$56.98
J9040	Bleomycin sulfate injection		K2		$35.52
J9041	Bortezomib injection		K2		$32.37
J9045	Carboplatin injection		K2		$8.38
J9050	Carmus bischl nitro inj		K2		$138.52
J9055	Cetuximab injection		K2		$49.34
J9060	Cisplatin 10 MG injection		N1		

ADDENDUM BB.—PROPOSED ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS code	Short descriptor	Comment indicator	Payment indicator	Proposed CY 2008 payment weight	Proposed CY 2008 payment
J9062	Cisplatin 50 MG injection	CH	N1		
J9065	Inj cladribine per 1 MG		K2		$35.78
J9070	Cyclophosphamide 100 MG inj		N1		
J9080	Cyclophosphamide 200 MG inj	CH	N1		
J9090	Cyclophosphamide 500 MG inj	CH	N1		
J9091	Cyclophosphamide 1.0 grm inj	CH	N1		
J9092	Cyclophosphamide 2.0 grm inj	CH	N1		
J9093	Cyclophosphamide lyophilized	CH	N1		
J9094	Cyclophosphamide lyophilized	CH	N1		
J9095	Cyclophosphamide lyophilized	CH	N1		
J9096	Cyclophosphamide lyophilized	CH	N1		
J9097	Cyclophosphamide lyophilized	CH	N1		
J9098	Cytarabine liposome		K2		$391.31
J9100	Cytarabine hcl 100 MG inj		N1		
J9110	Cytarabine hcl 500 MG inj	CH	N1		
J9120	Dactinomycin actinomycin d		K2		$488.78
J9130	Dacarbazine 100 mg inj	CH	N1		
J9140	Dacarbazine 200 MG inj	CH	N1		
J9150	Daunorubicin		K2		$20.28
J9151	Daunorubicin citrate liposom		K2		$55.40
J9160	Denileukin diftitox, 300 mcg		K2		$1,393.32
J9165	Diethylstilbestrol injection		N1		
J9170	Docetaxel		K2		$303.92
J9175	Elliotts b solution per ml		N1		
J9178	Inj, epirubicin hcl, 2 mg		K2		$21.01
J9181	Etoposide 10 MG inj		N1		
J9182	Etoposide 100 MG inj	CH	N1		
J9185	Fludarabine phosphate inj		K2		$234.21
J9190	Fluorouracil injection		N1		
J9200	Floxuridine injection		K2		$50.82
J9201	Gemcitabine HCl		K2		$123.98
J9202	Goserelin acetate implant		K2		$196.81
J9206	Irinotecan injection		K2		$124.81
J9208	Ifosfomide injection		K2		$46.15
J9209	Mesna injection		K2		$8.89
J9211	Idarubicin hcl injection		K2		$301.74
J9212	Interferon alfacon-1		K2		$4.60
J9213	Interferon alfa-2a inj		K2		$37.53
J9214	Interferon alfa-2b inj		K2		$13.75
J9215	Interferon alfa-n3 inj		K2		$9.03
J9216	Interferon gamma 1-b inj		K2		$287.13
J9217	Leuprolide acetate suspnsion		K2		$227.34
J9218	Leuprolide acetate injeciton		K2		$8.79
J9219	Leuprolide acetate implant		K2		$1,696.96
J9225	Histrelin implant		K2		$1,446.98
J9230	Mechlorethamine hcl inj		K2		$140.27
J9245	Inj melphalan hydrochl 50 MG		K2		$12.72
J9250	Methotrexate sodium inj		N1		
J9260	Methotrexate sodium inj	CH	N1		
J9261	Nelarabine injection		K2		$82.54
J9263	Oxaliplatin		K2		$8.89
J9264	Paclitaxel protein bound		K2		$7.03
J9265	Paclitaxel injection		K2		$12.47
J9266	Pegaspargase/singl dose vial		K2		$1,667.61
J9268	Pentostatin injection		K2		$1,916.66
J9270	Plicamycin (mithramycin) inj	CH	N1		
J9280	Mitomycin 5 MG inj		K2		$15.98
J9290	Mitomycin 20 MG inj	CH	K2		$63.93
J9291	Mitomycin 40 MG inj	CH	K2		$127.85
J9293	Mitoxantrone hydrochl / 5 MG		K2		$166.64
J9300	Gemtuzumab ozogamicin		K2		$2,334.75
J9305	Pemetrexed injection		K2		$43.38
J9310	Rituximab cancer treatment		K2		$491.54
J9320	Streptozocin injection		K2		$152.28
J9340	Thiotepa injection		K2		$40.32
J9350	Topotecan		K2		$822.90
J9355	Trastuzumab		K2		$57.33
J9357	Valrubicin, 200 mg		K2		$219.39

ADDENDUM BB.—PROPOSED ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS code	Short descriptor	Comment indicator	Payment indicator	Proposed CY 2008 payment weight	Proposed CY 2008 payment
J9360	Vinblastine sulfate inj		N1		
J9370	Vincristine sulfate 1 MG inj		N1		
J9375	Vincristine sulfate 2 MG inj	CH	N1		
J9380	Vincristine sulfate 5 MG inj	CH	N1		
J9390	Vinorelbine tartrate/10 mg		K2		$19.88
J9395	Injection, Fulvestrant		K2		$79.80
J9600	Porfimer sodium		K2		$2,539.13
J9999	Chemotherapy drug		N1		
L8600	Implant breast silicone/eq		N1		
L8603	Collagen imp urinary 2.5 ml		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		J7		
L8699	Prosthetic implant NOS		N1		
Q0163	Diphenhydramine HCl 50mg		N1		
Q0164	Prochlorperazine maleate 5mg		N1		
Q0166	Granisetron HCl 1 mg oral		K2		$44.44
Q0167	Dronabinol 2.5mg oral		N1		
Q0169	Promethazine HCl 12.5mg oral		N1		
Q0171	Chlorpromazine HCl 10mg oral		N1		
Q0173	Trimethobenzamide HCl 250mg		N1		
Q0174	Thiethylperazine maleate10mg		N1		
Q0175	Perphenazine 4mg oral		N1		
Q0177	Hydroxyzine pamoate 25mg		N1		
Q0179	Ondansetron HCl 8mg oral		K2		$36.21
Q0180	Dolasetron mesylate oral		K2		$47.07
Q0515	Sermorelin acetate injection		K2		$1.74
Q1003	NTIOL category 3		L6		$50.00
Q2004	Bladder calculi irrig sol		N1		
Q2009	Fosphenytoin, 50 mg		K2		$5.50
Q2017	Teniposide, 50 mg		K2		$261.93
Q3025	IM inj interferon beta 1-a		K2		$113.49
Q4079	Natalizumab injection		K2		$7.45
Q4083	Hyalgan/supartz inj per dose		K2		$103.86
Q4084	Synvisc inj per dose		K2		$184.89
Q4085	Euflexxa inj per dose		K2		$115.19
Q4086	Orthovisc inj per dose		K2		$196.47
Q9945	LOCM <=149 mg/ml iodine, 1ml	CH	N1		
Q9946	LOCM 150-199mg/ml iodine,1ml	CH	N1		
Q9947	LOCM 200-249mg/ml iodine,1ml	CH	N1		
Q9948	LOCM 250-299mg/ml iodine,1ml	CH	N1		
Q9949	LOCM 300-349mg/ml iodine,1ml	CH	N1		
Q9950	LOCM 350-399mg/ml iodine,1ml	CH	N1		
Q9951	LOCM >= 400 mg/ml iodine,1ml	CH	N1		
Q9952	Inj Gad-base MR contrast,1ml	CH	N1		
Q9953	Inj Fe-based MR contrast,1ml	CH	N1		
Q9954	Oral MR contrast, 100 ml	CH	N1		
Q9955	Inj perflexane lip micros,ml	CH	N1		
Q9956	Inj octafluoropropane mic,ml	CH	N1		
Q9957	Inj perflutren lip micros,ml	CH	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		

ADDENDUM BB.—PROPOSED ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS code	Short descriptor	Comment indicator	Payment indicator	Proposed CY 2008 payment weight	Proposed CY 2008 payment
Q9964	HOCM>= 400mg/ml iodine, 1ml		N1		
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.—PROPOSED OPPS PAYMENT STATUS INDICATORS

Indicator	Item/Code/Service	OPPS payment status
A	• Services furnished to a hospital outpatient that are paid under a fee schedule or payment system other than OPPS, for example: • Ambulance Services. • Clinical Diagnostic Laboratory Services. • Non-Implantable Prosthetic and Orthotic Devices. • EPO for ESRD Patients. • Physical, Occupational, and Speech Therapy. • Routine Dialysis Services for ESRD Patients Provided in a Certified Dialysis Unit of a Hospital. • Diagnostic Mammography. • Screening Mammography.	Not paid under OPPS. Paid by fiscal intermediaries under a fee schedule or payment system other than OPPS.
B	Codes that are not recognized by OPPS when submitted on an outpatient hospital Part B bill type (12x and 13x).	Not paid under OPPS. • May be paid by intermediaries when submitted on a different bill type, for example, 75x (CORF), but not paid under OPPS. • An alternate code that is recognized by OPPS when submitted on an outpatient hospital Part B bill type (12x and 13x) may be available.
C	Inpatient Procedures	Not paid under OPPS. Admit patient. Bill as inpatient.
D	Discontinued Codes	Not paid under OPPS or any other Medicare payment system.
E	Items, Codes, and Services: • That are not covered by Medicare based on statutory exclusion. • That are not covered by Medicare for reasons other than statutory exclusion. • That are not recognized by Medicare but for which an alternate code for the same item or service may be available. • For which separate payment is not provided by Medicare.	Not paid under OPPS or any other Medicare payment system.
F	Corneal Tissue Acquisition; Certain CRNA Services and Hepatitis B Vaccines.	Not paid under OPPS. Paid at reasonable cost.
G	Pass-Through Drugs and Biologicals	Paid under OPPS; Separate APC payment includes pass through amount.
H	Pass-Through Device Categories	Separate cost-based pass-through payment; Not subject to coinsurance.
K	(1) Non-Pass-Through Drugs and Biologicals (2) Therapeutic Radiopharmaceuticals (3) Brachytherapy Sources (4) Blood and Blood Products	(1) Paid under OPPS; Separate APC payment. (2) Paid under OPPS; Separate APC payment. (3) Paid under OPPS; Separate APC payment. (4) Paid under OPPS; Separate APC payment.
L	Influenza Vaccine; Pneumococcal Pneumonia Vaccine	Not paid under OPPS. Paid at reasonable cost; Not subject to deductible or coinsurance.
M	Items and Services Not Billable to the Fiscal Intermediary	Not paid under OPPS.
N	Items and Services Packaged into APC Rates	Paid under OPPS; Payment is packaged into payment for other services, including outliers. Therefore, there is no separate APC payment.
P	Partial Hospitalization	Paid under OPPS; Per diem APC payment.
Q	Packaged Services Subject to Separate Payment Under OPPS Payment Criteria.	Paid under OPPS; Addendum B displays APC assignments when services are separately payable. (1) Separate APC payment based on OPPS payment criteria. (2) If criteria are not met, payment is packaged into payment for other services, including outliers. Therefore, there is no separate APC payment.
S	Significant Procedure, Not Discounted when Multiple	Paid under OPPS; Separate APC payment.

ADDENDUM D1.—PROPOSED OPPS PAYMENT STATUS INDICATORS—Continued

Indicator	Item/Code/Service	OPPS payment status
T	Significant Procedure, Multiple Reduction Applies	Paid under OPPS; Separate APC payment.
V	Clinic or Emergency Department Visit	Paid under OPPS; Separate APC payment.
Y	Non-Implantable Durable Medical Equipment	Not paid under OPPS. All institutional providers other than home health agencies bill to DMERC.
X	Ancillary Services	Paid under OPPS; Separate APC payment.

