of, and assignment of payment groups for, the additions.

# V. Collection of Information Requirements

This document does not impose information collection and recordkeeping requirements.
Consequently, it need not be reviewed by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1980 (44 U.S.C. 3501 et seq.).

## VI. Regulatory Impact Statement

### A. Introduction

This final notice permits facility fees to be paid when the 30 surgical procedure codes being added by this notice are performed in an ASC. We are also deleting 5 codes from the ASC list. We believe the net effect of the addition and deletion of these codes will be negligible because of the low number of changes we are making at this time and because of the relatively low cost and volume of these codes.

Payments to ASCs are generally lower than payments to hospitals for surgery performed in a hospital, whether on an inpatient or OPD basis. Although we do not anticipate that many services will shift from the hospital inpatient setting to ASCs, we anticipate some program savings because payments to ASCs for a given surgical procedure are generally lower than payments to hospitals for the same procedure. Additional savings will be realized as a result of lower payments to a hospital when newly listed procedures continue to be performed on an OPD basis, because the OPD rate (less deductible and coinsurance) would be the lower of (1) the hospital's reasonable costs or charges, or (2) a blend of the hospital's reasonable costs or customary charges and the amount that would be paid to a free-standing ASC in the same area for the same procedure. The blend is comprised of 42 percent hospital cost and 58 percent ASC payment rate. We believe payments based on the ASC blended rate are approximately 10 percent lower than payments based solely on reasonable cost. A factor that could offset some savings would be a shift of services from the physician's office to the ASC setting as a result of the expansion of the list of covered ASC services. Since a facility fee is not paid when surgery is performed in a physician's office, this shifting will result in slightly increased program

The deletions to the ASC list could also result in some changes in program costs and savings depending upon whether the deleted services are shifted to the lower cost physician's office site or to the higher cost OPD setting. We do not anticipate mass shifting of the site of service associated with the procedure codes we are adding or deleting.

We believe this notice will result in no economic impact.

## B. Regulatory Flexibility Act

We generally prepare a regulatory flexibility analysis that is consistent with the Regulatory Flexibility Act (RFA) (5 U.S.C. 601 through 612) unless the Secretary certifies that a notice will not have a significant economic impact on a substantial number of small entities. For purposes of the RFA, all physicians, ASCs, and hospitals are considered to be small entities.

In addition, section 1102(b) of the Act requires the Secretary to prepare a regulatory impact analysis if a notice may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area and has fewer than 50 beds.

We will delete a procedure from the ASC list only if the combined hospital 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. Because procedures will not be added or deleted as a result of slight shifts of the site of service, we believe we are adding stability to the list that should assist all small entities to plan for the future.

Therefore, for the reasons cited above, we are not preparing analyses for either the RFA or section 1102(b) of the Act since we have determined, and the Secretary certifies, that this notice will not result in a significant economic impact on a substantial number of small entities and will not have a significant impact on the operations of a substantial number of small rural hospitals.

In accordance with the provisions of Executive Order 12866, this notice was not reviewed by the Office of Management and Budget.

(Section 1833(i)(1) of the Social Security Act (42 U.S.C. 13951(i)(1))

(Catalog of Federal Domestic Assistance Program No. 93.774, Medicare— Supplementary Medical Insurance Program) Dated: October 28, 1994.

#### Bruce C. Vladeck,

Administrator, Health Care Financing Administration.

Dated: December 10, 1994.

Donna E. Shalala,

# Secretary. Addendum A

# Deletions From the List of Covered Procedures for Ambulatory Surgical Centers

The following addendum is the final list of deletions from the ASC list. These deletions are effective April 26, 1995. In the first column is the CPT code for the procedure; and in the second column, the body system and description of the procedure. In this addendum, "combined" percentage refers to the total of inpatient hospital, hospital outpatient department, and ASC site-of-service percentages.

We are requesting public comments only on CPT code 36522 in Addendum A because we had not proposed this code for deletion in our December 1993 proposed notice.

CPT Code	Body system and description
	CARDIOVASCULAR SYSTEM
36522	Photopheresis, extracorporeal (73 percent inpatient, 2 percent office, 96 percent combined)
	EYE AND OCULAR ADNEXA
66762	Iridoplasty by photocoagulation (one

66762 Iridoplasty by photocoagulation (one or more sessions) (eg, for improvement of vision, for widening of anterior chamber angle) (2 percent inpatient, 59 percent office, 37 percent combined)

67101 Repair of retinal detachment, one or more sessions; cryotherapy or diathermy, with or without drainage of subretinal fluid (8 percent inpatient, 62 percent office, 37 percent combined)

67105 Repair of retinal detachment, one or more sessions; photocoagulation (laser or xenon arc, one or more sessions), with or without drainage of subretinal fluid (6 percent inpatient, 63 percent office, 36 percent combined)

67208 Destruction of localized lesion of retina (eg, maculopathy,
choroidopathy, small tumors), one
or more sessions; cryotherapy, diathermy (5 percent inpatient, 57 percent office, 40 percent combined)

#### Addendum B

# Additions to the List of Covered Procedures for Ambulatory Surgical Centers

The following addendum is the final list of additions to the ASC list and the