

this correcting document is intended to ensure that the information in the final rule accurately reflects the policies adopted in that document.

Even if this were a rulemaking to which the notice and comment and delayed effective date requirements applied, we find there is good cause to waive such requirements. Undertaking further notice and comment procedures to incorporate the corrections in this document in the final rule or delaying the effective date of the corrections would be contrary to the public interest to ensure that the rule accurately reflects our policies as of the date they take effect. Further, such procedures would be unnecessary because we are not making any substantive revisions to the final rule, but rather, we are simply correcting the **Federal Register** document to reflect the policies we previously proposed, received public comment on, and subsequently finalized in the final rule. For these reasons, we believe that we have good cause to waive the notice and comment and delay in effective date requirements.

IV. Correction of Errors

In FR Doc. 2018–24238 of November 14, 2018 (83 FR 56922), make the following corrections:

1. On page 57029, first column, second full paragraph,

a. In line 16, the reference “this rule” is corrected to read “the CY 2019 ESRD PPS DMEPOS proposed rule”.

b. In line 17, the reference “this final rule” is corrected to read “the CY 2019 ESRD PPS DMEPOS proposed rule”.

2. On page 57029, second column, second full paragraph, in lines 27 and 28, the reference “this final rule” is corrected to read “the CY 2019 ESRD PPS DMEPOS proposed rule”.

Dated: December 20, 2018.

Ann C. Agnew,

*Executive Secretary to the Department,
Department of Health and Human Services.*

[FR Doc. 2018–28347 Filed 12–21–18; 4:15 pm]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 416 and 419

[CMS–1695–CN2]

RIN 0938–AT30

Medicare Program: Changes to Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Correction

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Final rule; correction.

SUMMARY: This document corrects technical and typographical errors in the final rule with comment period that appeared in the November 21, 2018 **Federal Register** titled “Changes to Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs.”

DATES: The corrections in this document are effective January 1, 2019.

FOR FURTHER INFORMATION CONTACT:

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SUPPLEMENTARY INFORMATION:

I. Background

In FR Doc. 2018–24243 of November 21, 2018 (83 FR 58818), there were a number of technical and typographical errors that are identified and corrected in the Correction of Errors section of this correcting document. The provisions in this correction document are effective as if they had been included in the document that appeared in the November 21, 2018 **Federal Register**. Accordingly, the corrections are effective January 1, 2019.

II. Summary of Errors

A. Summary of Errors in the Preamble

1. Hospital Outpatient Prospective Payment System (OPPS) Corrections

On page 58822, we are correcting the section “Payment of Drugs, Biologicals, and Radiopharmaceuticals If Average Sales Price (ASP) Data Are Not Available” to remove the language that suggests that drugs with pass-through status with partial quarter WAC-based pricing are not paid at WAC + 3, which is incorrect. This correction is necessary to conform the introductory language regarding OPPS payment policy for drugs, biologicals, and

radiopharmaceuticals with WAC-based pricing with the policy adopted in the final rule to pay for these drugs, biologicals, and radiopharmaceuticals, including those with pass-through status, at WAC + 3 percent.

On page 58825, the headings for subsections “c. Impact of the Changes to the Hospital OQR Program” and “d. Impact of the Changes to the ASCQR Program” were alphabetically mislabeled and are corrected to be “g. Impact of the Changes to the Hospital OQR Program” and “h. Impact of the Changes to the ASCQR Program,” respectively.

On page 58833, Healthcare Common Procedure Coding System (HCPCS) code P9072 (Platelets, pheresis, pathogen reduced or rapid bacterial tested, each unit) was cited in a comment in error. The correct HCPCS code is “P9073” not “P9072”.

On page 58834, we transposed two numbers in the Healthcare Common Procedure Coding System (HCPCS) code P9037 (Platelets, pheresis, leukocytes reduced, irradiated, each unit). The correct HCPCS code is “P9037”, not “P9073”.

On page 58880, in “Table 12.—New Level II HCPCS Codes Effective April 1, 2018,” we incorrectly stated that the Medicare Ambulatory Payment Classification (APC) assignment for HCPCS code C9749 (Repair nasal stenosis w/imp) is “APC 5164,” rather than “APC 5165.” The correct APC assignment for this code is APC 5165, which we finalized on page 58922.

