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November 6, 2006

Leslie V. Norwalk, Esq.
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1506-P
Hubert H. Humphrey Building
Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

Re: 2007 OPPS Proposed Rule (CMS-1506-P) – Comments on Proposed Revised Ambulatory Surgical Center Payment System for Implementation January 1, 2008 (Section XVIII)

Dear Administrator Norwalk:

FASA is pleased to submit these comments on the proposed revised Medicare payment system for ambulatory surgical center (ASC) services. FASA is the nation's largest ASC organization, representing almost 2,100 ASCs, the professionals who provide care in such centers and the patients who receive high quality and cost-effective ASC services. FASA's members include all types of ASCs – small and large; for profit and non-profit; single specialty and multi-specialty; physician-owned, joint ventures between hospitals and physicians, joint ventures between physicians and management companies, and hospital-owned surgery centers.

We appreciate CMS's efforts to improve the ASC payment system and commend the agency for publishing its proposed revisions well in advance of their January 1, 2008 effective date. We are optimistic that this advance notice will allow adequate time to address serious flaws in the proposed rule and allow CMS to implement a revised ASC payment system that preserves the many benefits that ASCs offer to the Medicare program and to its beneficiaries.

To realize those benefits, FASA believes that a revised ASC payment system must promote two overarching and related goals:

- The first goal is access – that is, ensuring that Medicare (i) covers the full scope of services that ASCs are capable of performing safely and efficiently, and (ii) pays reasonable and adequate rates, so that ASCs are actually encouraged and able to expand their provision of services to Medicare beneficiaries.

- The second goal is transparency – which means aligning ASC and hospital outpatient department (HOPD) reimbursement so that physicians and patients are able to make

direct comparisons on the basis of quality and price in choosing the most appropriate clinical site for their surgical needs.

Through access and transparency, a well-designed payment system ultimately would promote more vigorous competition between hospitals and ASCs. And "vigorous competition," as the Federal Trade Commission (FTC) and the Department of Justice (DOJ) recently observed in their comprehensive study of health care markets, "promotes the delivery of high quality, cost-effective health care" by lowering prices and promoting quality and innovation that results in, among other things, "treatments offered in a manner and location consumers desire."[1] With respect to ASCs in particular, the FTC and DOJ concluded that as a competitive alternative to hospitals, ASCs "had a number of beneficial consequences for consumers,"[2] such as improved technology, a non-institutional, friendly environment, and "more convenient locations, shorter wait times, and lower coinsurance than a hospital department."[3] In a presentation to FASA earlier this year, former CMS Administrator Mark McClellan, MD, PhD echoed those conclusions, saying that "ASCs play a very important role in creating a modern, innovative health care system by providing care at a lower cost with better patient satisfaction." According to Dr. McClellan, "with the challenge of rising health care costs, it is clear...that innovation and creativity in ASCs can make a big difference in the quality and cost of health care."

Those competitive benefits cannot be realized, however, without access and transparency. Thus, as advances in surgical technology and techniques have dramatically increased the number of procedures that can be safely performed in ASCs, FASA and its members have continued to advocate for expanding the list of Medicare-covered ASC procedures and for aligning the ASC and HOPD payment systems. Certainly, the proposed revised payment system makes notable progress towards those ends by expanding the scope of covered ASC services and by basing payment on the hospital outpatient prospective payment system (OPPS) procedure groups (APCs) and relative weights. That said, we believe the proposal falls far short of promoting the kind of access and transparency that is needed to achieve the full competitive benefits of ASCs.

We are particularly concerned that inadequate payment rates under the revised system for certain services will present major obstacles to Medicare beneficiary access to ASCs. We fully appreciate the fact that CMS is required to work within the restraints of budget neutrality imposed by Congress in the Medicare Modernization Act of 2003 (MMA). As recently as 2003, however, ASC payments were at 86.5 percent of HOPD payments under OPPS.[4] In the intervening years, ASC rates were cut by Congress in MMA and frozen at the reduced levels

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[1] *Improving Health Care: A Dose of Competition*, a Report by the Federal Trade Commission and the Department of Justice (July 2004), Executive Summary at 4.

[2] *Improving Health Care*, Chapter 3, Industry Snapshot: Hospitals at 27.

[3] Id. at 25, citing the Medicare Payment Advisory Commission's 2003 *Report to the Congress: Medicare Payment Policy*, § 2F at 140 (2003).

[4] This 86.5 percent figure is based on an analysis performed by CMS and provided to FASA in August 2003. The CMS analysis used a strict interpretation of budget neutrality and applied 2002 ASC volume data and 2003 ASC and HOPD payment rates to the then-current list of ASC covered procedures.

through 2009, while HOPDs have received annual hospital market basket updates. Largely as a result of the MMA's multi-year payment rate freeze, CMS proposes a revised ASC payment system for 2008 with an estimated conversion factor at 62 percent of the OPPS conversion factor,[5] which would drop even lower in 2009, the final year of the rate freeze.

As the Medicare Payment Advisory Commission (MedPAC) observed in its October 10, 2006 comments on the proposed rule, with current ASC rates based on 1986 cost data, nobody is able to judge whether 62 percent is the "right" conversion factor. It is, in all fairness, an arbitrary number designed only to achieve budget neutrality, without regard to ASC costs. In fact, no studies were performed to confirm that the average cost of performing a diagnostic colonoscopy in an ASC, for example, is equal to or less than its proposed $398 payment rate. The MMA did require a Government Accountability Office (GAO) study of the current relative costs of services in ASCs and HOPDs to help inform CMS on the design of an appropriate payment system, but the GAO has not released it findings to date.

In the meantime, what we do know, as shown in Table 1, is that implementation of a revised ASC payment system on the basis described in the proposed rule will produce major cuts in Medicare reimbursement in a number of medical specialties where ASCs now are the dominant provider of some surgical services. This is especially true for gastrointestinal (GI) and endoscopic surgery, pain management, and ophthalmology, where the proposed payment cuts are substantial and will impose significant hardships on ASC operations, as well as a critical threat to Medicare beneficiary access. This analysis shows the estimated payment impact for some of the most high-volume ASC services, both with a 50-50 transition for 2008 and after full-phase in of the new payment system in 2009, as proposed by CMS.

[5] The Lewin Group estimates that the application of inflation updates to the HOPD rates since passage of the MMA account for 40 percent of the discount required to achieve budget neutrality under the proposed rule.

TABLE 1

ESTIMATED IMPACT OF PROPOSED ASC PAYMENT SYSTEM ON AGGREGATE MEDICARE PAYMENTS FOR SELECTED HIGH VOLUME PROCEDURES AND SPECIALTIES

HCPCS Code	Description	Specialty	Allowed Charges (in millions)	CY 2008 Percent Change (50/50 Blend)	CY 2009 Percent Change (Full Phase-In)
43239	Upper gi endoscopy, biopsy	GI	$166	-13%	-26%
45378	Diagnostic colonoscopy	GI	$147	-11%	-22%
45380	Colonoscopy and biopsy	GI	$112	-11%	-22%
45385	Lesion removal colonoscopy	GI	$108	-11%	-22%
66821	After cataract laser surgery	Ophthalmology	$97	-18%	-36%
62311	Inject spine l/s (cd)	Pain Management	$78	-12%	-24%
45384	Lesion remove colonoscopy	GI	$45	-11%	-22%
64483	Inj foramen epidural 1/s	Pain Management	$42	-12%	-24%
64476	Inj paravertebral 1/s add-on	Pain Management	$39	-17%	-34%
G0121	Colon ca screen; not high risk	GI	$37	-15%	-30%
15823	Revision of upper eyelid	Ophthalmology	$29	-13%	-26%
G0105	Colorectal screen; hi risk ind	GI	$26	-15%	-30%
64475	Inj paravertebral 1/s	Pain Management	$25	-12%	-24%
52000	Cystoscopy	Urology	$24	-10%	-20%
64484	Inj foramen epidural add-on	Pain Management	$20	-12%	-24%
43248	Upper gi endoscopy/guide wire	GI	$18	-13%	-26%

We are very concerned that payment reductions of this magnitude will lead inevitably to procedures being shifted to higher cost hospital settings, thus increasing expenditures for both Medicare beneficiaries and the government. We also thought that one of the primary goals for the new payment system was to eliminate artificial incentives in the current payment system for outpatient surgical services which are driving site-of-service selection.[6] A nearly 40 percent differential in ASC and hospital payment rates would seem to perpetuate, rather than diminish, the incentives for the use of higher cost settings. Indeed, as long as these kinds of payment disparities persist, market pressures will continue to favor the growth of hospitals and impair the ability of ASCs to serve as a fully-effective competitive counterbalance to more costly hospital-based surgery.

[6] Administrator McClellan discussed the elimination of these kinds of incentives in testimony before the Health Subcommittee of the House Energy and Commerce Committee in May 2005. Specifically, in his discussion of the disparity of payment systems for ASCs and hospital outpatient departments, Dr. McClellan indicated that "CMS is currently planning to reform the ASC fee schedule to diminish the divergence in payment levels that create artificial incentives for the creation of small orthopedic or surgical hospitals." *Hearings on Specialty Hospitals Before the Health Subcommittee of the House Energy and Commerce Committee* (May 12, 2005).

Beyond payment rates, several other features of the revised payment system impose unnecessary barriers to access and transparency. In particular, the proposed rule would continue to deny Medicare payment for large numbers of procedures that are routinely and safely performed in ASCs. In addition, the proposed rule would align ASC and HOPD payments in 2008, and then set them off again on separate tracks with different conversion factors, different relative weight adjustments, different payment caps, different packaging rules, different wage adjustments, and different inflation updates, which together will steadily widen the payment gap between ASCs and HOPDs. Indeed, the estimated 62 percent conversion factor for 2008 would likely represent the high mark for ASCs under the new system as proposed, with future years seeing a growing disparity in payments relative to HOPDs. The cumulative effect of these disparate payment policies also will undermine the transparency benefits of a new payment system by making direct comparisons between ASCs and HOPDs increasingly difficult. Indeed, by treating ASCs differently in so many ways, CMS seems to have proposed a payment system that will be both confusing to beneficiaries and unnecessarily burdensome to administer. Yet, there does not seem to be any good clinical or policy reasons for maintaining differing payment policies for ASCs and HOPDs.

With that as background, our comments on specific aspects of the proposed rule follow. In sum, we urge CMS to focus on the following principles to better promote access and transparency through the revised ASC payment system:

- ***Establishing more comparable payment rates for ASCs and HOPDs***, to the maximum extent possible given the mandate of budget neutrality. We believe this is essential to eliminate distortions between the ASC and OPPS payment systems that could inappropriately influence site-of-service selection and provide artificial incentives for the growth and expansion of hospital settings as alternatives to more efficient and cost-effective ASCs. Given the mandate of budget neutrality, this will require more reasonable assumptions regarding the likely migration of services under a revised ASC payment system that involves substantial changes in current payment rates. Since current rates are founded on 20-year old cost data and a six-year rate freeze, a broad approach to budget neutrality is necessary to ensure adequate rates and the competitive benefits of ASCs. We also believe it is essential that CMS address the critical problems facing GI under the proposed rule.