ADDENDUM D2.—PROPOSED OPPS COMMENT INDICATORS

Comment indicator	Descriptor
NI	New code, 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 is discontinued at the end of the current calendar year.

ADDENDUM DD1.—PROPOSED ASC PAYMENT INDICATORS

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; 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.
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 Medicare Physician Fee Schedule (MPFS) nonfacility practice expense (PE) relative value units (RVUs); payment based on OPPS relative payment weight.
P3	Office-based surgical procedure added to ASC list in CY 2008 or later with MPFS nonfacility PE RVUs; payment based on MPFS nonfacility PE RVUs.
R2	Office-based surgical procedure added to ASC list in CY 2008 or later without MPFS nonfacility PE RVUs; payment based on OPPS relative payment weight.
Z2	Radiology service paid separately when provided integral to a surgical procedure on ASC list; payment based on OPPS relative payment weight.
Z3	Radiology service paid separately when provided integral to a surgical procedure on ASC list; payment based on MPFS nonfacility PE RVUs.

ADDENDUM DD2.—PROPOSED ASC COMMENT INDICATORS

Indicator	Comment indicator definition
CH	Active HCPCS code in current year and next calendar year, payment indicator has changed; or active HCPCS code that is newly recognized as payable in an ASC; or active HCPCS code that is discontinued at the end of the current calendar year.
NI	New code, interim payment; comments will be accepted on the interim payment indicator for the new code.

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLYAS INPATIENT PROCEDURES FOR CY 2008

HCPCS code	Short descriptor	SI
00176	Anesth, pharyngeal surgery	C
00192	Anesth, facial bone surgery	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 < age 1	C
00562	Anesth, heart surg w/pump	C
00580	Anesth, heart/lung transplnt	C
00604	Anesth, sitting procedure	C
00622	Anesth, removal of nerves	C
00632	Anesth, removal of nerves	C
00670	Anesth, spine, cord surgery	C
00792	Anesth, hemorr/excise liver	C
00794	Anesth, pancreas removal	C
00796	Anesth, for liver transplant	C
00802	Anesth, fat layer removal	C
00844	Anesth, pelvis surgery	C
00846	Anesth, hysterectomy	C
00848	Anesth, pelvic organ surg	C
00864	Anesth, removal of bladder	C
00865	Anesth, removal of prostate	C
00866	Anesth, removal of adrenal	C
00868	Anesth, kidney transplant	C
00882	Anesth, major vein ligation	C
00904	Anesth, perineal surgery	C
00908	Anesth, removal of prostate	C
00932	Anesth, amputation of penis	C
00934	Anesth, penis, nodes removal	C
00936	Anesth, penis, nodes removal	C
00944	Anesth, vaginal hysterectomy	C
01140	Anesth, amputation at pelvis	C
01150	Anesth, pelvic tumor surgery	C
01212	Anesth, hip disarticulation	C
01214	Anesth, hip arthroplasty	C
01232	Anesth, amputation of femur	C
01234	Anesth, radical femur surg	C
01272	Anesth, femoral artery surg	C
01274	Anesth, femoral embolectomy	C
01402	Anesth, knee arthroplasty	C
01404	Anesth, amputation at knee	C
01442	Anesth, knee artery surg	C
01444	Anesth, knee artery repair	C
01486	Anesth, ankle replacement	C
01502	Anesth, lwr leg embolectomy	C
01632	Anesth, surgery of shoulder	C
01634	Anesth, shoulder joint amput	C
01636	Anesth, forequarter amput	C
01638	Anesth, shoulder replacement	C
01652	Anesth, shoulder vessel surg	C
01654	Anesth, shoulder vessel surg	C
01656	Anesth, arm-leg vessel surg	C
01756	Anesth, radical humerus surg	C
01990	Support for organ donor	C
11004	Debride genitalia & perineum	C
11005	Debride abdom wall	C
11006	Debride genit/per/abdom wall	C
11008	Remove mesh from abd wall	C
15756	Free myo/skin flap microvasc	C
15757	Free skin flap, microvasc	C
15758	Free fascial flap, microvasc	C
16036	Escharotomy; add'l incision	C
19271	Revision of chest wall	C
19272	Extensive chest wall surgery	C
19305	Mast, radical	C
19306	Mast, rad, urban type	C

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLYAS INPATIENT PROCEDURES FOR CY 2008—Continued

HCPCS code	Short descriptor	SI
19361	Breast reconstr w/lat flap	C
19364	Breast reconstruction	C
19367	Breast reconstruction	C
19368	Breast reconstruction	C
19369	Breast reconstruction	C
20660	Apply, rem fixation device	C
20661	Application of head brace	C
20664	Halo brace application	C
20802	Replantation, arm, complete	C
20805	Replant forearm, complete	C
20808	Replantation hand, complete	C
20816	Replantation digit, complete	C
20824	Replantation thumb, complete	C
20827	Replantation thumb, complete	C
20838	Replantation foot, complete	C
20930	Spinal bone allograft	C
20931	Spinal bone allograft	C
20936	Spinal bone autograft	C
20937	Spinal bone autograft	C
20938	Spinal bone autograft	C
20955	Fibula bone graft, microvasc	C
20956	Iliac bone graft, microvasc	C
20957	Mt bone graft, microvasc	C
20962	Other bone graft, microvasc	C
20969	Bone/skin graft, microvasc	C
20970	Bone/skin graft, iliac crest	C
21045	Extensive jaw surgery	C
21141	Reconstruct midface, lefort	C
21142	Reconstruct midface, lefort	C
21143	Reconstruct midface, lefort	C
21145	Reconstruct midface, lefort	C
21146	Reconstruct midface, lefort	C
21147	Reconstruct midface, lefort	C
21151	Reconstruct midface, lefort	C
21154	Reconstruct midface, lefort	C
21155	Reconstruct midface, lefort	C
21159	Reconstruct midface, lefort	C
21160	Reconstruct midface, lefort	C
21172	Reconstruct orbit/forehead	C
21179	Reconstruct entire forehead	C
21180	Reconstruct entire forehead	C
21182	Reconstruct cranial bone	C
21183	Reconstruct cranial bone	C
21184	Reconstruct cranial bone	C
21188	Reconstruction of midface	C
21193	Reconst lwr jaw w/o graft	C
21194	Reconst lwr jaw w/graft	C
21196	Reconst lwr jaw w/fixation	C
21247	Reconstruct lower jaw bone	C
21255	Reconstruct lower jaw bone	C
21256	Reconstruction of orbit	C
21268	Revise eye sockets	C
21343	Treatment of sinus fracture	C
21344	Treatment of sinus fracture	C
21346	Treat nose/jaw fracture	C
21347	Treat nose/jaw fracture	C
21348	Treat nose/jaw fracture	C
21366	Treat cheek bone fracture	C
21386	Treat eye socket fracture	C
21387	Treat eye socket fracture	C
21395	Treat eye socket fracture	C
21422	Treat mouth roof fracture	C
21423	Treat mouth roof fracture	C
21431	Treat craniofacial fracture	C
21432	Treat craniofacial fracture	C
21433	Treat craniofacial fracture	C
21435	Treat craniofacial fracture	C
21436	Treat craniofacial fracture	C
21510	Drainage of bone lesion	C
21615	Removal of rib	C

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLYAS INPATIENT PROCEDURES FOR CY 2008—Continued

HCPCS code	Short descriptor	SI
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
22210	Revision of neck spine	C
22212	Revision of thorax spine	C
22214	Revision of lumbar spine	C
22216	Revise, extra spine segment	C
22220	Revision of neck spine	C
22224	Revision of lumbar spine	C
22226	Revise, extra spine segment	C
22318	Treat odontoid fx w/o graft	C
22319	Treat odontoid fx w/graft	C
22325	Treat spine fracture	C
22326	Treat neck spine fracture	C
22327	Treat thorax spine fracture	C
22328	Treat each add spine fx	C
22532	Lat thorax spine fusion	C
22533	Lat lumbar spine fusion	C
22534	Lat thor/lumb, addl seg	C
22548	Neck spine fusion	C
22554	Neck spine fusion	C
22556	Thorax spine fusion	C
22558	Lumbar spine fusion	C
22585	Additional spinal fusion	C
22590	Spine & skull spinal fusion	C
22595	Neck spinal fusion	C
22600	Neck spine fusion	C
22610	Thorax spine fusion	C
22630	Lumbar spine fusion	C
22632	Spine fusion, extra segment	C
22800	Fusion of spine	C
22802	Fusion of spine	C
22804	Fusion of spine	C
22808	Fusion of spine	C
22810	Fusion of spine	C
22812	Fusion of spine	C
22818	Kyphectomy, 1-2 segments	C
22819	Kyphectomy, 3 or more	C
22830	Exploration of spinal fusion	C
22840	Insert spine fixation device	C
22841	Insert spine fixation device	C
22842	Insert spine fixation device	C
22843	Insert spine fixation device	C
22844	Insert spine fixation device	C
22845	Insert spine fixation device	C
22846	Insert spine fixation device	C
22847	Insert spine fixation device	C
22848	Insert pelv fixation device	C
22849	Reinsert spinal fixation	C
22850	Remove spine fixation device	C
22852	Remove spine fixation device	C
22855	Remove spine fixation device	C
22857	Lumbar artif diskectomy	C
22862	Revise lumbar artif disc	C
22865	Remove lumb artif disc	C
23200	Removal of collar bone	C
23210	Removal of shoulder blade	C

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLYAS INPATIENT PROCEDURES FOR CY 2008—Continued

HCPCS code	Short descriptor	SI
23220	Partial removal of humerus	C
23221	Partial removal of humerus	C
23222	Partial removal of humerus	C
23332	Remove shoulder foreign body	C
23472	Reconstruct shoulder joint	C
23900	Amputation of arm & girdle	C
23920	Amputation at shoulder joint	C
24900	Amputation of upper arm	C
24920	Amputation of upper arm	C
24930	Amputation follow-up surgery	C
24931	Amputate upper arm & implant	C
24940	Revision of upper arm	C
25900	Amputation of forearm	C
25905	Amputation of forearm	C
25909	Amputation follow-up surgery	C
25915	Amputation of forearm	C
25920	Amputate hand at wrist	C
25924	Amputation follow-up surgery	C
25927	Amputation of hand	C
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	Partial removal of hip bone	C
27071	Partial removal of hip bone	C
27075	Extensive hip surgery	C
27076	Extensive hip surgery	C
27077	Extensive hip surgery	C
27078	Extensive hip surgery	C
27079	Extensive hip surgery	C
27090	Removal of hip prosthesis	C
27091	Removal of hip prosthesis	C
27120	Reconstruction of hip socket	C
27122	Reconstruction of hip socket	C
27125	Partial hip replacement	C
27130	Total hip arthroplasty	C
27132	Total hip arthroplasty	C
27134	Revise hip joint replacement	C
27137	Revise hip joint replacement	C
27138	Revise hip joint replacement	C
27140	Transplant femur ridge	C
27146	Incision of hip bone	C
27147	Revision of hip bone	C
27151	Incision of hip bones	C
27156	Revision of hip bones	C
27158	Revision of pelvis	C
27161	Incision of neck of femur	C
27165	Incision/fixation of femur	C
27170	Repair/graft femur head/neck	C
27175	Treat slipped epiphysis	C
27176	Treat slipped epiphysis	C
27177	Treat slipped epiphysis	C
27178	Treat slipped epiphysis	C
27179	Revise head/neck of femur	C
27181	Treat slipped epiphysis	C
27185	Revision of femur epiphysis	C
27187	Reinforce hip bones	C
27215	Treat pelvic fracture(s)	C
27217	Treat pelvic ring fracture	C
27218	Treat pelvic ring fracture	C
27222	Treat hip socket fracture	C
27226	Treat hip wall fracture	C
27227	Treat hip fracture(s)	C
27228	Treat hip fracture(s)	C