On page 58909, under section “6. Endovascular Procedures (APCs 5191 through 5194)” of the “OPPS APC-Specific Policies” section, we inadvertently omitted a summary of a public comment and our response related to new calendar year (CY) 2019 Common Procedural Terminology (CPT) code 33274. Therefore, we are revising the discussion to include the comment and response.

On pages 58894 to 58897, we occasionally stated the wrong APC assignment for procedure code C9734 (Focused ultrasound ablation/therapeutic intervention, other than uterine leiomyomata, with magnetic resonance (mr) guidance) for CY 2018 and CY 2019. The correct APC assignment for procedure code C9734 is APC 5114 for CY 2018 and APC 5115 for CY 2019.

On page 58928 of the “OPPS APC-Specific Policies” section, we inadvertently omitted a summary of a public comment and response related to existing CPT code 47382 and new CY 2019 CPT code 95983. Therefore, we are adding a new subsection titled “21.

Other Procedures/Services” that includes this comment and response.

On page 58954, in “Table 37.—Drugs and Biologicals For Which Pass-through Payment Status Expires December 31, 2018,” we included an incorrect Pass-Through Payment Effective Date for HCPCS code Q5101. The correct Pass-Through Payment Effective Date for HCPCS code Q5101 is 01/01/2016, not 07/01/2015.

On page 58958, in Table 38.—Drugs and Biologicals With Pass-through Payment Status in CY 2019,” we included an incorrect Pass-Through Payment Effective Date for HCPCS code J7328. The correct Pass-Through Payment Effective Date for HCPCS code J7328 is 04/01/2017, not 01/01/16.

On page 58969, we inadvertently stated, “We also are finalizing our proposal to retain our established policy to assign new skin substitute products with pricing information to the low cost group.” We are correcting the word “with” to read “without” to clarify that skin substitutes *without* pricing information are assigned to the low cost group, consistent with our established policy, which is described on page 58967.

2. Ambulatory Surgical Center (ASC) Payment System Corrections

The ASC payment system uses the same APC classification groupings as the OPSS; however, ASC payment indicators and OPSS status indicators are not compatible across the two payment systems. In our final rule ratesetting for CY 2019, we inadvertently carried over OPSS C–APC status indicators in our ASC ratesetting process. This error impacted the application of our multiple procedure discounting rules and the calculation of the ASC weight scalar, which led to the calculation of incorrect ASC payment rates. Accordingly, on page 59079, in our response to a comment regarding our process of applying a weight scalar in calculation of ASC payment rates, and on page 59169, we are correcting our weight scalar in ASC payment rate calculations of “0.8792” to “0.8800.”

Additionally, on pages 59079, 59080 and 59169, we inadvertently excluded certain core-based statistical areas (CBSAs) and, therefore, incorrectly calculated the wage index budget neutrality factor that we applied to the 2018 ASC conversion factor. We previously calculated a wage index adjustment of 1.0004. We have recalculated the wage index adjustment taking into account the appropriate CBSAs, resulting in a corrected wage index adjustment of “1.0000.”

On pages 59080 and 59169, we are correcting the final CY 2019 conversion factor of \$46.551 for ASCs who meet quality reporting requirements and the final CY 2019 conversion factor of \$45.639 for ASCs who do not meet quality reporting requirements. These conversion factors are incorrect because they utilize the incorrect wage index adjustment. The correct conversion factors, calculated utilizing the correct wage index adjustment, are “\$46.532” and “\$45.621” for ASCs that meet quality reporting requirements and for ASCs that do not meet quality reporting requirements, respectively.

On page 59170, we are correcting our estimate of the increase in aggregate payments for ancillary items and services of 79 percent for CY 2019. The correct percentage is 68 percent, which accounts for removing HCPCS code 0474T from our list of covered surgical procedures and, therefore, no longer includes any estimated 2019 spending from HCPCS code 0474T. Further, on page 59170 in “Table 63.—Estimated Impact of the CY 2019 Update to the ASC Payment System on Aggregate CY 2019 Medicare Program Payments by Surgical Specialty or Ancillary Items and Services Group”, we are correcting the figure in the third column, titled “Estimated CY 2019 Percent Change” for the Ancillary Items and Services Group to reflect the change from 79 percent to 68 percent.