- ***Ensuring Medicare beneficiary access to the full range of surgical services that can be safely and efficiently performed in ASCs***, as well as access to related ancillary services such as intraoperative radiology and medicine services. As we explain below, this will require that CMS abandon outdated presumptions on the relative capabilities of hospitals and ASCs, especially the unfounded assumption that HOPDs are somehow inherently "safer" than ASCs.

- ***Maximizing alignment of the ASC and HOPD payment systems*** through use of a uniform conversion factor and the same bundles, annual updates, and other relevant adjustments, so that Medicare beneficiaries are able to understand their relative costs in

each setting. As President Bush articulated earlier this year at a White House event on promoting transparency in the health care sector, Medicare beneficiaries need to be able to make "apples to apples" comparisons between hospitals and ASCs.[7]

1. ASC Payable Procedures (Section XVIII.B.1)

We support CMS's decision to adopt MedPAC's recommendation from 2004 to replace the current "inclusive" list of ASC-covered procedures with an "exclusionary" list of procedures that would not be covered in ASCs based on two clinical criteria: (i) beneficiary safety; and (ii) the need for an overnight stay. We agree that existing site-of-service volume and operating and recovery time limits are no longer clinically relevant, and that an exclusionary list reflects the best approach to balancing the need to protect beneficiary safety with the desire to increase beneficiary access to ASCs.[8]

We are concerned, however, that the proposed rule implements the MedPAC recommendation too narrowly, and thus continues to exclude many procedures that can be safely and appropriately performed in ASCs. Thus, to achieve full access, we urge the following changes to the proposed rule's treatment of ASC payable procedures: (i) a broader definition of "surgical" procedures; (ii) using the OPPS safety criteria; (iii) elimination of the 80 percent inpatient

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[7] The following is an excerpt from the President's February 16, 2006 discussion at that event with Jerry Henderson, then the Administrator of the SurgiCenter of Baltimore and a FASA board member:

> THE PRESIDENT: Very good. And tell us, you know, the transparency issue – we had a little visit ahead of time, since it's not the first time I've seen her; she gave me a little hint about what she was going to talk about. Go ahead and share with people – small clinic, relatively small clinic, big hospital guy, small clinic person.
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> MS. HENDERSON: I think the ambulatory surgery centers offer a good, low cost alternative for outpatient surgery for patients. And what we do, I think we do a very good job of offering transparency for the patients because we think it's important that they have the information that they need, both for quality, safety and price. And so for our patients we offer information on our website about our payment policies, we give them a brochure about our patient payment policies. Then we also call the insurance companies and make sure that they have their coverage and how much that insurance company is going to pay. And then we call our patients and we tell them, okay, your insurance is going to cover this amount and you're going to be responsible for this other amount. But it's really difficult for patients to make those comparisons on price because the payment systems are outdated and ambulatory surgery centers are not paid on the same type of a payment system as the hospital. And it would be a lot more transparent for the patient if they had a system that was paid on the same type of a system.
>
> THE PRESIDENT: Yes, apples to apples.
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> MS. HENDERSON: Apples to apples, and then they could make those comparisons. We give them information, but I'm not sure that they can get that same information across the health care system.

[8] We note that in its comments on the proposed rule, MedPAC raised a question regarding whether CMS should seek statutory authority for the use of an exclusionary ASC list. We presume that MedPAC is referring to Section 1833(i)(1)(A) of the Social Security Act, which continues to require that the Secretary "specify" those services that can be performed in ASCs and HOPDs. We do not share MedPAC's concerns. By defining a universe of covered procedures (currently proposed as the Surgery section of CPT) and then excluding certain procedures from that list because they are considered unsafe or require an overnight stay, CMS seems to have adequately "specified" what is covered and met its statutory obligation. Indeed, a list of covered procedures is produced at Addendum BB of the proposed rule.

threshold as a basis for exclusion; and (iv) using 24 hours as the definition of an overnight stay. Further discussion of each of these recommendations follows.

- A broader definition of "surgical" procedures. Because FASA believes that the ability of physicians to select the most appropriate site of service for their patients is of paramount importance, we agree that any procedure within the "Surgery" section of CPT should continue to be defined as a surgical procedure eligible for payment under the revised ASC payment system, regardless of whether it is office-based or requires relatively inexpensive resources to perform. We also note, however, that traditional boundaries between surgery, radiology, and certain medical specialties that perform invasive procedures are fading as surgery becomes less invasive, radiology has developed an interventional subspecialty, and certain internal medicine subspecialists routinely perform invasive procedures.

  In particular, modern surgical techniques include a number of radiology procedures that are invasive in nature and that involve the use of imaging guidance integral to the performance of other surgical procedures. While these imaging modalities may have historically been viewed as radiology, they are now essential to certain advanced surgical techniques. Examples include percutaneous transluminal angioplasty; the placement of catheters for therapeutic embolization of tumors, arteriovenous malformations or bleeding sites; the placement of drainage catheters; removal of stones; balloon dilation of strictures; biopsies; arthrograms; and myelograms. To allow for the efficient performance of these procedures in ASCs, we believe the revised ASC payment system's definition of surgical procedure should be expanded to include the following invasive radiology procedures (also commonly referred to as interventional radiology):

  (i) X-ray, fluoroscopy or ultrasound procedures[9] that require the insertion of a needle, catheter, tube, or probe through the skin or into a body orifice; and

  (ii) Intraoperative radiology procedures that are integral to the performance of a non-radiological surgical procedure and performed during the non-radiological surgical procedure or immediately following the surgical procedure to confirm placement of an item, such as ultrasound used to provide guidance for biopsies and major surgical procedures or to determine, during surgery, whether surgery is being conducted successfully.[10]

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[9] Notably, this section of our proposed definition does not extend to pre-operative computerized axial tomography (CAT) or magnetic resonance imaging (MRI), which are strictly diagnostic in nature and where the interventional aspect of the procedure is limited to the injection of a contrast agent.

[10] Notably, regulations adopted pursuant to the federal physician self-referral law (commonly known as the "Stark law, Section 1877 of the Social Security Act) carve out these invasive and intraoperative radiology services from the definition of "radiology" services subject to the Stark law's self-referral prohibition. *See* 42 C.F.R. § 411.351. This Stark law exclusion is based "on the theory that the radiology services in these procedures are merely incidental or

Similarly, procedures in the "Medicine" section of CPT that are invasive or intraoperative, or that require general anesthesia, also would be appropriately considered surgical services eligible for payment in ASCs. It is a peculiarity of how the CPT manual is organized that the invasive procedures primarily performed by medical subspecialists such as gastroenterologists and pulmonologists have been classified as "Surgery," while the invasive procedures performed by medical subspecialists such as cardiologists have been classified in CPT as "Medicine." In the case of the invasive procedures performed by these subspecialists, the CPT distinction is an artificial one that disguises their similarities and common requirements. When considering whether services in the Medicine section of CPT are surgical in nature or not, it is more practical to focus on whether or not they are invasive procedures. Many procedures described in the Medicine section of CPT are invasive and, as such, require use of a dedicated procedure room, administration of anesthesia or sedation, patient monitoring, and/or use of a post-procedure recovery room. Therefore, such services are just as appropriately considered surgical as the gastrointestinal endoscopies and bronchoscopies located in the Surgery section of CPT.

Additionally, there are services described in the Medicine section of CPT which are, by definition, performed under general anesthesia or are intraoperative services. Services which, by definition, require general anesthesia should be considered appropriate to the outpatient surgical setting. With respect to intraoperative services, these services are appropriately regarded as an extension of the surgical service during which they are provided. In recognition of the role these services play during selected procedures, we propose they be included in the definition of surgical service. This inclusion recognizes the increasingly multidisciplinary approach seen in modern operating and procedure rooms.

At Appendix A, we identify the specific procedures from outside the Surgery range of CPT that we believe should be eligible for payment under the revised ASC payment system. This includes CPT Category III and HCPCS Level II codes which crosswalk to or are clinically similar to procedures in the expanded definition of surgical procedures that we are suggesting. Since such codes are eligible for payment under the OPPS, they also should be eligible for payment under the new ASC payment system.

- Using the OPPS safety criteria. CMS applies three criteria to determine which procedures to exclude from payment under OPPS as inpatient procedures: (i) the nature of the procedure; (ii) the need for at least 24 hours of postoperative recovery time or monitoring before the patient can be safely discharged; and (iii) the underlying physical condition of the patient. While these are generally similar to the safety criteria that CMS proposes to continue using for ASCs (i.e., extensive blood loss, major or prolonged invasion of body cavities, etc.), we see no inherit safety differences between ASCs and

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secondary to another procedure that the physician has ordered" and, thus, are less subject to abuse from overutilization. 63 Fed. Reg. 1645, 1676 (Jan. 9, 1998).

HOPDs to justify the use of different safety criteria. Indeed, a recent study by RAND Health commissioned by MedPAC looked adverse events for cataract surgery and colonoscopies performed in ASCs and HOPDs and concluded that the rates of adverse outcomes were "very low" in both settings, "so that the magnitudes of significant differences between settings are quite small."[11] Moreover, our experience has been that the general exclusions retained at Section 416.166(c) of the proposed rule are applied as proxies for safety and as a basis for excluding procedures from the ASC list which may be unsafe for some patients, but not for all or even most Medicare beneficiaries. Unless a procedure is inherently unsafe to perform on an outpatient basis – and thus a candidate for the OPPS inpatient list – we believe physicians are in the best position to determine the appropriate site-of-service based on the individual needs of their patients.

With that in mind, we recommend that CMS apply uniform safety criteria to ASCs and HOPDs. We also suggest that the agency develop a reasonable process for gathering and evaluating reliable information about the safety of performing surgical procedures in ASC and HOPD settings as a basis for making informed decisions about the relative safety of the two sites-of-service. This process should include additional studies like the RAND/MedPAC study. It also should include a requirement that if CMS proposes a procedure for exclusion from ASC coverage (other than procedures on the inpatient list), the agency must specify the clinical basis for exclusion, with available data and supporting arguments, and then provide the industry with an opportunity to respond with its own data, arguments and medical experts with ASC experience. As a general rule, a procedure should not be excluded from ASC coverage if it can be safely performed in an outpatient surgical setting pursuant to reasonable and generally accepted patient selection criteria, which are best applied by physicians applying their medical judgment, rather than CMS erring on the side of exclusion.

- Elimination of the 80 percent inpatient threshold as a basis for exclusion. We agree that the OPPS inpatient list should be equally applicable to ASCs. However, we see no basis for excluding from the ASC payment system any procedures that are performed 80 percent or more of the time in the hospital inpatient setting. By definition, such procedures are being performed up to 20 percent of the time in HOPDs or physician offices, apparently without any notable safety concerns. We are not aware of any empirical evidence to suggest that ASCs are inherently incapable of safely performing these same procedures. Indeed, we know of no evidence that establishes HOPDs as inherently safer than ASCs for any given type of procedure. The ASC community has always made patient safety its top priority, and the main reason why ASCs continue to be so popular with patients and physicians is their unwavering commitment to patient safety. If a surgical procedure cannot be safely performed on an outpatient basis, then we agree it should be added to the inpatient list. Otherwise, it is physicians who are in the best position to determine the appropriate site-of-service based on the individual needs of their

[11] *Further Analyses of Medicare Procedures Provided in Multiple Ambulatory Settings*, a study conducted by staff from RAND Health for the Medicare Payment Advisory Commission (October 2006) at 48.

patients and the relative capabilities of the facilities where they practice. HOPDs are not inherently safer or more capable than ASCs. In short, CMS needs to remove these kinds of unfounded presumptions from its decision-making, beginning by eliminating the arbitrary 80 percent inpatient threshold as a basis for excluding procedures from the new ASC payment system.

Moreover, claims data is not only irrelevant to safety, but its use in this context also stifles innovation and competition. Indeed, with the proposed 80 percent threshold, ASCs cannot obtain Medicare coverage for a new procedure until that procedure is adopted by a substantial number of hospitals. The result is an impediment to the progress and evolution of surgical technique, as what is being done today in hospitals artificially limits what can and should be done in ASCs.

If CMS insists on maintaining this 80 percent rule, then it should base its exclusions on more current information than 2005 BESS data and commit to reviewing the list of procedure excluded by this rule on an annual basis.

- Using 24 hours as the definition of an overnight stay. We believe that the terms "ambulatory" surgery and "outpatient" surgery describe the same kind of care, and that the same 24 hour postoperative recovery standard should apply in both settings. CMS's Survey and Certification Group seems to agree. In a May 2005 letter to FASA, CMS indicated that an overnight stay is a planned stay of over 24 hours and, conversely, when the "length of stay is less than 24 hours, it is not considered an overnight stay."[12] We also note that a number of states have likewise expanded the concept of "ambulatory" over the past 20 years by permitting ASCs to perform procedures requiring stays of up to 23 or 24 hours.[13]

  Should CMS decide not to use 24 hours as the definition of an overnight stay, then we note that several procedures listed in Table 45 of the proposed rule would not normally require recovery beyond the midnight cut-off in the proposed rule (assuming, as we think the proposed rule intended, that the procedure commenced during normal business hours). More specifically, additional procedure and recovery time data on a number of procedures is provided in Table 2 from selected members of the ASC Coalition.[14] When possible and reasonable to do so, this data is presented specifically for patients age 65 and older.

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[12] Letter from Thomas E. Hamilton, Director, Center for Medicaid and State Operations, Survey and Certification Group, to Kathy J. Bryant, Executive Director, Federated Ambulatory Surgery Association (May 16, 2005).

[13] We are aware of at least 14 states that permit ASCs to retain patients for up to 23 or 24 hours of overnight recovery care: Alabama, Arizona, Arkansas, Colorado, Georgia, Illinois, Kansas, Nevada, New York, North Carolina, Ohio, Oklahoma, Tennessee, and Utah.

[14] The ASC Coalition is a diverse coalition of national and state associations and companies representing all types of ASCs. The Coalition has submitted separate comments on the proposed rule.

TABLE 2

PROCEDURE AND RECOVERY TIMES FOR SELECT PROCEDURES EXCLUDED FROM COVERAGE AS REQUIRING AN OVERNIGHT STAY

CPT	Average Age	Age Range	Average OR + Recovery Time (minutes)	Range OR + Recovery Time (minutes)
19240	52	18-65	227	142-368
19260	55	49-75	139	93-176
21470	34	17-45	294	215-395
27412	28	13-50	242	155-293
27415	26	17-40	215	121-402
27524	73*	65-85	200	135-346
29866	36	14-51	200	130-232
29867	42	24-65	170	121-310
43280	52	48-58	202	171-226
44180	36	18-68	137	70-224
44970	36	23-50	216	105-426
47562	71*	65-86	153	84-214
49200	48	25-63	96	59-145
53500	56	36-75	100	68-125
57106	45	23-69	120	58-232
57295	60	44-77	144	67-400
58553	43	39-46	284	208-441
60210	49	36-70	250	131-437
63030	43	19-71	209	101-512
63075	45	28-64	246	155-515
* Data subset for patients age 65 and older only				

Based on the data presented above, there are a number of procedures that should not be excluded from ASC coverage in the final rule because they do not require an overnight stay, as defined in the proposed rule, and are otherwise safe to perform in ASCs under the other clinical safety standards set forth in the proposed rule.

2. ASC Unlisted Procedures (Section XVIII.B.2)

Because of concerns about the potential for safety risks when procedures that are reported with unlisted procedure codes (i.e., "catch-all" codes that do not contain a specific description of the procedure being billed), CMS proposes to prohibit any payment for unlisted CPT codes under the new ASC payment system. We see no rational basis for assuming that the safety risks associated with the performance of unlisted procedures in ASCs is greater than the risk in HOPDs, which may receive payment for unlisted CPT codes at the discretion of the Medicare carriers. Moreover, it seems unnecessary to eliminate the entire unlisted procedure code payment mechanism on the chance that it conceivably could be used to report procedures that may not be appropriate for the ASC setting. Certainly, there are other, more effective safeguards

against the performance of unsafe procedures, including licensure, certification, tort liability and the Medicare Quality Improvement Organization (QIO) Program.

There also does not appear to be any safety risk with unlisted CPT codes within a range of procedures that are all covered services, such as CPT 58579 (Unlisted hysteroscopy procedure). Therefore, at a minimum, when all the specific codes in a given section of CPT are eligible for payment under the revised ASC payment system, the associated unlisted code should be eligible for payment as well.

3. ASC Office-Based Procedures (Section XVIII.B.3)

We join MedPAC and the other members of the ASC Coalition in supporting CMS's proposal to extend the new ASC payment system to cover procedures that are commonly performed in physician offices. As we have contended for many years, while physicians may safely perform many procedures on healthy Medicare beneficiaries in the office setting, sicker beneficiaries may require the additional infrastructure and safeguards of an ASC to maximize the probability of a good clinical outcome. In other words, for a given procedure, the appropriate site of service is dependent on the individual patient and his specific condition. Thus, physicians and patients should have the discretion to decide which setting is most clinically appropriate. For a patient whose safety requires general anesthesia or a sterile operating room, if an ASC is not an option, most physicians will elect to perform the procedure at a hospital, at greater cost to the Medicare program and to the beneficiary.

Moreover, many office-based procedures are routinely performed in conjunction with other surgical procedures that require a facility setting. By establishing Medicare coverage for these secondary procedures when performed in ASCs, CMS will remove a major obstacle to their efficient performance with primary procedures in ASC settings.

4. ASC Ratesetting (Section XVIII.C.2)

FASA generally supports the proposal to base ASC payments on the APC groups and relative weights established under the OPPS. To better promote full transparency across sites of service, we believe it would be preferable to base payments to ASCs on a flat percentage of the payment for the same services established under the OPPS. We are concerned that the proposed use of a separate ASC conversion factor will be difficult for physicians and patients to understand and, thus, will impede their ability to make direct comparisons on the basis of quality and price.

Towards that end, in the comments that follow, we also urge CMS to further maximize alignment of the ASC and HOPD payment systems by adopting in the final rule the same packaging policies, the same payment caps for office-based procedures, the same multiple procedure discounts, the same wage index adjustments and the same inflation updates for ASCs and HOPDs.

In addition, given that ASC payments will be based on the APC groups and relative weights, we believe it would be appropriate to add ASC representatives to the APC Advisory Panel in 2007.

5. ASC Packaging (Section XVIII.C.3)

FASA believes it is essential that the new ASC payment system apply the OPPS packaging rules and pay ASCs the same way HOPDs are paid for items and services directly related to a surgical procedure. This would mean that payment for most surgically implanted devices and implantable DME would be packaged into the facility fee for the procedure. Conversely, payment for certain pass-through drugs, biologicals and devices and for diagnostic services directly related to performing a surgical procedure would not be packaged but, instead, would be paid separately.

In the proposed rule, CMS suggests that this logical option of parallel packaging rules for ASCs and HOPDs is countered by a belief that "ASCs generally treat a less complex and severely ill patient case mix and, as a result...are less likely to provide on a regular basis many of the separately payable items and services that patients might receive more consistently in a hospital outpatient setting."[15] We know of no basis for this belief. To the contrary, FASA members routinely perform intraoperative x-ray, fluoroscopy and ultrasound procedures for Medicare beneficiaries. Yet, the proposed rule essentially "packages" these costs by presuming they do not exist, thereby undermining a fundamental basis for applying the APC relative weights to ASCs. Similarly, while it may be the case that ASCs furnish other pass-through drugs, biologicals and devices less often that HOPDs, that is not a legitimate basis for not covering these items when they are medically necessary and appropriately provided by an ASC. If ASCs do not provide these items, then Medicare will not incur expenses for them. However, barring payment to all ASCs for all patients will result in under-payment or denied access to ASCs that do provide these items and the more innovative surgical services associated with them.

Other anomalies result from the proposed rule's approach to packaging. For example, services such as discography have both an injection component and a radiographic component. In CPT, the injection portion of the service is described by a code in the surgical range (in this example, 62290 or 62291), while the radiographic portion of the service is described by a code in the radiology range (in this example, 72285 and 72295). Under OPPS, the injection portion of the procedure is packaged into the radiographic portion of the procedure. As a result, only CPT codes 72285 and 72295 are payable under OPPS, but those codes would not be covered under the proposed rule's definition of surgical procedure eligible for coverage in ASCs or its packaging policies. Additional examples of surgery procedures that are bundled in radiology procedures under the OPPS are provided at Appendix B of these comments.

Therefore, to the extent ASCs provide non-packaged items and services under a payment system aligned with OPPS, they should be able to receive reimbursement for them just like hospitals.

At Appendix A, we identify the radiology procedures that we believe should be covered under the new payment system as ASC services. CMS could accomplish the coverage of these procedures through revised packaging rules or, as we suggest above in Section 1 of our

[15] 71 Fed. Reg. 49505, 49648 (Aug. 23, 2006).

Comments on "ASC Payable Procedures," an expanded definition of what is a "surgical" procedure eligible for payment in an ASC. A combination of these two approaches is preferable both to eliminate unnecessary regulatory costs and burdens associated with obtaining separate IDTF certification for facilities that only perform radiology procedures falling within an expanded definition of covered surgical procedures and to avoid anomalies like the discography example noted above.