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLYAS INPATIENT PROCEDURES FOR CY 2008—Continued

HCPCS code	Short descriptor	SI
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
27280	Fusion of sacroiliac joint	C
27282	Fusion of pubic bones	C
27284	Fusion of hip joint	C
27286	Fusion of hip joint	C
27290	Amputation of leg at hip	C
27295	Amputation of leg at hip	C
27303	Drainage of bone lesion	C
27365	Extensive leg surgery	C
27445	Revision of knee joint	C
27447	Total knee arthroplasty	C
27448	Incision of thigh	C
27450	Incision of thigh	C
27454	Realignment of thigh bone	C
27455	Realignment of knee	C
27457	Realignment of knee	C
27465	Shortening of thigh bone	C
27466	Lengthening of thigh bone	C
27468	Shorten/lengthen thighs	C
27470	Repair of thigh	C
27472	Repair/graft of thigh	C
27477	Surgery to stop leg growth	C
27479	Surgery to stop leg growth	C
27485	Surgery to stop leg growth	C
27486	Revise/replace knee joint	C
27487	Revise/replace knee joint	C
27488	Removal of knee prosthesis	C
27495	Reinforce thigh	C
27506	Treatment of thigh fracture	C
27507	Treatment of thigh fracture	C
27511	Treatment of thigh fracture	C
27513	Treatment of thigh fracture	C
27514	Treatment of thigh fracture	C
27519	Treat thigh fx growth plate	C
27535	Treat knee fracture	C
27536	Treat knee fracture	C
27540	Treat knee fracture	C
27556	Treat knee dislocation	C
27557	Treat knee dislocation	C
27558	Treat knee dislocation	C
27580	Fusion of knee	C
27590	Amputate leg at thigh	C
27591	Amputate leg at thigh	C
27592	Amputate leg at thigh	C
27596	Amputation follow-up surgery	C
27598	Amputate lower leg at knee	C
27645	Extensive lower leg surgery	C
27646	Extensive lower leg surgery	C
27702	Reconstruct ankle joint	C
27703	Reconstruction, ankle joint	C
27712	Realignment of lower leg	C
27715	Revision of lower leg	C
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

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLYAS INPATIENT PROCEDURES FOR CY 2008—Continued

HCPCS code	Short descriptor	SI
28805	Amputation thru metatarsal	C
31225	Removal of upper jaw	C
31230	Removal of upper jaw	C
31290	Nasal/sinus endoscopy, surg	C
31291	Nasal/sinus endoscopy, surg	C
31360	Removal of larynx	C
31365	Removal of larynx	C
31367	Partial removal of larynx	C
31368	Partial removal of larynx	C
31370	Partial removal of larynx	C
31375	Partial removal of larynx	C
31380	Partial removal of larynx	C
31382	Partial removal of larynx	C
31390	Removal of larynx & pharynx	C
31395	Reconstruct larynx & pharynx	C
31584	Treat larynx fracture	C
31587	Revision of larynx	C
31725	Clearance of airways	C
31760	Repair of windpipe	C
31766	Reconstruction of windpipe	C
31770	Repair/graft of bronchus	C
31775	Reconstruct bronchus	C
31780	Reconstruct windpipe	C
31781	Reconstruct windpipe	C
31786	Remove windpipe lesion	C
31800	Repair of windpipe injury	C
31805	Repair of windpipe injury	C
32035	Exploration of chest	C
32036	Exploration of chest	C
32095	Biopsy through chest wall	C
32100	Exploration/biopsy of chest	C
32110	Explore/repair chest	C
32120	Re-exploration of chest	C
32124	Explore chest free adhesions	C
32140	Removal of lung lesion(s)	C
32141	Remove/treat lung lesions	C
32150	Removal of lung lesion(s)	C
32151	Remove lung foreign body	C
32160	Open chest heart massage	C
32200	Drain, open, lung lesion	C
32215	Treat chest lining	C
32220	Release of lung	C
32225	Partial release of lung	C
32310	Removal of chest lining	C
32320	Free/remove chest lining	C
32402	Open biopsy chest lining	C
32440	Removal of lung	C
32442	Sleeve pneumonectomy	C
32445	Removal of lung	C
32480	Partial removal of lung	C
32482	Bilobectomy	C
32484	Segmentectomy	C
32486	Sleeve lobectomy	C
32488	Completion pneumonectomy	C
32491	Lung volume reduction	C
32500	Partial removal of lung	C
32501	Repair bronchus add-on	C
32503	Resect apical lung tumor	C
32504	Resect apical lung tum/chest	C
32540	Removal of lung lesion	C
32650	Thoracoscopy, surgical	C
32651	Thoracoscopy, surgical	C
32652	Thoracoscopy, surgical	C
32653	Thoracoscopy, surgical	C
32654	Thoracoscopy, surgical	C
32655	Thoracoscopy, surgical	C
32656	Thoracoscopy, surgical	C
32657	Thoracoscopy, surgical	C
32658	Thoracoscopy, surgical	C
32659	Thoracoscopy, surgical	C

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLYAS INPATIENT PROCEDURES FOR CY 2008—Continued

HCPCS code	Short descriptor	SI
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
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
33261	Ablate heart dysrhythm focus	C
33265	Ablate atria w/bypass, endo	C
33266	Ablate atria w/o bypass 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

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLYAS INPATIENT PROCEDURES FOR CY 2008—Continued

HCPCS code	Short descriptor	SI
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
33430	Replacement of mitral valve	C
33460	Revision of tricuspid valve	C
33463	Valvuloplasty, tricuspid	C
33464	Valvuloplasty, tricuspid	C
33465	Replace tricuspid valve	C
33468	Revision of tricuspid valve	C
33470	Revision of pulmonary valve	C
33471	Valvotomy, pulmonary valve	C
33472	Revision of pulmonary valve	C
33474	Revision of pulmonary valve	C
33475	Replacement, pulmonary valve	C
33476	Revision of heart chamber	C
33478	Revision of heart chamber	C
33496	Repair, prosth valve clot	C
33500	Repair heart vessel fistula	C
33501	Repair heart vessel fistula	C
33502	Coronary artery correction	C
33503	Coronary artery graft	C
33504	Coronary artery graft	C
33505	Repair artery w/tunnel	C
33506	Repair artery, translocation	C
33507	Repair art, intramural	C
33510	CABG, vein, single	C
33511	CABG, vein, two	C
33512	CABG, vein, three	C
33513	CABG, vein, four	C
33514	CABG, vein, five	C
33516	Cabg, vein, six or more	C
33517	CABG, artery-vein, single	C
33518	CABG, artery-vein, two	C
33519	CABG, artery-vein, three	C
33521	CABG, artery-vein, four	C
33522	CABG, artery-vein, five	C
33523	Cabg, art-vein, six or more	C
33530	Coronary artery, bypass/reop	C
33533	CABG, arterial, single	C
33534	CABG, arterial, two	C
33535	CABG, arterial, three	C
33536	Cabg, arterial, four or more	C
33542	Removal of heart lesion	C
33545	Repair of heart damage	C
33548	Restore/remodel, ventricle	C
33572	Open coronary endarterectomy	C
33600	Closure of valve	C
33602	Closure of valve	C
33606	Anastomosis/artery-aorta	C
33608	Repair anomaly w/conduit	C
33610	Repair by enlargement	C
33611	Repair double ventricle	C
33612	Repair double ventricle	C
33615	Repair, modified fontan	C
33617	Repair single ventricle	C
33619	Repair single ventricle	C
33641	Repair heart septum defect	C
33645	Revision of heart veins	C
33647	Repair heart septum defects	C
33660	Repair of heart defects	C
33665	Repair of heart defects	C
33670	Repair of heart chambers	C
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

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLYAS INPATIENT PROCEDURES FOR CY 2008—Continued

HCPCS code	Short descriptor	SI
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
33732	Repair heart-vein defect	C
33735	Revision of heart chamber	C
33736	Revision of heart chamber	C
33737	Revision of heart chamber	C
33750	Major vessel shunt	C
33755	Major vessel shunt	C
33762	Major vessel shunt	C
33764	Major vessel shunt & graft	C
33766	Major vessel shunt	C
33767	Major vessel shunt	C
33768	Cavopulmonary shunting	C
33770	Repair great vessels defect	C
33771	Repair great vessels defect	C
33774	Repair great vessels defect	C
33775	Repair great vessels defect	C
33776	Repair great vessels defect	C
33777	Repair great vessels defect	C
33778	Repair great vessels defect	C
33779	Repair great vessels defect	C
33780	Repair great vessels defect	C
33781	Repair great vessels defect	C
33786	Repair arterial trunk	C
33788	Revision of pulmonary artery	C
33800	Aortic suspension	C
33802	Repair vessel defect	C
33803	Repair vessel defect	C
33813	Repair septal defect	C
33814	Repair septal defect	C
33820	Revise major vessel	C
33822	Revise major vessel	C
33824	Revise major vessel	C
33840	Remove aorta constriction	C
33845	Remove aorta constriction	C
33851	Remove aorta constriction	C
33852	Repair septal defect	C
33853	Repair septal defect	C
33860	Ascending aortic graft	C
33861	Ascending aortic graft	C
33863	Ascending aortic graft	C
33870	Transverse aortic arch graft	C
33875	Thoracic aortic graft	C
33877	Thoracoabdominal graft	C
33880	Endovasc taa repr incl subcl	C
33881	Endovasc taa repr w/o subcl	C
33883	Insert endovasc prosth, taa	C
33884	Endovasc prosth, taa, add-on	C
33886	Endovasc prosth, delayed	C
33889	Artery transpose/endovas taa	C
33891	Car-car bp grft/endovas taa	C
33910	Remove lung artery emboli	C
33915	Remove lung artery emboli	C
33916	Surgery of great vessel	C
33917	Repair pulmonary artery	C
33920	Repair pulmonary atresia	C
33922	Transect pulmonary artery	C
33924	Remove pulmonary shunt	C
33925	Rpr pul art unifocal w/o cpb	C
33926	Repr pul art, unifocal w/cpb	C
33930	Removal of donor heart/lung	C

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLYAS INPATIENT PROCEDURES FOR CY 2008—Continued

HCPCS code	Short descriptor	SI
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
34001	Removal of artery clot	C
34051	Removal of artery clot	C
34151	Removal of artery clot	C
34401	Removal of vein clot	C
34451	Removal of vein clot	C
34502	Reconstruct vena cava	C
34800	Endovas aaa repr w/sm tube	C
34802	Endovas aaa repr w/2-p part	C
34803	Endovas aaa repr w/3-p part	C
34804	Endovas aaa repr w/1-p part	C
34805	Endovas aaa repr w/long tube	C
34808	Endovas iliac a device addon	C
34812	Xpose for endoprosth, femorl	C
34813	Femoral endovas graft add-on	C
34820	Xpose for endoprosth, iliac	C
34825	Endovasc extend prosth, init	C
34826	Endovasc exten prosth, add'l	C
34830	Open aortic tube prosth repr	C
34831	Open aortoiliac prosth repr	C
34832	Open aortofemor prosth repr	C
34833	Xpose for endoprosth, iliac	C
34834	Xpose, endoprosth, brachial	C
34900	Endovasc iliac repr w/graft	C
35001	Repair defect of artery	C
35002	Repair artery rupture, neck	C
35005	Repair defect of artery	C
35013	Repair artery rupture, arm	C
35021	Repair defect of artery	C
35022	Repair artery rupture, chest	C
35045	Repair defect of arm artery	C
35081	Repair defect of artery	C
35082	Repair artery rupture, aorta	C
35091	Repair defect of artery	C
35092	Repair artery rupture, aorta	C
35102	Repair defect of artery	C
35103	Repair artery rupture, groin	C
35111	Repair defect of artery	C
35112	Repair artery rupture,spleen	C
35121	Repair defect of artery	C
35122	Repair artery rupture, belly	C
35131	Repair defect of artery	C
35132	Repair artery rupture, groin	C
35141	Repair defect of artery	C
35142	Repair artery rupture, thigh	C
35151	Repair defect of artery	C
35152	Repair artery rupture, knee	C
35182	Repair blood vessel lesion	C
35189	Repair blood vessel lesion	C
35211	Repair blood vessel lesion	C
35216	Repair blood vessel lesion	C
35221	Repair blood vessel lesion	C

