

proposed ASC rates and ratesetting methodology with the proposed OPPS that was published in the **Federal Register** on September 8, 1998, followed by publication of an OPPS correction notice on June 30, 1999.

Notwithstanding the close of the comment period on July 30, 1999, the changes required to implement a new payment system for ASC facility services could not be implemented because our contractors had to prepare Medicare claims processing systems to be Year 2000 ("Y2K") compliant.

On November 29, 1999, the Balanced Budget Refinement Act of 1999 (BBRA)(Pub. L. 106-113) was enacted. Section 226 of BBRA required that full implementation of the proposed ASC rates be delayed over a 3 year period. Specifically, the BBRA stated that if a prospective payment system for ASCs, that is, one involving the June 1998 proposed rates, was implemented prior to incorporating data from a 1999 or subsequent Medicare cost survey, in the first year of implementation no more than $\frac{1}{3}$ of the new ASC payment would consist of this new rate and the remainder would consist of the current payment rate. In the following year, no more than $\frac{2}{3}$ of the new rate would consist of the June 1998 proposed rate and the remainder would consist of the current rate.

Significant changes in the OPPS were also required as a result of the enactment of the BBRA. Substantial pressures to implement the OPPS combined with the new OPPS requirements resulting from enactment of the BBRA compelled us to focus all available resources on the OPPS, which was implemented on August 1, 2000.

On December 21, 2000, the Medicare, Medicaid and SCHIP Benefit Improvement and Protection Act of 2000 (BIPA)(Pub. L. 106-554) was enacted. Section 424 of BIPA prohibited implementation of a revised prospective payment system for ASC facility services before January 1, 2002, extended the phase-in of the APC system for ASCs to four years and required that by January 1, 2003, ASC rates be rebased using data from a 1999 or later Medicare survey.

The changes mandated by the BBRA and the BIPA, combined with the diversion of resources necessitated by Y2K compliance activities and implementation and start-up issues related to the OPPS have resulted in the delay in issuing a final ASC rule to implement the changes in the June 12, 1998 proposed rule. As stated above, Section 424 of BIPA requires that payment rates effective January 1, 2003 be based on a survey of ASCs conducted

after 1999. We have developed an ASC survey instrument, but our experience in collecting ASC cost data in 1994 suggests that completion of the survey instrument, followed by an audit of the data reported by ASCs and the subsequent compilation of cost data upon which to base ASC payment rates, takes at least 2 years. Therefore, rather than delaying further the biennial update of the ASC list mandated by the statute, in this final rule with comment period we are making final only the additions to and deletions from the ASC list that we proposed in the June 12, 1998 proposed rule. We are not implementing at this time any of the other changes proposed in the June 1998 proposed rule. That is, we are not making final the regulatory changes in part 416 that we proposed or the proposed ratesetting methodology based on APC groups and survey data of ASC costs collected in 1994. We recognize that we are not in compliance with the requirements enacted by section 424 of BIPA, that we rebase rates by January 1, 2003 using data from a survey of ASC costs taken in 1999 or later. While we are committed to rebasing and restructuring the ASC payment rates, we are also committed to ensuring that the method we use to rebase ASC payment rates does not inadvertently result in rates that amplify payment differentials across ambulatory sites of service. We are studying approaches to ratesetting, some of which may require legislative change that will provide adequate payments to ASCs for surgical services and that are in line with what Medicare pays under the OPPS and the physician fee schedule for the same service.

In section III of this preamble, we respond to comments that we received timely on our proposed additions to and deletions from the ASC list. In addition, we are proposing to add to the list a limited number of new CPT codes that were added to CPT in 1999, 2000, 2001, 2002, and 2003 and that are similar to procedures on the updated ASC list. These new CPT codes are designated by an "A*" in column 2 of the Addendum. We solicit comments on the addition of these new CPT codes and the payment rates proposed for these new codes.

In the June 1998 proposed rule, we listed codes with corresponding new payment rates based on the 1994 survey of ASC costs. Because we do not have current survey data upon which to base new payment rates, we have assigned the codes being added to the ASC list in this final rule to one of the nine existing payment groups under which payments for ASC facility services are currently made. With the guidance of our medical advisors, we matched additions to the

ASC list with codes for procedures already on the ASC list that they most closely resemble in terms of clinical work and resource inputs such as equipment, supplies, and time required in the operating suite. We assigned the additions to the list to the same payment group to which the matching codes are currently assigned. For example, our medical advisors determined that CPT code 24341, Repair tendon or muscle, upper arm or elbow, each tendon or muscle, primary or secondary (excludes rotator cuff), is in the same family of codes as CPT code 24340, Tenodesis of biceps tendon at elbow (separate procedure) and CPT code 24342, Reinsertion of ruptured biceps or triceps tendon, distal, with or without tendon graft. CPT codes 24340 and 24342 are both currently assigned to payment group 3. Because the resource inputs such as supplies, equipment, and time in the operating suite for CPT code 24341 are similar to the resources required to perform CPT codes 24340 and 24342, we assigned CPT code 24341 to group 3 to maintain consistency in payment for this family of closely related codes.

In the case of some codes, such as CPT 47511, Introduction of percutaneous transhepatic stent for biliary drainage, we identified procedures on the current list that they most closely resemble clinically and in terms of resource inputs, but we assigned the code to a higher payment group to take into account expensive equipment or supplies that are required to perform the procedure. Therefore, while CPT code 47511 is similar to CPT code 47510, which is currently on the ASC list and assigned to payment group 2, we assigned CPT code 47511 to payment group 9 to take into account the added cost of expensive supplies required for this procedure.

There are some procedures that we proposed to add to the ASC list in the June 1998 proposed rule that we are not adding to the list at this time. We are not adding to the ASC list procedures that are inconsistent with our current criteria in § 416.65 for determining surgical procedures payable in an ASC. Also, we are not adding to the list procedures that would otherwise have met the criteria for inclusion on the ASC list, except that they would be significantly overpaid in the lowest ASC payment group, which could create an incentive to shift these procedures to an ASC setting. The payment rates proposed for many of these procedures in the June 12, 1998 proposed rule were significantly less than the lowest current ASC payment group because we were proposing a different ratesetting method