CMS also should allow ASCs to receive separate payment for non-packaged brachytherapy sources placed during a collaborative procedure for the placement of brachytherapy needles or applicators and subsequent application of the radiation source. This will facilitate the treatment of cancer patients who have brachytherapy delivery devices implanted in the ASCs.

In addition, an amendment to the Stark physician self-referral law regulations would be required to exempt pass-through drugs, biologicals and radiopharmaceuticals furnished by an ASC from the scope of "outpatient prescription drugs" covered by the Stark law, in the same way, and for the same reasons, that implanted devices are currently exempted when furnished during a surgical procedure performed in a physician-owned ASC.[16]

With regard to implanted devices and DME, we agree that as a matter of sound payment policy, packaging of these items also should be the same in ASCs and HOPDs. Historically, ASCs have struggled with inconsistent carrier coverage policies for separately payable devices and, thus, would welcome relief in the form of bundling payment for most devices into the facility fee. Because it is so difficult for ASCs to get paid by Medicare for implanted devices, less than three percent of highest volume device-dependent procedures are performed in ASCs.[17] This transition to a new ASC payment system offers CMS the opportunity to address the problem of inadequate payment for device-dependent services and achieve cost savings through the performance of more of these procedures in ASCs.

However, unless changes are made to the proposed rule's treatment of device costs, such savings will not be realized because at the currently proposed 62 percent conversion factor, many device-dependent procedures will remain economically unfeasible for ASCs. ASC payment for APCs

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[16] *See* 42 C.F.R. §411.355(f). CMS adopted a Stark law exception for implants furnished in ASCs because "the absence of an exception for...items implanted in ASCs is likely to result in these procedures moving to more costly hospital outpatient settings" and because the exclusion of these items from the reach of the Stark law "will not increase the risk of overutilization beyond what is already presented by the surgeon's Part B physician fee and is consistent with the Congress's decision to not include ambulatory surgical services as a specific designated health service [subject to the Stark law]." 66 Fed. Reg. 855, 934 (Jan. 4, 2001). In other words, as a practical matter, physicians are not going to subject patients to an unnecessary surgical procedure just to profit from an implant or a drug furnished during the procedure.

[17] This estimate is based on Medicare utilization statistics for the following CPT codes, which were the ten highest volume device-dependent procedures billed by HOPDs to Medicare in 2004, the most recent for which data is available: 33213 (Insertion of pulse generator); 36870 (Percut thrombect av fistula); 57288 (Repair bladder defect); 33212(Insertion of pulse generator); 63685 (Insrt/redo spine n generator); 69930 (Implant cochlear device); 54405 (Insert multi-comp penis pros); 62362 (Implant spine infusion pump); 63650 (Implant neuroelectrodes); and 64590 (Insrt/redo perph n generator).

with high device costs will result in underpayment for the non-device portion of the procedure, especially where the device represents a large proportion of the total procedure costs. Table 3 provides a list of procedures for which the reported device costs in 2005 exceed the proposed ASC payment rate.

TABLE 3

EXAMPLES OF DEVICE-DEPENDENT PROCEDURES WITH REPORTED DEVICE COSTS IN EXCESS OF 62% OF APC RATES

CPT	Description	2005 Device Related Percentages
63685	Insrt/redo spine n generator	86%
64590	Insrt/redo perph n generator	86%
69930	Implant cochlear device	85%
62360	Insert spine infusion device	85%
62361	Implant spine infusion pump	82%
62362	Implant spine infusion pump	82%
33214	Upgrade of pacemaker system	82%
33213	Insertion of pulse generator	81%
61885	Insrt/redo neurostim 1 array	80%
64553	Implant neuroelectrodes	79%
64573	Implant neuroelectrodes	79%
33282	Implant pat-active ht record	79%
33212	Insertion of pulse generator	79%
33206	Insertion of heart pacemaker	78%

Certainly, we have no reason to believe that the typical ASC is able to purchase medical devices at less cost than hospitals. In fact, due to the greater purchasing power of hospitals as a group, the opposite is almost certainly true. Moreover, the underpayment for device costs is further exacerbated by the transitional payment proposal for 2008, which will base 50 percent of the payment for all procedures, including those that are device-dependent, on 2007 ASC rates which do not include a device component.

Thus, to ensure adequate payment for procedures involving the implantation of costly devices, we urge CMS to implement the following in the final rule:

(i) account for the device portion of APC payments separately, allowing them to be passed through to ASCs and applying the budget neutrality discount and the 50-50 transitional blend only to the non-device portion of the ASC payment; and

(ii) extend transitional pass-through payments for innovative devices to ASCs.

We believe these measures are important to help ensure Medicare beneficiary access to innovative devices in ASCs. While these changes would increase per procedure reimbursement

to ASCs, we also believe they would have the effect of increasing the likelihood that device-dependent services will actually migrate to lower-cost ASCs. Without adequate reimbursement for device-dependent procedures, ASCs simply will not be able to perform such procedures for Medicare beneficiaries, which would result in a substantial missed opportunity to produce cost savings for the program and for beneficiaries.

6. ASC Payment for Corneal Tissue (Section XVIII.C.4)

FASA supports CMS's proposal to continue paying ASCs separately, based on their invoiced costs, for the procurement of corneal tissue, in the same way that physicians and HOPDs are paid for such costs. We agree that costs incurred to procure corneal tissue are highly variable, so that packaging those costs into the APC for corneal transplant procedures would result in overpayments for facilities that are able to acquire corneal tissue at little or no cost through philanthropic organizations and underpaying those facilities that must pay for the full cost of processing, testing, preserving and transporting corneal tissue.

7. ASC Payment for Office-Based Procedures (Section XVIII.C.5)

In an attempt to mitigate potentially inappropriate migration of services from physician offices to ASCs, the proposed rule provides that payment for services added to the ASC list in 2008 that are primarily performed in physician offices would be capped at the physician fee schedule non-facility practice expense rate. No such limitation is applied to payments under the OPPS, presumably because CMS recognizes that if these procedures are being performed in a hospital setting, it is because the physician has decided that a more capable and resource-intensive setting (e.g., more nursing staff, a sterile operating room, more advanced equipment and/or closer supervision of the patient) is necessary to meet that particular patient's clinical needs, or because it makes sense to combine the office-based procedure with another procedure and perform them at the same time.

These very same considerations also drive site-of-service selection for ASCs. Indeed, patient safety and convenience are far more important to site-of-service selection than Medicare reimbursement policy. Physicians seek to provide services in the most convenient setting that is medically appropriate, consistent with adequate reimbursement. Physicians who have acquired the equipment and personnel to perform procedures in their office want to continue providing services in their office. This seems to be borne out by CMS's own analysis of site-of-service utilization data. As was noted in the 2005 ASC list final rule, the rate of performance in ASCs of the office-based procedures originally proposed for deletion in 2005 was relatively stable over the preceding 10 years.[18] In other words, the inclusion of these procedures on the ASC list did not induce substantial shifts in sites of service, which suggests that site-of-service selection is being driven by clinical need and convenience, not financial considerations.

[18] 70 Fed. Reg. 23689, 23696 (May 4, 2005).

Thus, regardless of the payment rate, our members do not anticipate measurably increased performance of office-based procedures in ASCs under the new payment system. Indeed, if payment is capped at the physician rates, we expect that many ASCs will simply refuse to perform these procedures. Thus, although we appreciate the rationale for the proposed payment cap for office-based procedures, we do not believe it reflects good payment policy, since it may have the effect of limiting the ability of physicians and Medicare beneficiaries to choose the most appropriate site-of-service based on patient need. If CMS nevertheless believes that a cap on payment for office-based procedures is necessary, then the same rationale would seem to support a cap on HOPD payments for office-based procedures.

8. ASC Multiple Procedure Discounting (Section XVIII.C.6)

FASA agrees that the new ASC payment system should mirror the OPPS policy for multiple procedure discounting, including exempting from the policy procedures that involve the implantation of costly devices.

9. ASC Wage Index (Section XVIII.C.7)

To further promote transparency between ASC and HOPD payments, we believe the new ASC payment system should apply the same geographic adjustments applied to hospitals under OPPS. This should include use of the same wage index values, the same locality designations, and the same labor-related shares, which means using the June 2003 Core Based Statistical Areas (CBSAs) and adjusting 60 percent of ASC payment rates for wage variation, rather than the current and proposed rule's 34.45 percent adjustment. The current 34.45 labor adjustment factor is based on a 1986 survey of ASC costs.

With several years of nursing shortages, we expect that ASC labor costs today are more comparable to those of HOPDs. We also suspect that ASCs have higher benefit costs per employee due to their having fewer employees for purposes of pooling risk, which increases their overall labor costs.

10. ASC Inflation (Section XVIII.C.8)

The primary inflationary pressures on ASCs are the same as those facing hospitals – namely, intense competition for nurses, rapidly rising medical device costs, and a growing need to adapt new health information technology. Accordingly, we believe the hospital market basket unquestionably is a more appropriate basis for annual ASC updates than the CPI-U, which is a measure of general consumer inflation that is not used for any other Medicare payment system. Certainly, CMS recognizes that health care inflation continues to outstrip inflation in the general economy. Table 4 reveals that over the past five years, the average annual difference between the hospital market basket and the CPI-U proposed for use with ASCs has been 0.9 percent.

TABLE 4

COMPARISON OF HOSPITAL MARKET BASKET TO CPI-U (2001-2005)

Year	Hospital Market Basket	CPI-U	Difference
2001	3.4	2.8	-0.6
2002	3.3	1.6	-1.7
2003	3.5	2.3	-1.2
2004	3.4	2.7	-0.7
2005	3.7	3.4	-0.3
Average	3.46	2.56	-0.9

Both CBO and OMB project that this differential between CPI-U and the hospital market basket will persist for the foreseeable future.

It is the fact that ASCs have the same kinds of cost considerations as HOPDs which justifies linking the new ASC payment system to the OPPS relative payment weights and APC groups in the first place. Once that link is established, we see no sound policy basis for providing different inflation updates to ASCs and HOPDs. Indeed, we are concerned that over time, the cumulative effect of applying differing annual updates to ASCs and HOPDs will further exacerbate the already substantial disparity in payment rates contemplated in the proposed rule and create additional incentives for the creation and expansion of hospitals, rather than more cost-effective ASCs. Therefore, we urge CMS to update ASC payments using the hospital market basket once the MMA freeze on ASC payment rates expires.

In terms of the statutory authority for this policy, MMA gives CMS broad discretion to "implement a revised payment system for payment of surgical services furnished in ambulatory surgical centers," requiring only that the agency "tak[e] into account" the GAO's recommendations and implement the new system not later than January 1, 2008.[19] We believe this broad grant of authority allows CMS to further promote transparency in pricing between ASCs and HOPDs by applying the same inflationary adjustments in both settings.[20]

11. ASC Coinsurance (Section XVIII.C.9)

FASA supports retaining the Medicare beneficiary coinsurance for ASC services at 20 percent. For Medicare beneficiaries, lower coinsurance obligations will continue to be a significant

[19] Section 1833(i)(2)(D) of the Social Security Act, 42 U.S.C. § 1395l(i)(2)(D).

[20] We note that Section 1833(i)(2)(C)(i) of the Act retains a reference to using the CPI-U to adjust ASC payments in years when CMS has not otherwise updated the ASC rates. Since the proposed rule contemplates annual updates of ASC payments through the OPPS process and adjustments to the APC relative weights, this provision would be rendered obsolete by the new payment system.

advantage for choosing an ASC to meet their surgical needs. Beneficiaries will save millions of dollars each year under the revised ASC payment system because ASC payments will in all cases (other than screening colonoscopies, where the beneficiary coinsurance was recently increased to 25 percent effective January 1. 2007) be lower than the 20-40 percent HOPD coinsurance rates allowed under the OPPS.

12. ASC Phase-In (Section XVIII.C.10)

CMS proposes to phase-in the new payment system over one year. Given the size of the payment cuts contemplated for certain procedures and specialties under the proposed rule, one year does not provide adequate time to adjust to the changes. A one year transition is shorter than any other recent payment change made by CMS, including implementation of OPPS. ASCs are disproportionately small businesses, with 64 percent of ASCs having 20 or fewer full-time employees. While the preamble discussion contemplates that ASCs will respond to the proposed rule by "reconfigur[ing] their case mix"[21] and "beginning to perform other services for which the proposed rates under the revised system are significantly higher,"[22] adjustments to case mix and the addition of new procedures to a facility take significant time to implement, if they can be done at all.

Thus, we believe that the new system should be phased-in over several years as changes in reimbursement for specific procedures and specialties may disproportionately impact certain types of ASCs, especially certain types of single-specialty ASCs.

13. ASC Conversion Factor (Section XVIII.C.11)

Appropriate payment policies are driven by many factors, but ultimately only one matters to Medicare beneficiaries – is payment adequate to provide access to services? When the proposed methodology is projected to produce a payment rate of 62 percent of the HOPD rate, we believe the answer to this question will be no for many ASC services.

Certainly, some ASC payments under the proposed rule would increase over current rates and, thus, access for those procedures would likely be expanded. It is worth noting, however, that some large payment increases in the proposed rule, particularly for orthopedic procedures, are driven by inclusion of the device payment in the base rate. Thus, these increases are overstated when compared to current rates that do not include payment for the device (and, as we note above in our discussion of ASC Packaging of devices at pages 14-16, in many cases these increases still are not sufficient to cover the cost of the device).

Moreover, at the specialty level there will be no increases for the three specialties – GI, ophthalmology and pain management – that constitute the vast majority of Medicare ASC services today (approximately 83 percent of total Medicare volume). As we show in Table 1

[21] 71 Fed. Reg. at 49692.

[22] Id. at 49694.

above (page 4), payment for GI services, which currently constitute the largest volume of Medicare ASC services of any specialty at 34 percent, would be substantially cut following full phase-in of the proposed rule. The same applies to pain management, another high volume specialty. We are convinced that many ASCs will be unable to absorb these cuts and will discontinue providing GI and pain management services, among others slated for major payment reductions, if the new ASC system is implemented as proposed.

In assessing the capability of ASCs to absorb the kinds of payment cuts envisioned in the proposed rule, two factors warrant particular consideration. First, most ASCs are small businesses. According to FASA's 2005 ASC Employee Salary & Benefit Survey, 64 percent have 20 or fewer employees. Small businesses generally have less capability to absorb sudden decreases in payment of the sort contemplated in the proposed rule.

Second, a significant percentage of ASCs are single-specialty. Increases in payment rates on certain procedures may allow some ASCs to make up for losses on other procedures. Single-specialty ASCs will have a limited ability to do so, however. In GI, for example, only two of the 30 highest volume procedures are slated for a payment increase, and most will incur double digit decreases in the first year of the new system. In pain management, payment for nine of the ten highest volume procedures will decrease by more than 20 percent. In ophthalmology, prices are reduced for the two highest volume procedures, which constitute approximately 86 percent of total ophthalmic ASC volume.

Setting ASC payment rates too low has the potential to deny Medicare beneficiaries choices and increase their out-of-pocket costs, as well as increase overall expenditures for the Medicare program as procedures are shifted to more costly hospital settings. Thus, CMS should seek to set the payment rate at a reasonable and fair level to promote optimum access to ASCs. Simply put, we do not believe that 62 percent of HOPD rates is either reasonable or fair to ASCs. Nor is it sufficient to prevent services from shifting to hospitals and reduced access to ASCs for certain services.

As part of the ASC Coalition, we have proposed legislation that would set ASC payment rates at 75 percent of HOPD payments. Under this legislation, Medicare would save at least 25 cents on every dollar spent relative to HOPD prices. We believe 75 percent is a reasonable level of savings and that CMS should seek to use this as the optimum payment rate for ASCs. Even this rate would result in payments to ASCs significantly lower than what they received relative to HOPDs just a few years ago. When Congress enacted the new payment system requirement in 2003, the budget neutrality method that today results in a 62 percent ASC conversion factor would have resulted in an 84 to 86 percent conversion factor.

Given these realities, we believe CMS needs to more carefully consider how the new payment system is likely to effect a shift in procedures between ASCs, HOPDs and physician offices, and whether such migration supports a higher ASC conversion factor that actually will promote beneficiary access to ASC services, rather than reduce it. Of course, we understand that the conversion factor is a function of MMA's requirement that the new payment system be budget

neutral, which means the analysis must begin with confirming CMS's legal authority to make reasonable migration assumptions as the basis for an alternative ASC conversion factor.

CMS's Legal Authority to Make Migration Assumptions
in Calculating the ASC Conversion Factor

We believe CMS has clear legal authority to make assumptions regarding the migration of procedures between sites-of-service in the budget neutrality calculations which produce the ASC conversion factor. Specifically, Section 626 of MMA[23] provides that:

> "(ii) In the year the system described in clause (i) is implemented [i.e., the revised ASC payment system], such 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." (Emphasis added.)

The key to interpreting this budget neutrality provision is the underlined phrase, particularly the words in bold – that is, what "such services" are covered by this provision and how is their "aggregate" impact to be measured? The most logical reading of the term "such services" is that it relates to "such system" referenced in parallel form earlier in the same sentence, thus meaning the services covered by the new ASC payment system. With that established, "aggregate" expenditures then refers, by its plain meaning, to "total" or "overall" expenditures for the services covered by the new system, which we believe includes the probable migration of procedures currently performed in HOPDs and physician offices into ASCs, as well as beneficiary coinsurance payments. In other words, under this provision, budget neutrality is to be measured by reference to the impact the new ASC payment system will have on total expenditures for the complete package of services covered by the system, including beneficiary coinsurance payments. Thus, the budget impact is to be evaluated to include any savings that will be achieved through the performance of additional procedures in ASCs, rather than in more costly HOPDs (which we will refer to as "positive migration"), as well as any increased costs from the migration of procedures from physician offices to ASCs (or "negative migration"). The statute recognizes that the net impact of procedure migration is not capable of precise measurement; thus, it only requires that the system be "designed" to achieve budget neutrality, "as estimated by the Secretary."

When proposing significant changes to other Medicare payment systems, CMS has recognized and discussed the implications of changes in efficiency, site utilization, and behavioral modifications providers would make in adapting to the new payment system. For example, in proposing to implement the inpatient rehabilitation facility prospective payment system, the agency discussed how behavioral offsets of physicians played an important role in the discussion of budget neutrality:

[23] Section 1833(i)(2)(D)(ii) of the Social Security Act, 42 U.S.C. § 1395l(i)(2)(D)(ii).

> This provision requires the Secretary, in establishing budget neutral rates, to consider the effects of the new payment system on utilization and other factors reflected in the composition of Medicare payments...The purpose of the budget neutrality provision is to pay the same amount under the prospective payment system as would have been paid under the excluded hospital cost-based payment system for a given set of services, but not to pay that same amount for fewer services furnished as a result of the inherent incentives of the new prospective payment system. Thus, our methodology must account for the change in practice patterns due to new incentives in order to maintain a budget neutral payment system. Efficient providers are adept at modifying and adjusting practice patterns to maximize revenues while still maintaining optimum quality of care for the patient. We take this behavior into account in the behavioral offset. (Emphasis added.)[24]

To establish fair and reasonable payment rates within the congressionally imposed budget neutrality constraints, CMS likewise should calculate a budget neutral conversion factor by considering behavioral offsets in the form positive and negative migration into and out of ASCs as a result of the new payment system.

The ASC Coalition's Proposed Migration Assumptions and Adjusted Conversion Factor

To assist CMS in evaluating the impact of the new ASC payment system on aggregate Medicare expenditures, FASA joined with the other members of the ASC Coalition and commissioned The Lewin Group to conduct numerous studies on how changes in payment were likely to impact facility and physician behaviors. The Lewin Group and the Coalition constructed a series of impact models which produced comparable results. The Lewin Group has reviewed the budget neutrality calculations presented in these comments and have replicated them with their own models.

The following discussion is intended to illustrate the sort of analysis we believe CMS should conduct in evaluating budget neutrality under the new ASC payment system. In sum, we join with the other members of the ASC Coalition and The Lewin Group in asserting that certain changes to the budget neutrality model and assumptions in the proposed rule are appropriate to better capture *both* (i) actual expenditures under existing law, *and* (ii) the changes in behavior that are likely to occur as a consequence of the new payment system.

As we explain below, this includes accounting for spending for all services that will be performed in ASCs in 2008. It also involves accounts for the likely "positive" migration of

[24] 66 Fed. Reg. 41366 (August 7, 2001).

procedures into the ASC setting from other sites of service for procedures that will be newly reimbursed in ASCs in 2008 and for existing ASC procedures slated for substantial payment increases. As such, it captures savings to the Medicare program from procedures that are likely to move from HOPDs into less costly ASC following implementation of the proposed rule. Similarly, CMS should consider "negative" migration out of the ASC for procedures receiving lower payments.

Table 5 below shows each adjustment to the ASC conversion factor proposed by the ASC Coalition and the estimated impact of those adjustments. Following the table, a discussion of each recommended change, why the change is appropriate and the projected result of the change are discussed in greater detail.

TABLE 5

CALCULATION OF ADJUSTED ASC CONVERSION FACTOR

62.90%	CMS's "Alternative" Calculation (this includes HOPD migration at 25% for new procedures and migration from physician offices at 15% for new procedures).
+0.11	To accurately reflect ASC payment rates for procedures capped at HOPD rates if no new payment system in 2008.
=63.01	
+ 0.41	To account for 2007 device costs that were paid to ASCs in addition to facility fees.
=63.42	
+ 3.11	Net savings of reducing movement from physician offices; CMS assumed 15%; we reduce to 2%.
=66.53	
+ 0.43	Correction to exclude beneficiary co-payments for procedures subject to the physician office limit.
+1.04	Adjust for variable HOPD co-insurance by using total payment rates or by applying 20% co-insurance discount to all 2007 services in formula.
=68.00	
+ 5.57	Net savings of positive migration from HOPDs for procedure on the ASC list. Assume that for every 10% increase in reimbursement rate, 1.5% of HOPD volume moves, subject to maximum of 25% of HOPD volume or 25% increase in ASC volume if more than 4,600 procedures are performed in ASC.
=73.57	
-0.51	Net cost for negative migration from ASC to HOPD. Assume that for every 10% decrease in ASC reimbursement, 1.5% of ASC volume moves from ASC to HOPD.
=73.06	

Beginning with the CMS alternative model described on pages 49657-49658 of the proposed rule, which assumes migration of procedures that will first be on the ASC list in 2008, the base conversion factor is 62.90 percent. Under the new payment system, ASCs will be eligible for payment for more than 750 procedures that ASCs were not previously reimbursed for providing. Physicians have demonstrated a preference for performing surgical procedures in ASCs over HOPDs when the ASC is a clinically appropriate setting. To the extent that ASCs have

sufficient capacity to absorb the influx of procedures, new services will inevitably migrate into the ASC. CMS's model assumes that 25 percent of new procedures on the list currently provided in HOPDs and 15 percent of the new procedures on the list currently performed in physician offices would move to the ASC. We believe the later assumption significantly overstates the likely movement from the physician office to the ASC and will discuss our recommendations on this below.

From the 62.90 percent base conversion factor, the following adjustments are recommended:

- ***Use of 2007 ASC Rates for 2008.*** The Deficit Reduction Act (DRA) requires that ASCs be paid no more than the HOPD rate for a given service. This cap will be applied to ASC payments beginning in 2007 until a new payment system is implemented. Absent implementation of a revised payment system in 2008, the payments for services capped under the DRA would increase in 2008 consistent with increases in HOPD rates for these services. Based on our review of CMS's methodology, discussions with CMS staff and our attempts to replicate this model, we conclude that CMS's calculation of the costs for procedures affected by the cap did not include the 2008 update that would apply in the absence of a new payment system (i.e., the CMS model assumes the same rate for DRA-capped procedures in 2007 and 2008). Since HOPD rates are projected to increase 4 percent in 2008, the rates for these procedures should be projected to increase 4 percent, up to the appropriate ASC grouper rate. Our calculations show that this produces an increase of 0.11 percentage points in the conversion factor, bringing it to 63.01 percent. Of course, changes in the market basket would affect this number slightly. If the market basket were only 3 percent, the conversion factor would rise slightly less. (This adjustment should be made even if CMS uses the budget neutrality calculation that was described as the preferred method in the proposed rule.)

- ***Inclusion of Costs for Separately Payable Devices.*** Under the current ASC payment system, Medicare makes a separate payment to cover the costs of implantable prosthetics and DME, rather than reimbursing for the costs of these devices as part of the facility fee. For services with device costs, using only the ASC facility payment in the numerator understates the cost of the service to the government under the current payment system. The proposed system would bundle these devices with the facility payment and, thus, the formula used by CMS includes the costs for these items in the denominator. This can be corrected by adding the cost of the device into the numerator of the agency's calculation. Analysis shows that inclusion of these costs would increase the conversion factor by .41 percentage points, bringing it to 63.42 percent. (This adjustment also is needed if CMS uses the budget neutrality calculation in the proposed rule.)

  Unfortunately, inconsistent implementation of coverage policies for implantable devices by Medicare's administrative contractors results in an under-representation of device costs in the claims data. ASCs often do not receive payment for devices implanted during surgical procedures. In its formula, CMS could simply impute the device cost with HCPCS codes associated the insertion of prosthetic devices or DME. Because these costs

are bundled in the HOPD payment, the representation of the device cost in the numerator and denominator is essential for comparison of expected government expenditures. Because CMS cannot assume that the carriers will inappropriately deny claims for these procedures in 2007, an imputation of the expected device payments in the base year is the most appropriate way to represent the government's expected liabilities in the numerator.

- ***Migration of Procedures from Physician Offices to ASCs.*** Many of the procedures proposed to be added to the list in 2008 are frequently, and appropriately, performed in physician offices. A significant volume of these procedures are unlikely to migrate to the ASC, as physicians can safely and efficiently perform these procedures without moving patients to ASCs. ASCs find that once physicians have the equipment and resources to perform a given procedure in their offices, they prefer to perform the procedure there. Physicians tend to perform procedures in ASCs or HOPDs only when they believe a particular patient needs a facility setting. In this situation, movement from the physician office to the ASC would occur in lieu of movement of the procedure to the HOPD (at a savings to the government and beneficiary). Over time, many procedures currently on the Medicare ASC list have migrated to physician offices even though ASCs can be paid for those services. In the 2005 ASC list final rule, CMS noted that ASC list coverage did not appear to encourage the migration of office-based procedure to ASCs.

  In the proposed rule, CMS assumes that 15 percent of the physician office volume of procedures added to the ASC list in 2008 will migrate to ASCs. We believe this assumption is far too high, as the volume of office migration under a 15 percent assumption exceeds the current case volume of the entire ASC industry in 2005. The opportunity cost to ASCs of numerous low reimbursement minor procedures that are appropriately provided in physician offices would be great considering the alternate use of the ASC capacity in the provision of more complex procedures, which can be more efficiently provided in the ASC setting. Accordingly, we recommend that CMS assume only a 2 percent movement from physician offices to ASCs. When this migration is modeled, it increases the conversion factor by 3.11 percentage points, to a total of 66.53 percent.

- ***Treatment of Physician Office Beneficiary Coinsurance.*** In calculating costs of the proposed payment system, CMS discounts all payments by 20 percent to reflect coinsurance, except the payment rates that are capped at the physician office practice expense rate. Correctly applying 20 percent coinsurance to all services in the denominator increases the conversion factor by 0.43 percent, for a total of 66.96 percent.

- ***Treatment of Variable Coinsurance Rates.*** We believe a second coinsurance adjustment is appropriate to account for the fact that co-payments in hospitals can range from 20 to 40 percent. ASCs and beneficiaries should not be penalized because, for historical reasons, hospitals are allowed to charge higher co-payments. If total payments are used, the conversion factor rises by an additional 1.04 percentage point to a total of 68.00 percent.

- ***Recognizing Price Changes Will Impact Migration of Current ASC Procedures.*** The final two adjustments that we recommend would account for movement of procedures now performed in ASCs as a response to substantial payment rate changes. The current model does not fully capture the migration that will occur when payments within the ASC sector are redistributed among currently covered services.

    - Positive Migration. ASC payment rates for some services have been grossly inadequate. As a result, these services are infrequently performed in ASCs even though their clinical characteristics make them appropriate for this setting. Orthopedics is a good example of a specialty that could move many procedures from the HOPD to the ASC if the payment rates were more appropriate. An industry quarterly outcomes monitoring study shows that in the second quarter of 2006, only 22.5 percent of ASCs were operating above 60 percent operating room capacity, demonstrating the ability of ASCs to increase volume with price increases.

      To model positive migration, we assumed that for each 10 percent increase in the ASC payment rate, 1.5 percent of the volume currently performed in HOPDs would move to ASCs. Recognizing that there is a limit on how many procedures will move even with extremely large price increases, we assumed a maximum movement of 25 percent of the HOPD volume, the same assumption that CMS used for the new procedures added to the ASC list for 2008. In other words, the maximum movement we calculated for existing codes with price increases is identical to the percentage CMS assumed for new codes. In addition, we believe ASC capacity will limit movement and, accordingly, we limited the movement to ASCs to 25 percent of existing ASC volume. This last limit was not applied to procedures with ASC volumes of less than one per ASC, as we assume that this level of volume increase can be accommodated no matter the percentage increase. This assumption increases the conversion factor by 5.57 percentage points to a total of 73.57 percent. The assumptions used vary the calculation greatly. We believe this assumption results in a reasonable limit on movement from hospitals and a reasonable increase in total ASC volume.

    - Negative Migration. Finally, we believe that there will be a cost to Medicare for procedures that move to HOPDs as a result of price reductions. Some high volume ASC procedures may move to HOPDs. For these, we assumed that for every 10 percent decrease in ASC reimbursement, 1.5 percent of ASC volume will move to HOPDs. By paying a higher rate to ASCs, fewer procedures are likely to leave the ASC for the higher cost hospital setting. Although we believe that hospital capacity for procedures is limited, we did not limit the maximum movement. This assumption reduces the conversion factor by 0.51 percentage points, bringing it to 73.06 percent.

Taken together, the changes we propose to the ASC conversion factor calculation correct basic calculation errors in the proposed alternative budget neutrality methodology and account for how we believe the industry will respond to the changes in the ASC payment system. Establishing a budget neutrality factor of 73 percent maximizes the volume of procedures likely to migrate from the more expensive HOPD setting and minimizes the reductions in payment that would induce "negative" migration from ASCs to HOPDs. The discount produces significant savings for the Medicare program and for beneficiaries.

As we noted above, MMA requires that CMS implement a system that is designed to be budget neutral *in the year in which the new payment system is implemented.* Thus, the proposed rule provides for implementation in 2008 with the payment of a 50-50 blend of the 2007and 2008 rates. Accordingly, in its estimate of the ASC conversion factor, CMS uses this blended rate to calculate budget neutrality. We believe this is an appropriate interpretation of the legislation and produces the most reasonable result. As discussed elsewhere in these comments, to achieve the best result for the Medicare program and beneficiaries, reasonable payment must be provided. To accomplish this goal, CMS needs to use the discretion given to it by Congress. Using the blended rates for 2008 reflects one such opportunity and complies with the mandate given to the agency by Congress. We recognize that because the 2008 rates are blended, the system will have increased expenditures in 2009 unless migration follows a different pattern.

Given that the ASC payment system has not undergone a major recalibration of rates in almost two decades, during which time major changes in the volume, type and intensiveness of procedures performed in ASC has changed greatly, achieving the correct balance without driving cases back to the hospital supports our adjusted ASC conversion factor.

Moreover, due to the effects of the six-year rate freeze compounded by the DRA cuts, the conversion factor needed to achieve budget neutrality has decreased significantly. Had the ASC payment system been linked to OPPS in 2003 when Congress enacted the legislating calling for CMS to implement a new payment system, the budget neutral rate under the most conservative assumptions would have been in the 84 to 86 percent range. Congress gave CMS the authority to implement the new ASC payment system between 2006 and 2008. Had CMS implemented the new system in 2006, the first year that CMS was authorized to do so, the ASC conversion factor would have been at least eight percent higher.