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLYAS INPATIENT PROCEDURES FOR CY 2008—Continued

HCPCS code	Short descriptor	SI
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
35454	Repair arterial blockage	C
35456	Repair arterial blockage	C
35480	Atherectomy, open	C
35481	Atherectomy, open	C
35482	Atherectomy, open	C
35483	Atherectomy, open	C
35501	Artery bypass graft	C
35506	Artery bypass graft	C
35508	Artery bypass graft	C
35509	Artery bypass graft	C
35510	Artery bypass graft	C
35511	Artery bypass graft	C
35512	Artery bypass graft	C
35515	Artery bypass graft	C
35516	Artery bypass graft	C
35518	Artery bypass graft	C
35521	Artery bypass graft	C
35522	Artery bypass graft	C
35525	Artery bypass graft	C
35526	Artery bypass graft	C
35531	Artery bypass graft	C
35533	Artery bypass graft	C
35536	Artery bypass graft	C
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
35571	Artery bypass graft	C
35583	Vein bypass graft	C
35585	Vein bypass graft	C
35587	Vein bypass graft	C
35600	Harvest artery for cabg	C
35601	Artery bypass graft	C
35606	Artery bypass graft	C
35612	Artery bypass graft	C
35616	Artery bypass graft	C

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLYAS INPATIENT PROCEDURES FOR CY 2008—Continued

HCPCS code	Short descriptor	SI
35621	Artery bypass graft	C
35623	Bypass graft, not vein	C
35626	Artery bypass graft	C
35631	Artery bypass graft	C
35636	Artery bypass graft	C
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
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

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLYAS INPATIENT PROCEDURES FOR CY 2008—Continued

HCPCS code	Short descriptor	SI
39010	Exploration of chest	C
39200	Removal chest lesion	C
39220	Removal chest lesion	C
39499	Chest procedure	C
39501	Repair diaphragm laceration	C
39502	Repair paraesophageal hernia	C
39503	Repair of diaphragm hernia	C
39520	Repair of diaphragm hernia	C
39530	Repair of diaphragm hernia	C
39531	Repair of diaphragm hernia	C
39540	Repair of diaphragm hernia	C
39541	Repair of diaphragm hernia	C
39545	Revision of diaphragm	C
39560	Resect diaphragm, simple	C
39561	Resect diaphragm, complex	C
39599	Diaphragm surgery procedure	C
41130	Partial removal of tongue	C
41135	Tongue and neck surgery	C
41140	Removal of tongue	C
41145	Tongue removal, neck surgery	C
41150	Tongue, mouth, jaw surgery	C
41153	Tongue, mouth, neck surgery	C
41155	Tongue, jaw, & neck surgery	C
42426	Excise parotid gland/lesion	C
42845	Extensive surgery of throat	C
42894	Revision of pharyngeal walls	C
42953	Repair throat, esophagus	C
42961	Control throat bleeding	C
42971	Control nose/throat bleeding	C
43045	Incision of esophagus	C
43100	Excision of esophagus lesion	C
43101	Excision of esophagus lesion	C
43107	Removal of esophagus	C
43108	Removal of esophagus	C
43112	Removal of esophagus	C
43113	Removal of esophagus	C
43116	Partial removal of esophagus	C
43117	Partial removal of esophagus	C
43118	Partial removal of esophagus	C
43121	Partial removal of esophagus	C
43122	Partial removal of esophagus	C
43123	Partial removal of esophagus	C
43124	Removal of esophagus	C
43135	Removal of esophagus pouch	C
43300	Repair of esophagus	C
43305	Repair esophagus and fistula	C
43310	Repair of esophagus	C
43312	Repair esophagus and fistula	C
43313	Esophagoplasty congenital	C
43314	Tracheo-esophagoplasty cong	C
43320	Fuse esophagus & stomach	C
43324	Revise esophagus & stomach	C
43325	Revise esophagus & stomach	C
43326	Revise esophagus & stomach	C
43330	Repair of esophagus	C
43331	Repair of esophagus	C
43340	Fuse esophagus & intestine	C
43341	Fuse esophagus & intestine	C
43350	Surgical opening, esophagus	C
43351	Surgical opening, esophagus	C
43352	Surgical opening, esophagus	C
43360	Gastrointestinal repair	C
43361	Gastrointestinal repair	C
43400	Ligate esophagus veins	C
43401	Esophagus surgery for veins	C
43405	Ligate/staple esophagus	C
43410	Repair esophagus wound	C
43415	Repair esophagus wound	C
43420	Repair esophagus opening	C
43425	Repair esophagus opening	C

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLYAS INPATIENT PROCEDURES FOR CY 2008—Continued

HCPCS code	Short descriptor	SI
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
43641	Vagotomy & pylorus repair	C
43644	Lap gastric bypass/roux-en-y	C
43645	Lap gastr bypass incl smll i	C
43770	Lap, place gastr adjust band	C
43771	Lap, revise adjust gast band	C
43772	Lap, remove adjust gast band	C
43773	Lap, change adjust gast band	C
43774	Lap remov adj gast band/port	C
43800	Reconstruction of pylorus	C
43810	Fusion of stomach and bowel	C
43820	Fusion of stomach and bowel	C
43825	Fusion of stomach and bowel	C
43832	Place gastrostomy tube	C
43840	Repair of stomach lesion	C
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
44128	Enterectomy cong, add-on	C
44130	Bowel to bowel fusion	C
44132	Enterectomy, cadaver donor	C
44133	Enterectomy, live donor	C
44135	Intestine transplnt, cadaver	C
44136	Intestine transplant, live	C
44137	Remove intestinal allograft	C
44139	Mobilization of colon	C
44140	Partial removal of colon	C
44141	Partial removal of colon	C
44143	Partial removal of colon	C

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLYAS INPATIENT PROCEDURES FOR CY 2008—Continued

HCPCS code	Short descriptor	SI
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
44603	Suture, small intestine	C
44604	Suture, large intestine	C
44605	Repair of bowel lesion	C
44615	Intestinal stricturoplasty	C
44620	Repair bowel opening	C
44625	Repair bowel opening	C
44626	Repair bowel opening	C
44640	Repair bowel-skin fistula	C
44650	Repair bowel fistula	C
44660	Repair bowel-bladder fistula	C
44661	Repair bowel-bladder fistula	C
44680	Surgical revision, intestine	C
44700	Suspend bowel w/prosthesis	C
44715	Prepare donor intestine	C
44720	Prep donor intestine/venous	C
44721	Prep donor intestine/artery	C
44800	Excision of bowel pouch	C
44820	Excision of mesentery lesion	C
44850	Repair of mesentery	C
44899	Bowel surgery procedure	C
44900	Drain app abscess, open	C
44950	Appendectomy	C
44955	Appendectomy add-on	C
44960	Appendectomy	C
45110	Removal of rectum	C
45111	Partial removal of rectum	C
45112	Removal of rectum	C
45113	Partial proctectomy	C
45114	Partial removal of rectum	C
45116	Partial removal of rectum	C
45119	Remove rectum w/reservoir	C
45120	Removal of rectum	C
45121	Removal of rectum and colon	C
45123	Partial proctectomy	C
45126	Pelvic exenteration	C
45130	Excision of rectal prolapse	C
45135	Excision of rectal prolapse	C
45136	Excise ileoanal reservior	C
45395	Lap, removal of rectum	C
45397	Lap, remove rectum w/pouch	C

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLYAS INPATIENT PROCEDURES FOR CY 2008—Continued

HCPCS code	Short descriptor	SI
45400	Laparoscopic proc	C
45402	Lap proctopexy w/sig resect	C
45540	Correct rectal prolapse	C
45550	Repair rectum/remove sigmoid	C
45562	Exploration/repair of rectum	C
45563	Exploration/repair of rectum	C
45800	Repair rect/bladder fistula	C
45805	Repair fistula w/colostomy	C
45820	Repair rectourethral fistula	C
45825	Repair fistula w/colostomy	C
46705	Repair of anal stricture	C
46710	Repr per/vag pouch sngl proc	C
46712	Repr per/vag pouch dbl proc	C
46715	Rep perf anoper fistu	C
46716	Rep perf anoper/vestib fistu	C
46730	Construction of absent anus	C
46735	Construction of absent anus	C
46740	Construction of absent anus	C
46742	Repair of imperforated anus	C
46744	Repair of cloacal anomaly	C
46746	Repair of cloacal anomaly	C
46748	Repair of cloacal anomaly	C
46751	Repair of anal sphincter	C
47010	Open drainage, liver lesion	C
47015	Inject/aspirate liver cyst	C
47100	Wedge biopsy of liver	C
47120	Partial removal of liver	C
47122	Extensive removal of liver	C
47125	Partial removal of liver	C
47130	Partial removal of liver	C
47133	Removal of donor liver	C
47135	Transplantation of liver	C
47136	Transplantation of liver	C
47140	Partial removal, donor liver	C
47141	Partial removal, donor liver	C
47142	Partial removal, donor liver	C
47143	Prep donor liver, whole	C
47144	Prep donor liver, 3-segment	C
47145	Prep donor liver, lobe split	C
47146	Prep donor liver/venous	C
47147	Prep donor liver/arterial	C
47300	Surgery for liver lesion	C
47350	Repair liver wound	C
47360	Repair liver wound	C
47361	Repair liver wound	C
47362	Repair liver wound	C
47380	Open ablate liver tumor rf	C
47381	Open ablate liver tumor cryo	C
47400	Incision of liver duct	C
47420	Incision of bile duct	C
47425	Incision of bile duct	C
47460	Incise bile duct sphincter	C
47480	Incision of gallbladder	C
47550	Bile duct endoscopy add-on	C
47570	Laparo cholecystoenterostomy	C
47600	Removal of gallbladder	C
47605	Removal of gallbladder	C
47610	Removal of gallbladder	C
47612	Removal of gallbladder	C
47620	Removal of gallbladder	C
47700	Exploration of bile ducts	C
47701	Bile duct revision	C
47711	Excision of bile duct tumor	C
47712	Excision of bile duct tumor	C
47715	Excision of bile duct cyst	C
47719	Fusion 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

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLYAS INPATIENT PROCEDURES FOR CY 2008—Continued

HCPCS code	Short descriptor	SI
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
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
49201	Remove abdom lesion, complex	C
49215	Excise sacral spine tumor	C
49220	Multiple surgery, abdomen	C
49255	Removal of omentum	C
49425	Insert abdomen-venous drain	C
49428	Ligation of shunt	C
49605	Repair umbilical lesion	C
49606	Repair umbilical lesion	C
49610	Repair umbilical lesion	C
49611	Repair umbilical lesion	C
49900	Repair of abdominal wall	C
49904	Omental flap, extra-abdom	C
49905	Omental flap, intra-abdom	C
49906	Free omental flap, microvasc	C
50010	Exploration of kidney	C
50040	Drainage of kidney	C
50045	Exploration of kidney	C
50060	Removal of kidney stone	C
50065	Incision of kidney	C
50070	Incision of kidney	C
50075	Removal of kidney stone	C
50100	Revise kidney blood vessels	C
50120	Exploration of kidney	C
50125	Explore and drain kidney	C
50130	Removal of kidney stone	C
50135	Exploration of kidney	C
50205	Biopsy of kidney	C
50220	Remove kidney, open	C

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLYAS INPATIENT PROCEDURES FOR CY 2008—Continued