On page 59171, in “Table 64.—Estimated Impact of the CY 2019 Update to the ASC Payment System on Aggregate Payments for Selected Procedures”, we are correcting the figures in the fourth column of the table titled “Estimated CY 2019 Percent Change” to account for payment rates changes from the corrected ASC weight scalar and corrected ASC conversion factor.

3. Hospital Outpatient Quality Reporting (OQR) Program Corrections

On page 59088, first column, first full paragraph, the word “retaining” is corrected to “removing.” We inadvertently included the wrong word.

On page 59100 through 59102, the table footnoting for the Hospital OQR Program Measure Set for both the CY 2020 and CY 2021 Payment Determinations are corrected. Specifically, the footnote pertaining to OP–26 is removed from the un-numbered tables titled “Hospital OQR Program Measure Set for the CY 2020 Payment Determination” and “Hospital OQR Program Measure Set for the CY 2021 Payment Determination and Subsequent Years.” The measure is no longer in the program beginning with

the CY 2020 payment determination. In addition, for both tables, the National Quality Forum (NQF) status for OP–8: MRI Lumbar Spine for Low Back Pain and OP–33: External Beam Radiotherapy for Bone Metastases is updated to indicate that the NQF endorsement for these measures was removed. Furthermore, in both tables, we added an additional footnote to OP–31 to indicate “Measure voluntarily collected as set forth in section XIII.D.3.b. of the CY 2015 OPSS/ASC final rule with comment period (79 FR 66946 through 66947).” Subsequently, asterisks for the remaining footnotes are renumbered, as are the corresponding notations under the measure name in both tables. As a result of the renumbering, both tables are revised such that OP–37a, OP–37b, OP–37c, OP–37d, and OP–37e correspond with the appropriate footnote reading “Measure reporting delayed beginning with CY 2018 reporting and for subsequent years as discussed in section XIII.B.5. of the CY 2018 OPSS/ASC final rule with comment period (82 FR 59432 through 59433).”

4. Ambulatory Surgical Center Quality Reporting Program (ASCQR) Corrections

On page 59117, second column, first paragraph, the word “retaining” is corrected to “removing.” We inadvertently included the wrong word.

On page 59129, first column, second paragraph, the language, “Furthermore, this is the only measure in the ASCQR Program measure set that deals with cataract surgery, which is commonly performed in the ASC setting. If it is removed, the program will have a gap in coverage for this clinical area. As a result, we now believe that meaningful information can be provided to consumers regarding those facilities” is removed. This text pertains only to the Hospital OQR Program; it is factually inaccurate with respect to the ASCQR Program, since the ASC–14:Unplanned Anterior Vitrectomy measure also includes cataract surgery, and was erroneously included.

B. Summary of Errors in and Corrections to the OPSS and ASC Addenda Posted on the CMS Website

We are summarizing below the errors we have corrected in the addenda available on the internet at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html>. The addenda that are available on the internet have been updated to reflect the revisions discussed in this correcting document.

1. Summary of Errors in and Corrections to the OPSS Addenda Posted on the CMS Website

In Addendum B (Final OPSS Payment by HCPCS Code for CY 2019), we corrected the following:

- CPT code 0100T (Prosth retina receive&gen): APC revision from APC 1906 (New Technology—Level 51 (\$130,001–\$145,000)) to APC 1908 (New Technology—Level 52 (\$145,001–\$160,000)). In the preamble text, CPT code 0100T had been assigned to APC 1908. This action ensures the information in Addendum B reflects the APC assignment that was finalized in the preamble.

- CPT code 0474T (Insj aqueous drg dev io rsrv): Status indicator revision from status indicator “J1” (Hospital Part B Services Paid Through a C–APC) to status indicator “E1” (Not Paid by Medicare) because the device associated with this procedure was withdrawn from marketing in September 2018 and the procedure is no longer separately payable under the OPSS.

- HCPCS code A6460: We made a typographical error in listing the HCPCS short descriptor. Specifically, we are correcting the short descriptor from “Arg II ext com/sup/acc misc” to “Synthetic drsg <= 16 sq in”.

- HCPCS code A6461: We made a typographical error in listing the HCPCS short descriptor. Specifically, we are correcting the short descriptor from “Enzyme cartridge enteral nut” to “Synthetic drsg >16 <=48 sq in”.

