provision requiring the Secretary to publish a list of procedures covered in an ASC through issuance of periodic notices in the **Federal Register**.

Section 9343 of the Omnibus Budget Reconciliation Act of 1986 (OBRA '86) (Public Law 99-509), enacted on October 21, 1986, amended section 1833(i)(1) of the Act to require that the ASC list of procedures be reviewed and updated by April 21, 1987, and not less often than every 2 years thereafter. As a result, we published updates in the Federal Register on April 21, 1987 (52 FR 13176), June 1, 1989 (54 FR 23540), and December 31, 1991 (56 FR 67666). These updates supplement the original list of covered ASC procedures published on August 5, 1982 (47 FR 34099).

In line with the Congressional intent, current regulations (42 CFR 416.65(a)) list the following general requirements regarding the range of covered ASC services:

- Procedures on the list are commonly performed on an inpatient basis but, consistent with accepted medical practice, also may be performed in an ASC.
- The list excludes procedures that are commonly performed, or may be safely performed, in a physician's office.
- Procedures are limited to those requiring a dedicated operating room and generally do not require an overnight stay.
- The list does not contain procedures excluded from Medicare coverage.

In addition, current regulations (§ 416.65(b)) list the following specific requirements:

- Covered surgical procedures are limited to those that do not generally exceed—
 - + A total of 90 minutes operating time; and
 - + A total of 4 hours recovery or convalescent time.
- If the covered surgical procedures require anesthesia, the anesthesia must be—
 - + Local or regional anesthesia; or
 - + General anesthesia of 90 minutes or less duration.
- Covered surgical procedures may not be of a type that—
 - + Generally result in extensive blood loss;
 - + Require major or prolonged invasion of body cavities;
 - + Directly involve major blood vessels; or
 - + Are generally emergency or lifethreatening in nature.

Currently, ASC covered procedures are classified according to an eight

group payment classification system, as follows:

Group 1—\$295 Group 2—\$395

Group 3—\$453

Group 4—\$558 Group 5—\$637

Group 6—\$750 (\$600+\$150)

Group 7—\$883

Group 8—\$880 (\$730+\$150)

(The \$150 payment allowance in Groups 6 and 8 is for intraocular lenses (IOLs).) A ninth payment group allotted exclusively to extracorporeal shock wave lithotripsy (ESWL) services was established in the notice with comment period published December 31, 1991 (56 FR 67666). The decision in American Lithotripsy Society v. Sullivan, 785 F. Supp. 1034 (D.D.C. 1992) prohibits us from paying for these services under the ASC benefit at this time. ESWL payment rates are the subject of a separate Federal Register proposed notice, which was published October 1, 1993 (58 FR 51355)

The ASC facility payment for all procedures in each group is established at a single rate adjusted for geographic variation. This prospectively determined facility group rate does not include physicians' fees and other medical items and services (for example, prosthetic devices, except IOLs) for which separate payment is authorized under other provisions of the Medicare program. Rather, the rate is a standard overhead amount that covers the cost of services such as nursing, supplies, equipment, and use of the facility.

Section 9343 of OBRA '86 amended section 1833(i)(2)(A) of the Act to require updating of the ASC payment rates annually beginning no later than July 1, 1987. In addition, so that the most current wage index values can be used in determining payment amounts for ASC facility services, annual ASC payment rate updates are implemented concurrently with the annual update of the inpatient hospital prospective payment system (PPS) wage index published in the **Federal Register**.

Section 13531 of the Omnibus Budget Reconciliation Act of 1993 (OBRA '93) (Public Law 103–66), enacted on August 10, 1993, prohibited the Secretary from providing for any inflation update in the ASC payment rates for fiscal year 1995. In addition, the legislation reduced the allowance for an IOL furnished during or subsequent to cataract surgery performed in an ASC from \$200 to \$150 beginning January 1, 1994, and before January 1, 1999. As a result, the payment rates and the \$150 payment allowance for an IOL in Groups 6 and

8 will remain the same in fiscal year 1995.

In our December 1991 notice, we stated that changes in ASC payment rates and the list of ASC covered procedures would be implemented concurrently during the years in which both are updated (56 FR 67677). The ASC payment rates and the ASC procedure list were updated concurrently for the first time effective for ASC services furnished beginning December 31, 1991. Because of the OBRA '93 freeze on the ASC payment rates for fiscal year 1995, the ASC payment rate update notice will not be published this year although we will instruct our carriers to adopt the fiscal year 1995 hospital inpatient PPS wage index, published in the Federal Register on September 1, 1994 (59 FR 45330), to adjust payment rates for regional wage differences.

II. Provisions of the Proposed Notice

In the proposed notice, which was published December 14, 1993 (58 FR 65357), we proposed specific procedures for addition to or deletion from the ASC list. These proposed changes were the result of our consideration of data on site of service from the National Claims History File (NCHF) and general correspondence received from the public and medical community over the few years preceding publication of the proposed notice. (The NCHF is a database maintained by our Bureau of Data Management and Strategy. The data in the NCHF are derived from 100 percent of the Medicare Part A and Part B claims processed.) For each proposed addition, we proposed a payment group based on payment rates for codes on the existing ASC list, and in the same Physicians Current Procedural Terminology (CPT) grouping, that are similar in surgical method and resource consumption. (The CPT is published annually by the American Medical Association.)

With the advice of our medical staff, we proposed to add surgical procedures that are performed in ASCs and meet certain standards contained in existing regulations. We also proposed to modify our criteria for deleting procedures from the ASC list. As the practice of medicine has changed over the years, procedures that were at one time commonly performed on an inpatient basis gradually have shifted to the hospital outpatient department (OPD) as the most common site of service, and a few eventually have shifted to the physician's office as the primary site of service. Procedures that are not performed on an inpatient basis or are primarily performed in a physician's