HCPCS code	Short descriptor	SI
50225	Removal kidney open, complex	C
50230	Removal kidney open, radical	C
50234	Removal of kidney & ureter	C
50236	Removal of kidney & ureter	C
50240	Partial removal of kidney	C
50250	Cryoablate renal mass open	C
50280	Removal of kidney lesion	C
50290	Removal of kidney lesion	C
50300	Remove cadaver donor kidney	C
50320	Remove kidney, living donor	C
50323	Prep cadaver renal allograft	C
50325	Prep donor renal graft	C
50327	Prep renal graft/venous	C
50328	Prep renal graft/arterial	C
50329	Prep renal graft/ureteral	C
50340	Removal of kidney	C
50360	Transplantation of kidney	C
50365	Transplantation of kidney	C
50370	Remove transplanted kidney	C
50380	Reimplantation of kidney	C
50400	Revision of kidney/ureter	C
50405	Revision of kidney/ureter	C
50500	Repair of kidney wound	C
50520	Close kidney-skin fistula	C
50525	Repair renal-abdomen fistula	C
50526	Repair renal-abdomen fistula	C
50540	Revision of horseshoe kidney	C
50545	Laparo radical nephrectomy	C
50546	Laparoscopic nephrectomy	C
50547	Laparo removal donor kidney	C
50548	Laparo remove w/ureter	C
50600	Exploration of ureter	C
50605	Insert ureteral support	C
50610	Removal of ureter stone	C
50620	Removal of ureter stone	C
50630	Removal of ureter stone	C
50650	Removal of ureter	C
50660	Removal of ureter	C
50700	Revision of ureter	C
50715	Release of ureter	C
50722	Release of ureter	C
50725	Release/revise ureter	C
50727	Revise ureter	C
50728	Revise ureter	C
50740	Fusion of ureter & kidney	C
50750	Fusion of ureter & kidney	C
50760	Fusion of ureters	C
50770	Splicing of ureters	C
50780	Reimplant ureter in bladder	C
50782	Reimplant ureter in bladder	C
50783	Reimplant ureter in bladder	C
50785	Reimplant ureter in bladder	C
50800	Implant ureter in bowel	C
50810	Fusion of ureter & bowel	C
50815	Urine shunt to intestine	C
50820	Construct bowel bladder	C
50825	Construct bowel bladder	C
50830	Revise urine flow	C
50840	Replace ureter by bowel	C
50845	Appendico-vesicostomy	C
50860	Transplant ureter to skin	C
50900	Repair of ureter	C
50920	Closure ureter/skin fistula	C
50930	Closure ureter/bowel fistula	C
50940	Release of ureter	C
51060	Removal of ureter stone	C
51525	Removal of bladder lesion	C
51530	Removal of bladder lesion	C
51550	Partial removal of bladder	C
51555	Partial removal of bladder	C

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLYAS INPATIENT PROCEDURES FOR CY 2008—Continued

HCPCS code	Short descriptor	SI
51565	Revise bladder & ureter(s)	C
51570	Removal of bladder	C
51575	Removal of bladder & nodes	C
51580	Remove bladder/revise tract	C
51585	Removal of bladder & nodes	C
51590	Remove bladder/revise tract	C
51595	Remove bladder/revise tract	C
51596	Remove bladder/create pouch	C
51597	Removal of pelvic structures	C
51800	Revision of bladder/urethra	C
51820	Revision of urinary tract	C
51840	Attach bladder/urethra	C
51841	Attach bladder/urethra	C
51845	Repair bladder neck	C
51860	Repair of bladder wound	C
51865	Repair of bladder wound	C
51900	Repair bladder/vagina lesion	C
51920	Close bladder-uterus fistula	C
51925	Hysterectomy/bladder repair	C
51940	Correction of bladder defect	C
51960	Revision of bladder & bowel	C
51980	Construct bladder opening	C
53415	Reconstruction of urethra	C
53448	Remov/replc ur sphinctr comp	C
54125	Removal of penis	C
54130	Remove penis & nodes	C
54135	Remove penis & nodes	C
54332	Revise penis/urethra	C
54336	Revise penis/urethra	C
54390	Repair penis and bladder	C
54411	Remov/replc penis pros, comp	C
54417	Remv/replc penis pros, compl	C
54430	Revision of penis	C
54535	Extensive testis surgery	C
54650	Orchiopexy (Fowler-Stephens)	C
55605	Incise sperm duct pouch	C
55650	Remove sperm duct pouch	C
55801	Removal of prostate	C
55810	Extensive prostate surgery	C
55812	Extensive prostate surgery	C
55815	Extensive prostate surgery	C
55821	Removal of prostate	C
55831	Removal of prostate	C
55840	Extensive prostate surgery	C
55842	Extensive prostate surgery	C
55845	Extensive prostate surgery	C
55862	Extensive prostate surgery	C
55865	Extensive prostate surgery	C
55866	Laparo radical prostatectomy	C
56630	Extensive vulva surgery	C
56631	Extensive vulva surgery	C
56632	Extensive vulva surgery	C
56633	Extensive vulva surgery	C
56634	Extensive vulva surgery	C
56637	Extensive vulva surgery	C
56640	Extensive vulva surgery	C
57110	Remove vagina wall, complete	C
57111	Remove vagina tissue, compl	C
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

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLYAS INPATIENT PROCEDURES FOR CY 2008—Continued

HCPCS code	Short descriptor	SI
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
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	Revise fallopian tube(s)	C
58750	Repair oviduct	C
58752	Revise ovarian tube(s)	C
58760	Remove tubal obstruction	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
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

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLYAS INPATIENT PROCEDURES FOR CY 2008—Continued

HCPCS code	Short descriptor	SI
61140	Pierce skull for biopsy	C
61150	Pierce skull for drainage	C
61151	Pierce skull for drainage	C
61154	Pierce skull & remove clot	C
61156	Pierce skull for drainage	C
61210	Pierce skull, implant device	C
61250	Pierce skull & explore	C
61253	Pierce skull & explore	C
61304	Open skull for exploration	C
61305	Open skull for exploration	C
61312	Open skull for drainage	C
61313	Open skull for drainage	C
61314	Open skull for drainage	C
61315	Open skull for drainage	C
61316	Implt cran bone flap to abdo	C
61320	Open skull for drainage	C
61321	Open skull for drainage	C
61322	Decompressive craniotomy	C
61323	Decompressive lobectomy	C
61332	Explore/biopsy eye socket	C
61333	Explore orbit/remove lesion	C
61340	Subtemporal decompression	C
61343	Incise skull (press relief)	C
61345	Relieve cranial pressure	C
61440	Incise skull for surgery	C
61450	Incise skull for surgery	C
61458	Incise skull for brain wound	C
61460	Incise skull for surgery	C
61470	Incise skull for surgery	C
61480	Incise skull for surgery	C
61490	Incise skull for surgery	C
61500	Removal of skull lesion	C
61501	Remove infected skull bone	C
61510	Removal of brain lesion	C
61512	Remove brain lining lesion	C
61514	Removal of brain abscess	C
61516	Removal of brain lesion	C
61517	Implt brain chemotx add-on	C
61518	Removal of brain lesion	C
61519	Remove brain lining lesion	C
61520	Removal of brain lesion	C
61521	Removal of brain lesion	C
61522	Removal of brain abscess	C
61524	Removal of brain lesion	C
61526	Removal of brain lesion	C
61530	Removal of brain lesion	C
61531	Implant brain electrodes	C
61533	Implant brain electrodes	C
61534	Removal of brain lesion	C
61535	Remove brain electrodes	C
61536	Removal of brain lesion	C
61537	Removal of brain tissue	C
61538	Removal of brain tissue	C
61539	Removal of brain tissue	C
61540	Removal of brain tissue	C
61541	Incision of brain tissue	C
61542	Removal of brain tissue	C
61543	Removal of brain tissue	C
61544	Remove & treat brain lesion	C
61545	Excision of brain tumor	C
61546	Removal of pituitary gland	C
61548	Removal of pituitary gland	C
61550	Release of skull seams	C
61552	Release of skull seams	C
61556	Incise skull/sutures	C
61557	Incise skull/sutures	C
61558	Excision of skull/sutures	C
61559	Excision of skull/sutures	C
61563	Excision of skull tumor	C
61564	Excision of skull tumor	C

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLYAS INPATIENT PROCEDURES FOR CY 2008—Continued

HCPCS code	Short descriptor	SI
61566	Removal of brain tissue	C
61567	Incision of brain tissue	C
61570	Remove foreign body, brain	C
61571	Incise skull for brain wound	C
61575	Skull base/brainstem surgery	C
61576	Skull base/brainstem surgery	C
61580	Craniofacial approach, skull	C
61581	Craniofacial approach, skull	C
61582	Craniofacial approach, skull	C
61583	Craniofacial approach, skull	C
61584	Orbitocranial approach/skull	C
61585	Orbitocranial approach/skull	C
61586	Resect nasopharynx, skull	C
61590	Infratemporal approach/skull	C
61591	Infratemporal approach/skull	C
61592	Orbitocranial approach/skull	C
61595	Transtemporal approach/skull	C
61596	Transcochlear approach/skull	C
61597	Transcondylar approach/skull	C
61598	Transpetrosal approach/skull	C
61600	Resect/excise cranial lesion	C
61601	Resect/excise cranial lesion	C
61605	Resect/excise cranial lesion	C
61606	Resect/excise cranial lesion	C
61607	Resect/excise cranial lesion	C
61608	Resect/excise cranial lesion	C
61609	Transect artery, sinus	C
61610	Transect artery, sinus	C
61611	Transect artery, sinus	C
61612	Transect artery, sinus	C
61613	Remove aneurysm, sinus	C
61615	Resect/excise lesion, skull	C
61616	Resect/excise lesion, skull	C
61618	Repair dura	C
61619	Repair dura	C
61624	Transcath occlusion, cns	C
61680	Intracranial vessel surgery	C
61682	Intracranial vessel surgery	C
61684	Intracranial vessel surgery	C
61686	Intracranial vessel surgery	C
61690	Intracranial vessel surgery	C
61692	Intracranial vessel surgery	C
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, add'l	C
61870	Implant neuroelectrodes	C
61875	Implant neuroelectrodes	C
62005	Treat skull fracture	C
62010	Treatment of head injury	C
62100	Repair brain fluid leakage	C
62115	Reduction of skull defect	C
62116	Reduction of skull defect	C
62117	Reduction of skull defect	C
62120	Repair skull cavity lesion	C

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLYAS INPATIENT PROCEDURES FOR CY 2008—Continued

HCPCS code	Short descriptor	SI
62121	Incise skull repair	C
62140	Repair of skull defect	C
62141	Repair of skull defect	C
62142	Remove skull plate/flap	C
62143	Replace skull plate/flap	C
62145	Repair of skull & brain	C
62146	Repair of skull with graft	C
62147	Repair of skull with graft	C
62148	Retr bone flap to fix skull	C
62161	Dissect brain w/scope	C
62162	Remove colloid cyst w/scope	C
62163	Neuroendoscopy w/fb removal	C
62164	Remove brain tumor w/scope	C
62165	Remove pituit tumor w/scope	C
62180	Establish brain cavity shunt	C
62190	Establish brain cavity shunt	C
62192	Establish brain cavity shunt	C
62200	Establish brain cavity shunt	C
62201	Brain cavity shunt w/scope	C
62220	Establish brain cavity shunt	C
62223	Establish brain cavity shunt	C
62256	Remove brain cavity shunt	C
62258	Replace brain cavity shunt	C
63043	Laminotomy, add'l cervical	C
63044	Laminotomy, add'l lumbar	C
63050	Cervical laminoplasty	C
63051	C-laminoplasty w/graft/plate	C
63076	Neck spine disk surgery	C
63077	Spine disk surgery, thorax	C
63078	Spine disk surgery, thorax	C
63081	Removal of vertebral body	C
63082	Remove vertebral body add-on	C
63085	Removal of vertebral body	C
63086	Remove vertebral body add-on	C
63087	Removal of vertebral body	C
63088	Remove vertebral body add-on	C
63090	Removal of vertebral body	C
63091	Remove vertebral body add-on	C
63101	Removal of vertebral body	C
63102	Removal of vertebral body	C
63103	Remove vertebral body add-on	C
63170	Incise spinal cord tract(s)	C
63172	Drainage of spinal cyst	C
63173	Drainage of spinal cyst	C
63180	Revise spinal cord ligaments	C
63182	Revise spinal cord ligaments	C
63185	Incise spinal column/nerves	C
63190	Incise spinal column/nerves	C
63191	Incise spinal column/nerves	C
63194	Incise spinal column & cord	C
63195	Incise spinal column & cord	C
63196	Incise spinal column & cord	C
63197	Incise spinal column & cord	C
63198	Incise spinal column & cord	C
63199	Incise spinal column & cord	C
63200	Release of spinal cord	C
63250	Revise spinal cord vessels	C
63251	Revise spinal cord vessels	C
63252	Revise spinal cord vessels	C
63265	Excise intraspinal lesion	C
63266	Excise intraspinal lesion	C
63267	Excise intraspinal lesion	C
63268	Excise intraspinal lesion	C
63270	Excise intraspinal lesion	C
63271	Excise intraspinal lesion	C
63272	Excise intraspinal lesion	C
63273	Excise intraspinal lesion	C
63275	Biopsy/excise spinal tumor	C
63276	Biopsy/excise spinal tumor	C
63277	Biopsy/excise spinal tumor	C

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLYAS INPATIENT PROCEDURES FOR CY 2008—Continued

HCPCS code	Short descriptor	SI
63278	Biopsy/excise spinal tumor	C
63280	Biopsy/excise spinal tumor	C
63281	Biopsy/excise spinal tumor	C
63282	Biopsy/excise spinal tumor	C
63283	Biopsy/excise spinal tumor	C
63285	Biopsy/excise spinal tumor	C
63286	Biopsy/excise spinal tumor	C
63287	Biopsy/excise spinal tumor	C
63290	Biopsy/excise spinal tumor	C
63295	Repair of laminectomy defect	C
63300	Removal of vertebral body	C
63301	Removal of vertebral body	C
63302	Removal of vertebral body	C
63303	Removal of vertebral body	C
63304	Removal of vertebral body	C
63305	Removal of vertebral body	C
63306	Removal of vertebral body	C
63307	Removal of vertebral body	C
63308	Remove vertebral body add-on	C
63700	Repair of spinal herniation	C
63702	Repair of spinal herniation	C
63704	Repair of spinal herniation	C
63706	Repair of spinal herniation	C
63707	Repair spinal fluid leakage	C
63709	Repair spinal fluid leakage	C
63710	Graft repair of spine defect	C
63740	Install spinal shunt	C
64752	Incision of vagus nerve	C
64755	Incision of stomach nerves	C
64760	Incision of vagus nerve	C
64809	Remove sympathetic nerves	C
64818	Remove sympathetic nerves	C
64866	Fusion of facial/other nerve	C
64868	Fusion of facial/other nerve	C
65273	Repair of eye wound	C
69155	Extensive ear/neck surgery	C
69535	Remove part of temporal bone	C
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
99251	Inpatient consultation	C
99252	Inpatient consultation	C
99253	Inpatient consultation	C
99254	Inpatient consultation	C
99255	Inpatient consultation	C
99293	Ped critical care, initial	C
99294	Ped critical care, subseq	C
99295	Neonate crit care, initial	C
99296	Neonate critical care subseq	C
99298	Ic for lbw infant < 1500 gm	C
99299	Ic, lbw infant 1500-2500 gm	C
99356	Prolonged service, inpatient	C
99357	Prolonged service, inpatient	C
99433	Normal newborn care/hospital	C
0024T	Transcath cardiac reduction	C

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLYAS INPATIENT PROCEDURES FOR CY 2008—Continued

HCPCS code	Short descriptor	SI
0048T	Implant ventricular device	C
0049T	External circulation assist	C
0050T	Removal circulation assist	C
0051T	Implant total heart system	C
0052T	Replace component heart syst	C
0053T	Replace component heart syst	C
0075T	Perq stent/chest vert art	C
0076T	S&i stent/chest vert art	C
0077T	Cereb therm perfusion probe	C
0078T	Endovasc aort repr w/device	C
0079T	Endovasc visc extnsn repr	C
0080T	Endovasc aort repr rad s&i	C
0081T	Endovasc visc extnsn s&i	C
0090T	Cervical artific disc	C
0092T	Artific disc addl	C
0093T	Cervical artific diskectomy	C
0095T	Artific diskectomy addl	C
0096T	Rev cervical artific disc	C
0098T	Rev artific disc addl	C
0153T	Tcath sensor aneurysm sac	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
G0341	Percutaneous islet celltrans	C
G0342	Laparoscopy islet cell trans	C
G0343	Laparotomy islet cell transp	C

ADDENDUM L.—PROPOSED OUT-MIGRATION ADJUSTMENT

Provider No.	Out-Migration adjustment	Qualifying county name
010005	0.0322	MARSHALL
010008	0.0245	CRENSHAW
010009	0.0092	MORGAN
010010	0.0322	MARSHALL
010012	0.0182	DE KALB
010015	0.0043	CLARKE
010022	0.1106	CHEROKEE
010025	0.0235	CHAMBERS
010029	0.0281	LEE
010032	0.0320	RANDOLPH
010035	0.0263	CULLMAN
010038	0.0039	CALHOUN
010045	0.0216	FAYETTE
010047	0.0178	BUTLER
010052	0.0103	TALLAPOOSA
010054	0.0092	MORGAN
010061	0.0566	JACKSON
010065	0.0103	TALLAPOOSA
010078	0.0039	CALHOUN
010083	0.0125	BALDWIN
010085	0.0092	MORGAN
010091	0.0043	CLARKE
010100	0.0125	BALDWIN
010101	0.0209	TALLADEGA
010109	0.0451	PICKENS
010110	0.0302	BULLOCK
010125	0.0471	WINSTON
010128	0.0043	CLARKE
010129	0.0125	BALDWIN
010138	0.0113	SUMTER
010143	0.0263	CULLMAN
010146	0.0039	CALHOUN
010150	0.0178	BUTLER
010158	0.0067	FRANKLIN
010164	0.0209	TALLADEGA
013027	0.0125	BALDWIN
030040	0.0012	SANTA CRUZ
030067	0.0230	LAPAZ
040014	0.0163	WHITE
040019	0.0254	ST. FRANCIS
040039	0.0172	GREENE
040047	0.0117	RANDOLPH
040067	0.0008	COLUMBIA
040071	0.0149	JEFFERSON
040076	0.1001	HOT SPRING
040081	0.0358	PIKE
040100	0.0163	WHITE
050002	0.0009	ALAMEDA
050007	0.0141	SAN MATEO
050008	0.0026	SAN FRANCISCO
050009	0.0196	NAPA
050013	0.0196	NAPA
050014	0.0147	AMADOR
050016	0.0103	SAN LUIS OBISPO
050042	0.0184	TEHAMA
050043	0.0009	ALAMEDA
050047	0.0026	SAN FRANCISCO
050055	0.0026	SAN FRANCISCO
050069	0.0006	ORANGE
050070	0.0141	SAN MATEO
050073	0.0169	SOLANO
050075	0.0009	ALAMEDA
050076	0.0026	SAN FRANCISCO
050084	0.0135	SAN JOAQUIN
050089	0.0005	SAN BERNARDINO
050090	0.0085	SONOMA
050099	0.0005	SAN BERNARDINO
050101	0.0169	SOLANO
050113	0.0141	SAN MATEO
050118	0.0135	SAN JOAQUIN
050122	0.0135	SAN JOAQUIN

ADDENDUM L.—PROPOSED OUT-MIGRATION ADJUSTMENT—Continued

Provider No.	Out-Migration adjustment	Qualifying county name
050129	0.0005	SAN BERNARDINO
050133	0.0186	YUBA
050136	0.0085	SONOMA
050140	0.0005	SAN BERNARDINO
050150	0.0357	NEVADA
050152	0.0026	SAN FRANCISCO
050167	0.0135	SAN JOAQUIN
050168	0.0006	ORANGE
050173	0.0006	ORANGE
050174	0.0085	SONOMA
050193	0.0006	ORANGE
050194	0.0052	SANTA CRUZ
050195	0.0009	ALAMEDA
050197	0.0141	SAN MATEO
050211	0.0009	ALAMEDA
050224	0.0006	ORANGE
050226	0.0006	ORANGE
050228	0.0026	SAN FRANCISCO
050230	0.0006	ORANGE
050232	0.0103	SAN LUIS OBISPO
050242	0.0052	SANTA CRUZ
050245	0.0005	SAN BERNARDINO
050264	0.0009	ALAMEDA
050272	0.0005	SAN BERNARDINO
050279	0.0005	SAN BERNARDINO
050283	0.0009	ALAMEDA
050289	0.0141	SAN MATEO
050291	0.0085	SONOMA
050298	0.0005	SAN BERNARDINO
050300	0.0005	SAN BERNARDINO
050305	0.0009	ALAMEDA
050313	0.0135	SAN JOAQUIN
050320	0.0009	ALAMEDA
050325	0.0046	TUOLUMNE
050327	0.0005	SAN BERNARDINO
050335	0.0046	TUOLUMNE
050336	0.0135	SAN JOAQUIN
050348	0.0006	ORANGE
050366	0.0025	CALAVERAS
050367	0.0169	SOLANO
050385	0.0085	SONOMA
050407	0.0026	SAN FRANCISCO
050426	0.0006	ORANGE
050444	0.0229	MERCED
050454	0.0026	SAN FRANCISCO
050457	0.0026	SAN FRANCISCO
050476	0.0275	LAKE
050488	0.0009	ALAMEDA
050494	0.0357	NEVADA
050506	0.0103	SAN LUIS OBISPO
050512	0.0009	ALAMEDA
050517	0.0005	SAN BERNARDINO
050526	0.0006	ORANGE
050528	0.0229	MERCED
050541	0.0141	SAN MATEO
050543	0.0006	ORANGE
050547	0.0085	SONOMA
050548	0.0006	ORANGE
050551	0.0006	ORANGE
050567	0.0006	ORANGE
050570	0.0006	ORANGE
050580	0.0006	ORANGE
050584	0.0005	SAN BERNARDINO
050586	0.0005	SAN BERNARDINO
050589	0.0006	ORANGE
050603	0.0006	ORANGE
050609	0.0006	ORANGE
050618	0.0005	SAN BERNARDINO
050633	0.0103	SAN LUIS OBISPO
050667	0.0196	NAPA
050668	0.0026	SAN FRANCISCO

ADDENDUM L.—PROPOSED OUT-MIGRATION ADJUSTMENT—Continued

Provider No.	Out-Migration adjustment	Qualifying county name
050678	0.0006	ORANGE
050680	0.0169	SOLANO
050690	0.0085	SONOMA
050693	0.0006	ORANGE
050707	0.0141	SAN MATEO
050714	0.0052	SANTA CRUZ
050720	0.0006	ORANGE
050744	0.0006	ORANGE
050745	0.0006	ORANGE
050746	0.0006	ORANGE
050747	0.0006	ORANGE
050748	0.0135	SAN JOAQUIN
050754	0.0141	SAN MATEO
050756	0.0005	SAN BERNARDINO
052034	0.0009	ALAMEDA
052035	0.0006	ORANGE
052037	0.0005	SAN BERNARDINO
052039	0.0006	ORANGE
053034	0.0006	ORANGE
053037	0.0005	SAN BERNARDINO
053301	0.0009	ALAMEDA
053304	0.0006	ORANGE
054074	0.0169	SOLANO
054093	0.0005	SAN BERNARDINO
054110	0.0009	ALAMEDA
054111	0.0005	SAN BERNARDINO
054122	0.0196	NAPA
054123	0.0135	SAN JOAQUIN
060001	0.0045	WELD
060003	0.0075	BOULDER
060010	0.0153	LARIMER
060027	0.0075	BOULDER
060030	0.0153	LARIMER
060103	0.0075	BOULDER
060116	0.0075	BOULDER
064007	0.0075	BOULDER
080001	0.0063	NEW CASTLE
080003	0.0063	NEW CASTLE
083300	0.0063	NEW CASTLE
084002	0.0063	NEW CASTLE
100014	0.0059	VOLUSIA
100017	0.0059	VOLUSIA
100045	0.0059	VOLUSIA
100047	0.0026	CHARLOTTE
100068	0.0059	VOLUSIA
100072	0.0059	VOLUSIA
100077	0.0026	CHARLOTTE
100102	0.0125	COLUMBIA
100118	0.0179	FLAGLER
100156	0.0125	COLUMBIA
100232	0.0057	PUTNAM
100236	0.0026	CHARLOTTE
100252	0.0146	OKEECHOBEE
100290	0.0582	SUMTER
110023	0.0416	GORDON
110029	0.0056	HALL
110040	0.1727	JACKSON
110041	0.0624	HABERSHAM
110100	0.0789	JEFFERSON
110101	0.0067	COOK
110142	0.0202	EVANS
110146	0.0805	CAMDEN
110150	0.0227	BALDWIN
110187	0.0643	LUMPKIN
110190	0.0242	MACON
110205	0.0514	GILMER
130024	0.0422	BONNER
130049	0.0320	KOOTENAI
130066	0.0320	KOOTENAI
130067	0.0696	BINGHAM
130068	0.0320	KOOTENAI

ADDENDUM L.—PROPOSED OUT-MIGRATION ADJUSTMENT—Continued

Provider No.	Out-Migration adjustment	Qualifying county name
140001	0.0362	FULTON
140026	0.0288	LA SALLE
140043	0.0055	WHITESIDE
140058	0.0125	MORGAN
140110	0.0288	LA SALLE
140160	0.0302	STEPHENSON
140161	0.0193	LIVINGSTON
140167	0.1055	IROQUOIS
140234	0.0288	LA SALLE
150006	0.0113	LA PORTE
150015	0.0113	LA PORTE
150022	0.0151	MONTGOMERY
150030	0.0186	HENRY
150072	0.0101	CASS
150076	0.0210	MARSHALL
150088	0.0111	MADISON
150091	0.0047	HUNTINGTON
150102	0.0103	STARKE
150113	0.0111	MADISON
150133	0.0167	KOSCIUSKO
150146	0.0319	NOBLE
154014	0.0167	KOSCIUSKO
160013	0.0179	MUSCATINE
160030	0.0040	STORY
160032	0.0235	JASPER
160080	0.0066	CLINTON
170137	0.0336	DOUGLAS
170150	0.0176	COWLEY
180012	0.0081	HARDIN
180017	0.0035	BARREN
180049	0.0497	MADISON
180064	0.0319	MONTGOMERY
180066	0.0449	LOGAN
180070	0.0240	GRAYSON
180079	0.0263	HARRISON
183028	0.0081	HARDIN
190003	0.0085	IBERIA
190015	0.0231	TANGIPAHOA
190017	0.0184	ST. LANDRY
190034	0.0188	VERMILION
190044	0.0258	ACADIA
190050	0.0044	BEAUREGARD
190053	0.0100	JEFFRSON DAVIS
190054	0.0085	IBERIA
190078	0.0184	ST. LANDRY
190086	0.0050	LINCOLN
190088	0.0410	WEBSTER
190099	0.0188	AVOYELLES
190106	0.0101	ALLEN
190116	0.0084	MOREHOUSE
190133	0.0101	ALLEN
190140	0.0034	FRANKLIN
190144	0.0410	WEBSTER
190145	0.0090	LA SALLE
190184	0.0161	CALDWELL
190190	0.0161	CALDWELL
190191	0.0184	ST. LANDRY
190246	0.0161	CALDWELL
190257	0.0050	LINCOLN
192022	0.005	LINCOLN
193044	0.0231	TANGIPAHOA
193047	0.0188	VERMILION
193069	0.0084	MOREHOUSE
200024	0.0092	ANDROSCOGGIN
200032	0.0466	OXFORD
200034	0.0092	ANDROSCOGGIN
200050	0.0223	HANCOCK
210001	0.0184	WASHINGTON
210023	0.0070	ANNE ARUNDEL
210028	0.0512	ST. MARYS
210043	0.0070	ANNE ARUNDEL

ADDENDUM L.—PROPOSED OUT-MIGRATION ADJUSTMENT—Continued

Provider No.	Out-Migration adjustment	Qualifying county name
220002	0.0235	MIDDLESEX
220010	0.0461	ESSEX
220011	0.0235	MIDDLESEX
220029	0.0461	ESSEX
220033	0.0461	ESSEX
220035	0.0461	ESSEX
220049	0.0235	MIDDLESEX
220063	0.0235	MIDDLESEX
220070	0.0235	MIDDLESEX
220080	0.0461	ESSEX
220082	0.0235	MIDDLESEX
220084	0.0235	MIDDLESEX
220098	0.0235	MIDDLESEX
220101	0.0235	MIDDLESEX
220105	0.0235	MIDDLESEX
220171	0.0235	MIDDLESEX
220174	0.0461	ESSEX
222000	0.0235	MIDDLESEX
222026	0.0461	ESSEX
222044	0.0461	ESSEX
223026	0.0235	MIDDLESEX
224007	0.0235	MIDDLESEX
224022	0.0235	MIDDLESEX
224038	0.0235	MIDDLESEX
230003	0.0217	OTTAWA
230005	0.0473	LENAWEE
230013	0.0023	OAKLAND
230015	0.0297	ST. JOSEPH
230019	0.0023	OAKLAND
230021	0.0099	BERRIEN
230022	0.0212	BRANCH
230029	0.0023	OAKLAND
230035	0.0096	MONTCALM
230037	0.0211	HILLSDALE
230047	0.0018	MACOMB
230069	0.0209	LIVINGSTON
230071	0.0023	OAKLAND
230072	0.0217	OTTAWA
230075	0.0048	CALHOUN
230078	0.0099	BERRIEN
230092	0.0221	JACKSON
230093	0.0060	MECOSTA
230096	0.0297	ST. JOSEPH
230099	0.0230	MONROE
230121	0.0695	SHIAWASSEE
230130	0.0023	OAKLAND
230151	0.0023	OAKLAND
230174	0.0217	OTTAWA
230195	0.0018	MACOMB
230204	0.0018	MACOMB
230207	0.0023	OAKLAND
230208	0.0096	MONTCALM
230217	0.0048	CALHOUN
230222	0.0037	MIDLAND
230223	0.0023	OAKLAND
230227	0.0018	MACOMB
230254	0.0023	OAKLAND
230257	0.0018	MACOMB
230264	0.0018	MACOMB
230269	0.0023	OAKLAND
230277	0.0023	OAKLAND
230279	0.0209	LIVINGSTON
232023	0.0018	MACOMB
232025	0.0099	BERRIEN
232030	0.0023	OAKLAND
233025	0.0048	CALHOUN
234011	0.0023	OAKLAND
234021	0.0018	MACOMB
234023	0.0023	OAKLAND
240018	0.0872	GOODHUE
240044	0.0671	WINONA

ADDENDUM L.—PROPOSED OUT-MIGRATION ADJUSTMENT—Continued

Provider No.	Out-Migration adjustment	Qualifying county name
240064	0.0130	ITASCA
240069	0.0301	STEELE
240071	0.0377	RICE
240117	0.0593	MOWER
240211	0.0386	PINE
250023	0.0430	PEARL RIVER
250040	0.0022	JACKSON
250117	0.0430	PEARL RIVER
250128	0.0393	PANOLA
250160	0.0393	PANOLA
260059	0.0127	LACLEDE
260064	0.0092	AUDRAIN
260097	0.0295	JOHNSON
270081	0.0237	MUSSELSHELL
280077	0.0057	DODGE
280123	0.0118	GAGE
290002	0.0280	LYON
300011	0.0069	HILLSBOROUGH
300012	0.0069	HILLSBOROUGH
300020	0.0069	HILLSBOROUGH
300034	0.0069	HILLSBOROUGH
310002	0.0264	ESSEX
310009	0.0264	ESSEX
310010	0.0092	MERCER
310011	0.0115	CAPE MAY
310013	0.0264	ESSEX
310018	0.0264	ESSEX
310021	0.0092	MERCER
310031	0.0130	BURLINGTON
310032	0.0027	CUMBERLAND
310038	0.0368	MIDDLESEX
310039	0.0368	MIDDLESEX
310044	0.0092	MERCER
310054	0.0264	ESSEX
310057	0.0130	BURLINGTON
310061	0.0130	BURLINGTON
310070	0.0368	MIDDLESEX
310076	0.0264	ESSEX
310083	0.0264	ESSEX
310092	0.0092	MERCER
310093	0.0264	ESSEX
310096	0.0264	ESSEX
310108	0.0368	MIDDLESEX
310110	0.0092	MERCER
310119	0.0264	ESSEX
310127	0.0130	BURLINGTON
313025	0.0264	ESSEX
313027	0.0092	MERCER
313032	0.013B	URLINGTON
313036	0.0027	CUMBERLAND
314011	0.0368	MIDDLESEX
314021	0.013B	URLINGTON
320003	0.0629	SAN MIGUEL
320011	0.0442	RIO ARRIBA
320018	0.0025	DONA ANA
320085	0.0025	DONA ANA
330004	0.0615	ULSTER
330008	0.0102	WYOMING
330010	0.0042	MONTGOMERY
330027	0.0149	NASSAU
330033	0.0205	CHENANGO
330047	0.0042	MONTGOMERY
330073	0.0122	GENESEE
330094	0.0463	COLUMBIA
330103	0.0121	CATTARAUGUS
330106	0.0149	NASSAU
330126	0.0675	ORANGE
330132	0.0121	CATTARAUGUS
330135	0.0675	ORANGE
330167	0.0149	NASSAU
330175	0.0241	CORTLAND

ADDENDUM L.—PROPOSED OUT-MIGRATION ADJUSTMENT—Continued

Provider No.	Out-Migration adjustment	Qualifying county name
330181	0.0149	NASSAU
330182	0.0149	NASSAU
330191	0.0017	WARREN
330198	0.0149	NASSAU
330205	0.0675	ORANGE
330224	0.0615	ULSTER
330225	0.0149	NASSAU
330235	0.0281	CAYUGA
330259	0.0149	NASSAU
330264	0.0675	ORANGE
330331	0.0149	NASSAU
330332	0.0149	NASSAU
330372	0.0149	NASSAU
330386	0.0687	SULLIVAN
340020	0.0143	LEE
340021	0.0162	CLEVELAND
340024	0.0171	SAMPSON
340027	0.0125	LENOIR
340037	0.0162	CLEVELAND
340038	0.0253	BEAUFORT
340039	0.0101	IREDELL
340068	0.0094	COLUMBUS
340069	0.0083	WAKE
340070	0.0417	ALAMANCE
340071	0.0168	HARNETT
340073	0.0083	WAKE
340085	0.0250	DAVIDSON
340096	0.0250	DAVIDSON
340104	0.0162	CLEVELAND
340114	0.0083	WAKE
340124	0.0168	HARNETT
340126	0.0084	WILSON
340129	0.0101	IREDELL
340133	0.0242	MARTIN
340138	0.0083	WAKE
340144	0.0101	IREDELL
340145	0.0337	LINCOLN
340151	0.0053	HALIFAX
340173	0.0083	WAKE
344014	0.0083	WAKE
360002	0.0142	ASHLAND
360010	0.0076	TUSCARAWAS
360013	0.0136	SHELBY
360025	0.0072	ERIE
360036	0.0168	WAYNE
360040	0.0392	KNOX
360044	0.0124	DARKE
360065	0.0077	HURON
360071	0.0035	VAN WERT
360086	0.0187	CLARK
360096	0.0072	COLUMBIANA
360107	0.0095	SANDUSKY
360125	0.0137	ASHTABULA
360156	0.0095	SANDUSKY
360175	0.0176	CLINTON
360185	0.0072	COLUMBIANA
360187	0.0187	CLARK
360245	0.0137	ASHTABULA
362007	0.0095	SANDUSKY
370014	0.0363	BRYAN
370015	0.0369	MAYES
370023	0.0090	STEPHENS
370065	0.0097	CRAIG
370072	0.0260	LATIMER
370083	0.0051	PUSHMATAHA
370100	0.0101	CHOCTAW
370149	0.0292	POTTAWATOMIE
370156	0.0122	GARVIN
370169	0.0164	MCINTOSH
370172	0.0260	LATIMER
370214	0.0122	GARVIN

ADDENDUM L.—PROPOSED OUT-MIGRATION ADJUSTMENT—Continued

Provider No.	Out-Migration adjustment	Qualifying county name
380022	0.0068	LINN
380029	0.0075	MARION
380051	0.0075	MARION
380056	0.0075	MARION
390008	0.0055	LAWRENCE
390016	0.0055	LAWRENCE
390030	0.0284	SCHUYLKILL
390031	0.0284	SCHUYLKILL
390044	0.0191	BERKS
390052	0.0044	CLEARFIELD
390065	0.0490	ADAMS
390066	0.0364	LEBANON
390086	0.0044	CLEARFIELD
390096	0.0191	BERKS
390113	0.0049	CRAWFORD
390122	0.0049	CRAWFORD
390138	0.0213	FRANKLIN
390146	0.0019	WARREN
390150	0.0019	GREENE
390151	0.0213	FRANKLIN
390162	0.0200	NORTHAMPTON
390181	0.0284	SCHUYLKILL
390183	0.0284	SCHUYLKILL
390201	0.1091	MONROE
390313	0.0284	SCHUYLKILL
393026	0.0191	BERKS
394020	0.0364	LEBANON
420007	0.0037	SPARTANBURG
420009	0.0113	OCONEE
420019	0.0142	CHESTER
420027	0.0145	ANDERSON
420030	0.0051	COLLETON
420039	0.0153	UNION
420043	0.0132	CHEROKEE
420062	0.0109	CHESTERFIELD
420069	0.0023	CLARENDON
420083	0.0037	SPARTANBURG
422004	0.0142	CHESTER
423029	0.0145	ANDERSON
430008	0.0537	BROOKINGS
430048	0.0055	LAWRENCE
430094	0.0055	LAWRENCE
440007	0.0226	COFFEE
440008	0.0449	HENDERSON
440016	0.0144	CARROLL
440024	0.0230	BRADLEY
440030	0.0056	HAMBLEN
440031	0.0025	ROANE
440033	0.0036	CAMPBELL
440035	0.0309	MONTGOMERY
440047	0.0338	GIBSON
440051	0.0071	MC NAIRY
440057	0.0028	CLAIBORNE
440060	0.0338	GIBSON
440067	0.0056	HAMBLEN
440070	0.0109	DECATUR
440081	0.0069	SEVIER
440084	0.0033	MONROE
440109	0.0070	HARDIN
440115	0.0338	GIBSON
440137	0.0763	BEDFORD
440144	0.0226	COFFEE
440148	0.0306	DE KALB
440153	0.0007	COCKE
440174	0.0310	HAYWOOD
440180	0.0036	CAMPBELL
440181	0.0361	HARDEMAN
440182	0.0144	CARROLL
440185	0.0230	BRADLEY
450032	0.0253	HARRISON
450039	0.0024	TARRANT

ADDENDUM L.—PROPOSED OUT-MIGRATION ADJUSTMENT—Continued

Provider No.	Out-Migration adjustment	Qualifying county name
450052	0.0276	BOSQUE
450059	0.0074	COMAL
450064	0.0024	TARRANT
450087	0.0024	TARRANT
450090	0.0651	COOKE
450099	0.0143	GRAY
450135	0.0024	TARRANT
450137	0.0024	TARRANT
450144	0.0558	ANDREWS
450163	0.0053	KLEBERG
450192	0.0271	HILL
450194	0.0213	CHEROKEE
450210	0.0150	PANOLA
450224	0.0195	WOOD
450236	0.0389	HOPKINS
450270	0.0271	HILL
450283	0.0655	VAN ZANDT
450324	0.0132	GRAYSON
450347	0.0379	WALKER
450348	0.0058	FALLS
450370	0.0240	COLORADO
450389	0.0619	HENDERSON
450393	0.0132	GRAYSON
450395	0.0451	POLK
450419	0.0024	TARRANT
450438	0.0241	COLORADO
450451	0.0537	SOMERVELL
450460	0.0048	TYLER
450469	0.0132	GRAYSON
450497	0.0395	MONTAGUE
450539	0.0071	HALE
450547	0.0195	WOOD
450563	0.0024	TARRANT
450565	0.0486	PALO PINTO
450573	0.0115	JASPER
450596	0.0744	HOOD
450639	0.0024	TARRANT
450641	0.0395	MONTAGUE
450672	0.0024	TARRANT
450675	0.0024	TARRANT
450677	0.0024	TARRANT
450698	0.0135	LAMB
450747	0.0127	ANDERSON
450755	0.0294	HOCKLEY
450770	0.0182	MILAM
450779	0.0024	TARRANT
450813	0.0127	ANDERSON
450838	0.0115	JASPER
450872	0.0024	TARRANT
450880	0.0024	TARRANT
450884	0.0050	UPSHUR
450886	0.0024	TARRANT
450888	0.0024	TARRANT
452019	0.0024	TARRANT
452028	0.0024	TARRANT
452041	0.0132	GRAYSON
452088	0.0024	TARRANT
453040	0.0024	TARRANT
453041	0.0024	TARRANT
453042	0.0024	TARRANT
453089	0.0127	ANDERSON
453300	0.0024	TARRANT
454012	0.0024	TARRANT
460017	0.0364	BOX ELDER
460039	0.0364	BOX ELDER
490019	0.1081	CULPEPER
490084	0.0145	ESSEX
490110	0.0327	MONTGOMERY
500003	0.0164	SKAGIT
500007	0.0164	SKAGIT
500019	0.0140	LEWIS

ADDENDUM L.—PROPOSED OUT-MIGRATION ADJUSTMENT—Continued

Provider No.	Out-Migration adjustment	Qualifying county name
500039	0.0101	KITSAP
500041	0.0020	COWLITZ
510018	0.0187	JACKSON
510047	0.0270	MARION
510077	0.0021	MINGO
520028	0.0297	GREEN
520035	0.0083	SHEBOYGAN
520044	0.0083	SHEBOYGAN
520057	0.0184	SAUK
520059	0.0189	RACINE
520060	0.0048	GREEN LAKE
520071	0.0174	JEFFERSON
520076	0.0159	DODGE
520095	0.0184	SAUK
520096	0.0189	RACINE
520102	0.0242	WALWORTH
520116	0.0174	JEFFERSON
522005	0.0189	RACINE

ADDENDUM M.—PROPOSED HCPCS CODES FOR ASSIGNMENT TO COMPOSITE APCS FOR CY 2008

HCPCS code	Short descriptor	CI	SI	Single code APC assignment	Composite APC assignment
90801	Psy dx interview	CH	Q	0323	0034
90802	Intac psy dx interview	CH	Q	0323	0034
90804	Psytx, office, 20–30 min	CH	Q	0322	0034
90805	Psytx, off, 20–30 min w/e&m	CH	Q	0322	0034
90806	Psytx, off, 45–50 min	CH	Q	0323	0034
90807	Psytx, off, 45–50 min w/e&m	CH	Q	0323	0034
90808	Psytx, office, 75–80 min	CH	Q	0323	0034
90809	Psytx, off, 75–80, w/e&m	CH	Q	0323	0034
90810	Intac psytx, off, 20–30 min	CH	Q	0322	0034
90811	Intac psytx, 20–30, w/e&m	CH	Q	0322	0034
90812	Intac psytx, off, 45–50 minv	CH	Q	0323	0034
90813	Intac psytx, 45–50 min w/e&m	CH	Q	0323	0034
90814	Intac psytx, off, 75–80 min	CH	Q	0323	0034
90815	Intac psytx, 75–80 w/e&m	CH	Q	0323	0034
90816	Psytx, hosp, 20–30 min	CH	Q	0322	0034
90817	Psytx, hosp, 20–30 min w/e&m	CH	Q	0322	0034
90818	Psytx, hosp, 45–50 min	CH	Q	0323	0034
90819	Psytx, hosp, 45–50 min w/e&m	CH	Q	0323	0034
90821	sytx, hosp, 75–80 min	CH	Q	0323	0034
90822	Psytx, hosp, 75–80 min w/e&m	CH	Q	0323	0034
90823	Intac psytx, hosp, 20–30 min	CH	Q	0322	0034
90824	Intac psytx, hsp 20–30 w/e&m	CH	Q	0322	0034
90826	Intac psytx, hosp, 45–50 min	CH	Q	0323	0034
90827	Intac psytx, hsp 45–50 w/e&m	CH	Q	0323	0034
90828	Intac psytx, hosp, 75–80 min	CH	Q	0323	0034
90829	Intac psytx, hsp 75–80 w/e&m	CH	Q	0323	0034
90845	Psychoanalysis	CH	Q	0323	0034
90846	Family psytx w/o patient	CH	Q	0324	0034
90847	Family psytx w/patient	CH	Q	0324	0034
90849	Multiple family group psytx	CH	Q	0325	0034
90853	Group psychotherapy	CH	Q	0325	0034
90857	Intac group psytx	CH	Q	0325	0034
90862	Medication management	CH	Q	0605	0034
90865	Narcosynthesis	CH	Q	0323	0034
90880	Hypnotherapy	CH	Q	0323	0034
90899	Psychiatric service/therapy	CH	Q	0322	0034
96101	Psycho testing by pscy/phys	CH	Q	0382	0034
96102	Psycho testing by technician	CH	Q	0373	0034
96103	Psycho testing admin by comp	CH	Q	0373	0034
96110	Developmental test, lim	CH	Q	0373	0034
96111	Developmental test, exten	CH	Q	0382	0034
96116	Neurobehavioral status exam	CH	Q	0382	0034
96118	Neuropsych test by pscyh/phys	CH	Q	0382	0034
96119	Neuropscyh testing by tec	CH	Q	0382	0034
96120	Neuropsych tst admin w/comp	CH	Q	0373	0034
96150	Assess hlth/behave, initi	CH	Q	0432	0034
96151	Assess hlth/behave, subseq	CH	Q	0432	0034
96152	Intervene hlth/behave,indiv	CH	Q	0432	0034
96153	Intervene hlth/bhave, group	CH	Q	0432	0034
96154	Intevene hlth/behave, fam w/pt	CH	Q	0432	0034
M0064	Visit for drug monitoring	CH	Q	0605	0034
93619	Electrophysiology evaluation	CH	Q	0085	8000
93620	Electrophysiology evaluation	CH	Q	0085	8000
93650	Ablate heart dysrhythm focus	CH	Q	0085	8000
93651	Ablate heart dysrhythm focus	CH	Q	0086	8000
93652	Ablate heart dysrhythm focus	CH	Q	0086	8000
55875	Transperi needle place, pros	CH	Q	0163	8001
77778	Apply interstit radiat compl	CH	Q	0651	8001

[FR Doc. 07–3509 Filed 7–16–07; 4:00 pm]

BILLING CODE 4120–01–P