- HCPCS code C9752 (Intraosseous des lumb/sacrum): We made a typographical error in listing the APC assignment. Specifically, we are correcting the APC assignment from APC 5155 (Level 5 Airway Endoscopy) to APC 5115 (Level 5 Musculoskeletal Procedures).

In Addendum C (Final HCPCS Codes Payable Under the 2019 OPSS by APC), we corrected the following:

- APC 1906 (New Technology—Level 51 (\$130,001–\$145,000)): Deleted HCPCS code 0100T from the list We inadvertently listed the code in this APC when it should have been listed under APC 1908 (New Technology—Level 52 (\$145,001–\$160,000)), as correctly listed in the preamble and Addendum B of the CY 2019 OPSS/ASC final rule with comment period.

- APC 1908 (New Technology—Level 52 (\$145,001–\$160,000)): Added HCPCS code 0100T to the list.

- APC 5115 (Level 5 Musculoskeletal Procedures): We made a typographical error by assigning HCPCS code C9752 to APC 5155 (Level 5 Airway Endoscopy) when it should have been assigned to

APC 5115. Specifically, we are correcting the APC assignment for HCPCS code C9752 to APC 5115.

- APC 5155 (Level 5 Airway Endoscopy): Removed HCPCS code C9752 from the list.

- APC 5492 (Level 2 Intraocular Procedures): Deleted CPT code 0474T from the list because the device associated with this procedure was withdrawn from marketing in September 2018 and the procedure is no longer separately payable under the OPSS.

In Addendum P (Device-Intensive Procedures for CY 2019), we corrected the following errors in both tabs, 2019 FR Device Intensive List and 2019 FR HCPCS Offsets:

- CPT code 0100T: Revised the APC assignment from APC 1906 to APC 1908 and the final payment rate. We inadvertently listed the code in APC 1906 when it should have been listed under APC 1908 (New Technology—Level 52 (\$145,001–\$160,000)), as correctly listed in Addendum B of the CY 2019 OPSS/ASC final rule.

- CPT code 0474T: Removed from the list because the device associated with this procedure was withdrawn from marketing in September 2018 and this procedure is no longer separately payable under the OPSS.

- HCPCS code C9752: Added to the list along with the associated status indicator, APC, final CY 2019 payment rate, device offset percentage, and device offset amount, because we inadvertently omitted this code from Addendum P. This code should have received device-intensive status based on the CY 2019 policy to apply device-intensive status with a default device offset set at 31 percent for new HCPCS codes describing procedures requiring the implantation or insertion of a medical device that do not yet have associated claims data until claims data are available to establish the HCPCS code-level device offset for the procedures adopted in the final rule.

- HCPCS code C9754 (Perc av fistula, direct): Added to the list along with the associated status indicator, APC, final CY 2019 payment rate, device offset percentage, and device offset amount, because we inadvertently omitted this code from Addendum P. This code should have received device-intensive status based on the CY 2019 policy to apply device-intensive status with a default device offset set at 31 percent for new HCPCS codes describing procedures requiring the implantation or insertion of a medical device that do not yet have associated claims data until claims data are available to establish the

HCPCS code-level device offset for the procedures adopted in the final rule.

- HCPCS code C9755 (Rf magnetic-guide av fistula): Added to the list along with the associated status indicator, APC, final CY 2019 payment rate, device offset percentage, and device offset amount, because we inadvertently omitted this code from Addendum P. This code should have received device-intensive status based on the CY 2019 policy to apply device-intensive status with a default device offset set at 31 percent for new HCPCS codes describing procedures requiring the implantation or insertion of a medical device that do not yet have associated claims data until claims data are available to establish the HCPCS code-level device offset for the procedures adopted in the final rule.

- In the tab titled “2019 FR Device Intensive List,” we inadvertently excluded CPT code 33285 (Insj subq car rhythm mntr) from the list. Therefore, we added this code along with the associated status indicator, APC, final CY 2019 payment rate, device offset percentage, and device offset amount to the list. This code should have received device-intensive status based on the device-intensive policy adopted in the final rule.

In the tab titled “2019 FR HCPCS Offsets,” the first bullet of the header was corrected from “*List of HCPCS codes payable under the OPSS that are designated as device-intensive procedures.” to “*List of all HCPCS codes payable under the OPSS that describe a clinical service including both those that are designated as device-intensive and those that are not designated as device intensive” because this tab in Addendum P includes device offsets for all codes for which we have data.

To view the corrected CY 2019 OPSS status indicators, APC assignments, relative weights, copayment rates, device-intensive status, and short descriptors for Addenda A, B, C, and P that resulted from these technical and typographical corrections, we refer readers to the Addenda and supporting files that are posted on the CMS website at: <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html>. Select “CMS–1695–CN2” from the list of regulations. All corrected Addenda for this correcting document are contained in the zipped folder titled “2019 OPSS Final Rule Addenda” at the bottom of the page for CMS–1695–CN2.

2. Summary of Errors in and Corrections to the ASC Payment System Addenda Posted on the CMS Website

In Addendum AA, we inadvertently mislabeled several CPT codes in the "Subject to Multiple Procedure Discounting" column. As discussed in section II.A.2 of this correction notice, we inadvertently carried over OPSS C-APC status indicators in our ASC ratesetting process. This error impacted the application of our multiple procedure discounting rules and the calculation of the ASC weight scalar, and ASC payment rates. Accordingly, we have updated Addenda AA to accurately reflect the list of CPT codes that are subject to multiple procedure discounting.

As stated in the CY 2018 final rule with comment period (83 FR 59409), ASC device intensive procedures are those with a HCPCS code-level device offset percentage greater than the threshold when calculated according to the standard OPSS APC ratesetting methodology, among other criteria. In inputting OPSS APC rate data into the ASC payment system for the CY 2019 OPSS/ASC final rule, several procedures were inadvertently assigned incorrect payment indicators.

Accordingly, we have reviewed the ASC payment system data for consistency with the OPSS APC rates and have corrected the payment indicators for the following procedures in Addendum AA:

- CPT Code 19298: Revised the payment indicator from "J8" to "G2" in addition to the payment weight and payment rate; this code had inadvertently been assigned the incorrect payment indicator in the final rule.

- CPT code 28435: Revised the payment indicator from "J8" to "A2" in addition to the payment weight and payment rate; this code had inadvertently been assigned the incorrect payment indicator in the final rule.

- CPT code 28446: Revised the payment indicator from "J8" to "G2" in addition to the payment weight and payment rate; this code had inadvertently been assigned the incorrect payment indicator in the final rule.

- CPT code 32550: Revised the payment indicator from "J8" to "G2" in addition to the payment weight and payment rate; this code had inadvertently been assigned the incorrect payment indicator in the final rule.

- CPT code 33210: Revised the payment indicator from "J8" to "G2" in addition to the payment weight and

payment rate; this code had inadvertently been assigned the incorrect payment indicator in the final rule.

- CPT code 33226: Revised the payment indicator from "J8" to "G2" in addition to the payment weight and payment rate; this code had inadvertently been assigned the incorrect payment indicator in the final rule.

- CPT code 33274: Revised the payment indicator from "G2" to "J8" in addition to the payment weight and payment rate; this code had inadvertently been assigned the incorrect payment indicator in the final rule.

- CPT code 33285: Revised the payment indicator from "G2" to "J8" in addition to the payment weight and payment rate; this code had inadvertently been assigned the incorrect payment indicator in the final rule.

- CPT code 36560: Revised the payment indicator from "J8" to "G2" in addition to the payment weight and payment rate; this code had inadvertently been assigned the incorrect payment indicator in the final rule.

- CPT code 36563: Revised the payment indicator from "J8" to "A2" in addition to the payment weight and payment rate; this code had inadvertently been assigned the incorrect payment indicator in the final rule.

- CPT code 36578: Revised the payment indicator from "J8" to "A2" in addition to the payment weight and payment rate; this code had inadvertently been assigned the incorrect payment indicator in the final rule.

- CPT code 36583: Revised the payment indicator from "J8" to "A2" in addition to the payment weight and payment rate; this code had inadvertently been assigned the incorrect payment indicator in the final rule.

- CPT code 36904: Revised the payment indicator from "J8" to "G2" in addition to the payment weight and payment rate; this code had inadvertently been assigned the incorrect payment indicator in the final rule.

- CPT code 37211: Revised the payment indicator from "J8" to "G2" in addition to the payment weight and payment rate; this code had inadvertently been assigned the incorrect payment indicator in the final rule.

- CPT code 37212: Revised the payment indicator from "J8" to "G2" in

addition to the payment weight and payment rate; this code had inadvertently been assigned the incorrect payment indicator in the final rule.

- CPT code 43274: Revised the payment indicator from "J8" to "G2" in addition to the payment weight and payment rate; this code had inadvertently been assigned the incorrect payment indicator in the final rule.

- CPT code 43276: Revised the payment indicator from "J8" to "G2" in addition to the payment weight and payment rate; this code had inadvertently been assigned the incorrect payment indicator in the final rule.

- CPT code 44384: Revised the payment indicator from "J8" to "G2" in addition to the payment weight and payment rate; this code had inadvertently been assigned the incorrect payment indicator in the final rule.

- CPT code 47554: Revised the payment indicator from "J8" to "A2" in addition to the payment weight and payment rate; this code had inadvertently been assigned the incorrect payment indicator in the final rule.

- CPT code 58356: Revised the payment indicator from "J8" to "P3" in addition to the payment weight and payment rate; this code had inadvertently been assigned the incorrect payment indicator in the final rule.

- CPT code 65125: Revised the payment indicator from "J8" to "G2" in addition to the payment weight and payment rate; this code had inadvertently been assigned the incorrect payment indicator in the final rule.

- HCPCS code C9752 (Intraosseous des lumb/sacrum): Revised the payment indicator from "G2" to "J8" in addition to the payment weight and payment rate; this code had inadvertently been assigned the incorrect payment indicator in the final rule.

- HCPCS code C9754 (Perc av fistula, direct): Revised the payment indicator from "G2" to "J8" in addition to the payment weight and payment rate; this code had inadvertently been assigned the incorrect payment indicator in the final rule.

- HCPCS code C9755 (RF magnetic-guide AV fistula): Revised the payment indicator from "G2" to "J8" in addition to the payment weight and payment rate; this code had inadvertently been assigned the incorrect payment indicator in the final rule.

We also corrected the following in Addendum AA:

- CPT code 0100T: Updated the payment rate from \$134,051.87 to \$141,780.75 to reflect the New Tech APC to which this code was assigned in the CY 2019 OPPTS/ASC final rule with comment period.
- CPT code 0474T: Removed the code from the list because the device associated with this procedure was withdrawn from marketing in September 2018 and this procedure is no longer separately payable under the ASC payment system.
- CPT code 28540: Revised the payment indicator from “P3” to “P2” in addition to the payment rate; the revised OPPTS-based payment rate for CPT code 28540 is less than the PFS-based payment rate and the corrected payment indicator reflects this fact.
- HCPCS code C9753 (Intraosseous destruct add'l): Added to Addendum AA with a payment indicator of “N1”; this is a new code beginning January 1, 2019 and had inadvertently been left out of Addendum AA in the final rule.

In Addendum BB, we corrected the following:

- CPT code 74485 (Dilation urtr/urt rs&i): Revised the payment indicator to “N1”; this code had inadvertently been assigned no payment indicator in the final rule.

To view the corrected final CY 2019 ASC payment indicators, payment weights, payment rates, and multiple procedure discounting indicator for Addenda AA and BB that resulted from these technical corrections, we refer readers to the Addenda and supporting files on the CMS website at: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/ASC-Regulations-and-Notices.html>. Select “CMS–1695–CN2” from the list of regulations. All corrected ASC addenda for this correcting document are contained in the zipped folder entitled “Addendum AA, BB, DD1, DD2, and EE” at the bottom of the page for CMS–1695–CN2.

III. Waiver of Proposed Rulemaking

Under 5 U.S.C. 553(b) of the Administrative Procedure Act (APA), the agency is required to publish a notice of the proposed rule in the **Federal Register** before the provisions of a rule take effect. Similarly, section 1871(b)(1) of the Act requires the Secretary to provide for notice of the proposed rule in the **Federal Register** and provide a period of not less than 60 days for public comment. In addition, section 553(d) of the APA, and section 1871(e)(1)(B)(i) of the Act mandate a 30-day delay in effective date after issuance

or publication of a rule. