Common Procedure Coding System (HCPCS) code L8612) is not a part of the facility fee, but rather is made separately under Medicare Part B.

Comment: A dozen commenters disagreed with the assignment of CPT code 58990 (hysteroscopy, diagnostic) to payment group 1, recommending that it be placed in payment group 3.

Response: CPT code 58990 was added as a payment group 1 procedure to the list of Medicare-covered ASC procedures, effective for services furnished beginning on January 30, 1992. CPT code 58990 was replaced by CPT code 56350 (hysteroscopy diagnostic (separate procedure)) in the 1993 CPT, and CPT code 58990 was deleted from both the CPT and the ASC list. Because this change constituted essentially an editorial rather than a substantive revision, we retained CPT code 56350 in payment group 1, the same payment group to which its predecessor, CPT code 58990, had been assigned. CPT code 56350 is on the list of procedures for which we are collecting resource cost data in Part II of the Medicare ASC survey, and its payment group assignment, along with that of all other procedures on the list of Medicare-covered ASC procedures, will be reevaluated within the context of the survey data. In the interim, CPT code 56350 will remain in payment group 1.

Additional Information

We received several dozen comments on payment issues that were not raised in our December 1993 proposed notice. Primarily, commenters recommended placing CPT codes that are currently on the ASC list in a higher payment group. A few commenters expressed disappointment over the lack of a payment rate update for inflation as a result of the 2-year freeze enacted by the Congress in OBRA '93.

As indicated in our December 1993 proposed notice, we are deferring changes of payment group assignments for individual procedures on the current ASC list pending completion of Part II of the Medicare ASC payment rate survey (Form HCFA 452B). On March 15, 1994, we mailed the Medicare ASC survey, Part II, to 320 facilities that constitute a randomly selected, representative sample of Medicareparticipating ASCs. The survey collects data on facility overhead and procedurespecific costs. The payment group assignment and payment group amounts for all CPT codes on the list of Medicare-covered ASC procedures will be reviewed collectively, within the context of the survey data. Therefore, while we are not making any changes in

existing payment group assignments in this notice, we will publish in the **Federal Register** in accordance with notice and comment procedures any changes that we propose to make on the basis of updated cost data collected in the ASC survey.

IV. Provisions of the Final Notice

We are adopting the following new quantitative criteria, suggested in our December 1993 proposed notice, for deleting a procedure from ASC coverage: The combined inpatient, OPD, and ASC site-of-service percentage is less than 46 percent of the total volume; and either—

• The procedure is performed 50 percent of the time or more in a physician's office; or

• The procedure is performed 10 percent of the time or less in an inpatient hospital setting.

This change allows the site of service for procedures in the physician's office to grow from below 50 percent (when it is added) to as high as 54 percent, as long as the proportion of time the procedure is performed in the operating room remains at 46 percent. Similarly, the criteria allow procedures to move from an inpatient hospital site of service to an OPD site of service without being deleted from the ASC list.

We are deleting 4 of the 25 procedure codes we had proposed for deletion from the ASC list in our December 1993 proposed notice. For the reasons discussed in the analysis of the public comments in section III. of this notice, we are retaining the remaining 21 codes on the ASC list. Addendum A lists the 4 CPT codes that we are deleting (with the body system and description of each procedure, according to appropriate CPT terminology). Addendum A also lists a fifth deletion, CPT code 36522 (photopheresis, extracorporeal), which was not suggested in our December 1993 proposed notice. We are deleting this code based on information from a provider that this procedure cannot be safely performed in an ASC. Our review of the billing data indicates that, although this procedure has been on the ASC list, it is performed 0 percent of the time in an ASC. It is performed 73 percent of the time on an inpatient basis and 23 percent of the time in the OPD. We are requesting public comment on the appropriateness of this deletion.

We are adding a total of 30 new procedure codes to the ASC list. These codes are listed in Addendum B with the body system and description of each procedure and the corresponding payment group. We are adding the 20 procedure codes that we had proposed for addition to the ASC list in our

December 1993 proposed notice. For the reasons discussed in the analysis of the public comments in section III. of this notice, we are also adding 10 other procedure codes: CPT codes 29804, 43259, 51040, 52450, 56309, 56316, 56317, 56351, 56356, and 64421. We are requesting public comment on the appropriateness of the addition of these 10 new CPT codes and the assignment of payment groups for them since these codes were not suggested in our December 1993 proposed notice.

Further, the CPT is updated annually and some deletions and additions affect the ASC list. Parts 1 and 3 of Addendum C list CPT codes (with the body system and description of each procedure) that were deleted by changes to the Medicare Carriers Manual as a result of the update of the 1992 and 1993 editions of the CPT, respectively. We had proposed these deletions in our December 1993 proposed notice and received no comments on them. This notice makes these deletions final. Parts 2 and 4 of Addendum C list CPT codes (with the body system and description of each procedure and corresponding payment group) that were added by changes to the Medicare Carriers Manual as a result of the update of the 1992 and 1993 editions of the CPT. We had proposed these additions in our December 1993 proposed notice and received no comments on them. This notice makes these additions final. Part 5 of Addendum C lists CPT codes (with the body system and description of each procedure) that were deleted by changes to the Medicare Carriers Manual as a result of the update of the 1994 edition of the CPT. Because these codes were not suggested for deletion in our December 1993 proposed notice, we are now requesting public comment on the appropriateness of these deletions. This list of deletions differs from the **Medicare Carriers Manual instruction** that was effective April 11, 1994, in that we are retaining four of the nasal and sinus endoscopy codes: CPT codes 31254 through 31256 and 31267. We are retaining these codes since we anticipate that they will be reinstated by the CPT Editorial Panel effective January 1995. Part 6 of Addendum C lists CPT codes (with the body system and description of each procedure and corresponding payment group) that were added by changes to the Medicare Carriers Manual as a result of the update of the 1994 edition of the CPT. Because these codes were not suggested for addition in our December 1993 proposed notice, we are now requesting public comment on the appropriateness