Conclusions on the ASC Conversion Factor

For the reasons stated above, we believe the ASC Coalition's adjusted conversion factor is more appropriate than the methodology followed in the proposed rule. The proposed rule's methodology reflects an extremely narrow view of budget neutrality that, in particular, does not evaluate the likely migration of procedures currently provided in ASCs as a result of substantial changes in reimbursement rates, both up and down. We also believe CMS's approach is inadequate because it ignores the preference of physicians to perform procedures in ASCs and the likelihood that expansion of the list of ASC-covered procedures will allow thousands of procedures currently performed in HOPDs to migrate to ASCs at a savings to the government

and to beneficiaries. We strongly recommend that in the final rule, CMS reject its methodology in favor of the alternative methodology described above.

We also urge CMS to reconsider its plan to perform a secondary rescaling of the APC relative weights as part of the new ASC payment system. Under the OPPS, CMS applies a budget neutrality adjustment to the APC relative weight values after they are recalibrated with new cost data each year. A secondary rescaling of these relative weights is proposed that would be specific to ASCs. We are concerned that this secondary rescaling will result in annual and potentially cumulative variations between ASC and HOPD payments without any evidence that the relative cost of providing services has further diverged between the two settings.

14. ASC Updates (Section XVIII.C.12)

We are pleased that CMS is committing to annual updates of the new ASC payment system, and agree it makes sense to do that conjunction with the OPPS update cycle so as to help further advance transparency between the two systems. Regular, predictable and timely updates will promote beneficiary access to ASCs as changes in clinical practice and innovations in technology continue to expand the scope of services that can be safely performed on an outpatient basis.

15. ASC Addenda (Section XVIII.D)

We noted the following technical errors and omissions in Addendum BB of the proposed rule:

- CPT 19298 (placement of brachytherapy catheters following partial mastectomy) is listed in Addendum BB without an ASC relative payment weight or a CY 08 payment amount without the 50/50 transition. The CY 08 payment amount with the 50/50 transition is listed as $166.50, even though 19298 is an APC 1524 procedure with an OPPS payment amount of $3,250 for CY 07. We note that pursuant to Section XVII.B.6 of the proposed rule, 19298 is being reassigned to ASC payment group 9 (from group 1) for 2007.

- CPT 37206 (transcatheter placement of intravascular stent, each additional vessel) is a new code for the 2007 ASC list and appears in Addendum AA, but is not listed in Addendum BB for 2008.

- CPT 47562 (laparoscopic cholecystectomy) and 47563 (laparoscopic cholecystectomy with cholangiography) are listed in Addendum BB. However, a third CPT code for laparoscopic cholecystectomy with common bile duct exploration (47564) is omitted from Addendum BB. Like the other two laparoscopic cholecystectomy procedures, 47564 can be safely performed in ASCs without an overnight stay, as defined in the proposed rule, and thus should be added to Addendum BB.

* * *

Thank you for your consideration of our comments. We look forward to continuing to work with CMS on development and implementation of the revised payment system for ASCs.

Sincerely,

Kathy J. Bryant
President

APPENDIX A

MEDICINE, RADIOLOGY, CATEGORY III CPT AND HCPCS LEVEL II CODES FOR ADDITION TO COVERAGE IN ASCs

CPT Code(s)	Descriptor or Type of Service	Rationale
92018	Ophthal exam under general anesthesia	Invasive medical procedure
92019	Ophthal exam under general anesthesia	Invasive medical procedure
92502	Otolaryngologic exam under general anesthesia	Invasive medical procedure
92960-98	Therapeutic cardiovascular services	Invasive medical procedures
93312-18	Transesophageal echocardiography	Invasive medical procedures
935xx	Cardiac catheterization	Invasive medical procedures
93600-62	Electrophysiologic studies	Invasive medical procedures
95920	Intraoperative neurophysiology testing	Invasive medical procedure
95971-75	Intraoperative neurostimulator program/analysis	Invasive medical procedure
70170	X-ray exam of tear duct	Invasive radiologic procedure
70332	X-ray exam of jaw joint	Invasive radiologic procedure
70373	Contrast x-ray of larynx	Invasive radiologic procedure
70390	X-ray exam of salivary duct	Invasive radiologic procedure
71040	Contrast x-ray of bronchi	Invasive radiologic procedure
71060	Contrast x-ray of bronchi	Invasive radiologic procedure
71090	X-ray and pacemaker insertion	Invasive radiologic procedure
72240	Contrast x-ray of neck spine	Invasive radiologic procedure
72255	Contrast x-ray, thorax spine	Invasive radiologic procedure
72265	Contrast x-ray, lower spine	Invasive radiologic procedure
72270	Contrast x-ray, spine	Invasive radiologic procedure
72275	Epidurography	Invasive radiologic procedure
72285	Diskography, cervical or thoracic	Invasive radiologic procedure
72295	Diskography, lumbar	Invasive radiologic procedure
73040	Contrast x-ray of shoulder	Invasive radiologic procedure
73085	Contrast x-ray of elbow	Invasive radiologic procedure
73115	Contrast x-ray of wrist	Invasive radiologic procedure
73525	Contrast x-ray of hip	Invasive radiologic procedure
73530	X-ray exam of hip	Concurrent radiologic procedure
73542	X-ray exam, sacroiliac joint	Invasive radiologic procedure
73580	Contrast x-ray of knee joint	Invasive radiologic procedure
73615	Contrast x-ray of ankle	Invasive radiologic procedure
74190	X-ray exam of peritoneum	Invasive radiologic procedure
74235	Remove esophagus obstruction	Invasive radiologic procedure
74300	X-ray bile ducts/pancreas at surgery	Concurrent radiologic procedure
74301	X-ray bile ducts/pancreas at surgery add-on	Concurrent radiologic procedure
74305	X-ray bile ducts/pancreas	Invasive radiologic procedure
74320	Contrast x-ray of bile ducts	Invasive radiologic procedure
74327	X-ray bile stone removal	Invasive radiologic procedure
74340	X-ray guide for GI tube	Invasive radiologic procedure
74350	X-ray guide, stomach tube	Invasive radiologic procedure
74355	X-ray guide, intestinal tube	Invasive radiologic procedure
74360	X-ray guide, GI dilation	Invasive radiologic procedure
74363	X-ray, bile duct dilation	Invasive radiologic procedure
74420	Urography, retrograde	Concurrent radiologic procedure
74425	Contrast x-ray, urinary tract	Concurrent radiologic procedure
74430	Contrast x-ray, bladder	Concurrent radiologic procedure

CPT Code(s)	Descriptor or Type of Service	Rationale
74440	X-ray, male genital tract	Invasive radiologic procedure
74445	X-ray exam of penis	Invasive radiologic procedure
74450	X-ray, urethra/bladder	Invasive radiologic procedure
74455	X-ray, urethra/bladder	Invasive radiologic procedure
74475	X-ray control, cath insert	Invasive radiologic procedure
74480	X-ray control, cath insert	Invasive radiologic procedure
74485	X-ray guide, GU dilation	Invasive radiologic procedure
74740	Hysterosalpingography	Concurrent radiologic procedure
74742	X-ray, fallopian tube	Invasive radiologic procedure
75600	Contrast X-ray exam of aorta	Invasive radiologic procedure
75605	Contrast X-ray exam of aorta	Invasive radiologic procedure
75625	Contrast X-ray exam of aorta	Invasive radiologic procedure
75630	X-ray aorta, leg arteries	Invasive radiologic procedure
75650	Artery x-rays, head & neck	Invasive radiologic procedure
75658	Artery x-rays, arm	Invasive radiologic procedure
75660	Artery x-rays, head & neck	Invasive radiologic procedure
75662	Artery x-rays, head & neck	Invasive radiologic procedure
75665	Artery x-rays, head & neck	Invasive radiologic procedure
75671	Artery x-rays, head & neck	Invasive radiologic procedure
75676	Artery x-rays, neck	Invasive radiologic procedure
75680	Artery x-rays, neck	Invasive radiologic procedure
75685	Artery x-rays, spine	Invasive radiologic procedure
75705	Artery x-rays, spine	Invasive radiologic procedure
75710	Artery x-rays, arm/leg	Invasive radiologic procedure
75716	Artery x-rays, arms/legs	Invasive radiologic procedure
75722	Artery x-rays, kidney	Invasive radiologic procedure
75724	Artery x-rays, kidneys	Invasive radiologic procedure
75726	Artery x-rays, abdomen	Invasive radiologic procedure
75731	Artery x-rays, adrenal gland	Invasive radiologic procedure
75733	Artery x-rays, adrenals	Invasive radiologic procedure
75736	Artery x-rays, pelvis	Invasive radiologic procedure
75741	Artery x-rays, lung	Invasive radiologic procedure
75743	Artery x-rays, lungs	Invasive radiologic procedure
75746	Artery x-rays, lung	Invasive radiologic procedure
75756	Artery x-rays, chest	Invasive radiologic procedure
75774	Artery x-rays, each vessel	Invasive radiologic procedure
75790	Visualize A-V shunt	Invasive radiologic procedure
75801	Lymph vessel x-ray, arm /leg	Invasive radiologic procedure
75803	Lymph vessel x-ray, arm /legs	Invasive radiologic procedure
75805	Lymph vessel x-ray, trunk	Invasive radiologic procedure
75807	Lymph vessel x-ray, trunk	Invasive radiologic procedure
75809	Nonvascular shunt, x-ray	Invasive radiologic procedure
75810	Vein x-ray, spleen/liver	Invasive radiologic procedure
75820	Vein x-ray, arm/leg	Invasive radiologic procedure
75822	Vein x-ray, arms/legs	Invasive radiologic procedure
75825	Vein x-ray, trunk	Invasive radiologic procedure
75827	Vein x-ray, chest	Invasive radiologic procedure
75831	Vein x-ray, kidney	Invasive radiologic procedure
75833	Vein x-ray, kidneys	Invasive radiologic procedure
75840	Vein x-ray, adrenal gland	Invasive radiologic procedure
75842	Vein x-ray, adrenal glands	Invasive radiologic procedure
75860	Vein x-ray, neck	Invasive radiologic procedure

CPT Code(s)	Descriptor or Type of Service	Rationale
75870	Vein x-ray, skull	Invasive radiologic procedure
75872	Vein x-ray, skull	Invasive radiologic procedure
75880	Vein x-ray, eye socket	Invasive radiologic procedure
75885	Vein x-ray, liver	Invasive radiologic procedure
75887	Vein x-ray, liver	Invasive radiologic procedure
75889	Vein x-ray, liver	Invasive radiologic procedure
75891	Vein x-ray, liver	Invasive radiologic procedure
75894	X-rays, transcath therapy	Invasive radiologic procedure
75896	X-rays, transcath therapy	Invasive radiologic procedure
75898	Follow-up angiography	Invasive radiologic procedure
75901	Remove cva device obstruct	Invasive radiologic procedure
75902	Remove cva lumen obstruct	Invasive radiologic procedure
75940	X-ray placement, vein filter	Invasive radiologic procedure
75945	Intravascular us	Invasive radiologic procedure
75946	Intravascular us add-on	Invasive radiologic procedure
75960	Transcath iv stent	Invasive radiologic procedure
75961	Retrieval, broken catheter	Invasive radiologic procedure
75962	Repair arterial blockage	Invasive radiologic procedure
75964	Repair artery blockage, each	Invasive radiologic procedure
75966	Repair artery blockage	Invasive radiologic procedure
75968	Repair artery blockage, each	Invasive radiologic procedure
75970	Vascular biopsy	Invasive radiologic procedure
75978	Repair venous blockage	Invasive radiologic procedure
75980	Contrast xray exam bile duct	Invasive radiologic procedure
75982	Contrast xray exam bile duct	Invasive radiologic procedure
75984	Xray control catheter change	Invasive radiologic procedure
75992	Atherectomy, x-ray exam	Invasive radiologic procedure
75993	Atherectomy, x-ray exam	Invasive radiologic procedure
75994	Atherectomy, x-ray exam	Invasive radiologic procedure
75995	Atherectomy, x-ray exam	Invasive radiologic procedure
75996	Atherectomy, x-ray exam	Invasive radiologic procedure
76000	Fluoroscopy, up to one hour	Concurrent radiologic procedure
76012	Fluoroscopy, for percutaneous vertebroplasty	Concurrent radiologic procedure
76013	CT guidance for percutaneous vertebroplasty	Concurrent radiologic procedure
76080	X-ray exam of fistula	Invasive radiologic procedure
76086	X-ray of mammary duct	Invasive radiologic procedure
76088	X-ray of mammary ducts	Invasive radiologic procedure
76095	Stereotactic guidance breast biopsy or needle	Concurrent radiologic procedure
76096	Mammographic guidance, placement breast needle	Concurrent radiologic procedure
76098	Radiologic examination surgical specimen	Concurrent radiologic procedure
76355	Ct scan for localization	Concurrent radiologic procedure
76360	Ct scan for needle biopsy	Concurrent radiologic procedure
76362	Ct scan for tissue ablation	Concurrent radiologic procedure
76393	Mr guidance for needle place	Concurrent radiologic procedure
76394	Mri for tissue ablation	Concurrent radiologic procedure
76496	Fluoroscopic procedure	Concurrent radiologic procedure
76497	Ct procedure	Concurrent radiologic procedure
76498	Mri procedure	Concurrent radiologic procedure
76529	Echo exam of eye	Concurrent radiologic procedure
76831	Echo exam, uterus	Concurrent radiologic procedure
76872	Us, transrectal	Concurrent radiologic procedure
76930	Echo guide, cardiocentesis	Concurrent radiologic procedure

CPT Code(s)	Descriptor or Type of Service	Rationale
76932	Echo guide for heart biopsy	Concurrent radiologic procedure
76936	Echo guide for artery repair	Concurrent radiologic procedure
76940	US guide, tissue ablation	Concurrent radiologic procedure
76941	Echo guide for transfusion	Concurrent radiologic procedure
76942	Echo guide for biopsy	Concurrent radiologic procedure
76945	Echo guide, villus sampling	Concurrent radiologic procedure
76946	Echo guide for amniocentesis	Concurrent radiologic procedure
76948	Echo guide, ova aspiration	Concurrent radiologic procedure
76965	Echo guidance radiotherapy	Concurrent radiologic procedure
76975	Gastrointestinal endoscopic ultrasound	Concurrent radiologic procedure
76986	Ultrasonic guidance, intraoperative	Concurrent radiologic procedure
77750-89	Brachytherapy source application	Concurrent radiologic procedure
0008T	Upper GI endoscopy w/suture	Clinically similar to covered procedure
0016T	Thermotx choroids vasc lesion	Clinically similar to covered procedure
0017T	Photocoagulat macular drusen	Clinically similar to covered procedure
0027T	Endoscopic epidural lysis	Clinically similar to covered procedure
0046T	Cath lavage, mammary duct	Clinically similar to covered procedure
0047T	Cath lavage, mammary ducts	Clinically similar to covered procedure
0054T	Bone surgery using computer	Clinically similar to covered procedure
0055T	Bone surgery using computer	Clinically similar to covered procedure
0056T	Bone surgery using computer	Clinically similar to covered procedure
0062T	Rep intradisc annulus; 1 level	Clinically similar to covered procedure
0063T	Rep intradisc annulus; >1 level	Clinically similar to covered procedure
0071T	U/S leiomyomata ablate <200	Clinically similar to covered procedure
0072T	U/S leiomyomata ablate <200	Clinically similar to covered procedure
0084T	Temp prostate urethral stent	Clinically similar to covered procedure
0088T	RF tongue base vol reduxn	Clinically similar to covered procedure
0099T	Implant corneal ring	Clinically similar to covered procedure
0100T	Prosth retina receive & gen	Clinically similar to covered procedure
0101T	Extracorp shockwv tx, hi enrg	Clinically similar to covered procedure
0102T	Extracorp shockwv tx, anesth	Clinically similar to covered procedure
0120T	Fibroadenoma cryoablate, ea	Clinically similar to covered procedure
0123T	Scleral fistulization	Clinically similar to covered procedure
0124T	Conjunctival drug placement	Clinically similar to covered procedure
0133T	Esophageal implant injexn	Clinically similar to covered procedure
0135T	Perc cryoablate renal tumor	Clinically similar to covered procedure
0137T	Prostate saturation sampling	Clinically similar to covered procedure
0155T	Lap ins gastr eltrd for mo	Clinically similar to covered procedure
0156T	Lap redo gastr eltrd for mo	Clinically similar to covered procedure
0170T	Anorectal fistula plug rpr	Clinically similar to covered procedure
0173T	Intraop monitor IO pressure	Clinically similar to covered procedure
C9716	Radiofrequency energy to anus	Clinically similar to covered procedure
C9724	EPS gast cardia plic	Clinically similar to covered procedure
C9725	Place endorectal app	Clinically similar to covered procedure
C9726	Rxt breast appl place/remov	Clinically similar to covered procedure
D3460	Endodontic endosseous implan	Clinically similar to covered procedure
D3999	Endodontic procedure	Clinically similar to covered procedure
D4260	Osseous surgery per quadrant	Clinically similar to covered procedure
D4263	Bone replce graft first site	Clinically similar to covered procedure
D4264	Bone replce graft each add	Clinically similar to covered procedure
D4268	Surgical revision procedure	Clinically similar to covered procedure
D4270	Pedicle soft tissue graft pr	Clinically similar to covered procedure

CPT Code(s)	Descriptor or Type of Service	Rationale
D4271	Free soft tissue graft proc	Clinically similar to covered procedure
D4273	Subepithelial tissue graft	Clinically similar to covered procedure
D4355	Full mouth debridement	Clinically similar to covered procedure
D4381	Localized delivery antimicro	Clinically similar to covered procedure
D7111	Extraction coronal remnants	Clinically similar to covered procedure
D7140	Extraction erupted tooth/exr	Clinically similar to covered procedure
D7210	Rem imp tooth w mucoper flp	Clinically similar to covered procedure
D7220	Impact tooth remov soft tiss	Clinically similar to covered procedure
D7230	Impact tooth remov part bony	Clinically similar to covered procedure
D7240	Impact tooth remov comp bony	Clinically similar to covered procedure
D7241	Impact tooth remov bony w/comp	Clinically similar to covered procedure
D7250	Tooth root removal	Clinically similar to covered procedure
D7260	Oral antral fistula closure	Clinically similar to covered procedure
D7261	Primary closure sinus perf	Clinically similar to covered procedure
D7291	Transseptral fiberotomy	Clinically similar to covered procedure
D7490	Reshaping bone orthognathic	Clinically similar to covered procedure
D9930	Treatment of complications	Clinically similar to covered procedure
D9951	Limited occlusal adjustment	Clinically similar to covered procedure
D9952	Complete occlusal adjustment	Clinically similar to covered procedure
G0259	Inject for sacroiliac joint	Clinically similar to covered procedure
G0293	Non-cov surg proc, clin trial	Clinically similar to covered procedure
G0294	Non-cov proc, clinical trial	Clinically similar to covered procedure
G0297	Insert single chamber/cd	Clinically similar to covered procedure
G0298	Insert dual chamber/cd	Clinically similar to covered procedure
G0299	Inser/repos single icd+leads	Clinically similar to covered procedure
G0300	Insert reposit lead dual+gen	Clinically similar to covered procedure

APPENDIX B

SURGERY SERVICES PACKAGED INTO RADIOLOGY SERVICES UNDER OPPS

Surgery Code(s)	Corresponding CPT Code(s) for Radiology Service	Descriptor of Radiology Service
68850	70170	X-ray exam of tear duct
21116	70332	X-ray exam of jaw joint
31708	70373	Contrast x-ray of larynx
42550	70390	X-ray exam of salivary duct
31708, 31710, 31715	71040-60	Contrast x-ray of bronchi
62284	72240-70	Contrast x-ray of spine
62291	72285	Diskography, cervical or thoracic
62290	72295	Diskography, lumbar
23350	73040	Contrast x-ray of shoulder
24220	73085	Contrast x-ray of elbow
25246	73115	Contrast x-ray of wrist
27093, 27095	73525	Contrast x-ray of hip
27370	73580	Contrast x-ray of knee joint
27648	73615	Contrast x-ray of ankle
49400	74190	X-ray exam of peritoneum
47505	74305	X-ray bile ducts/pancreas
47500	74320	Contrast x-ray of bile ducts
50394, 50684, 50690	74425	Contrast x-ray, urinary tract
51600, 51605	74430	Contrast x-ray, bladder
55300	74440	X-ray, male genital tract
54230	74445	X-ray exam of penis
51610	74450	X-ray, urethra/bladder
51600	74455	X-ray, urethra/bladder
58340	74740	Hysterosalpingography
38790	75801-07	Lymph vessel x-ray
49427	75809	Nonvascular shunt, x-ray
38200	75810	Vein x-ray, spleen/liver
36481	75885-87	Vein x-ray, liver
20501, 49424	76080	X-ray exam of fistula
19030	76086-88	X-ray of mammary duct
19290, 19291	76095	Stereotactic guidance breast biopsy or needle
19290, 19291	76096	Mammographic guidance, placement breast needle
58340	76831	Echo exam, uterus
19290, 19291	76942	Echo guide for biopsy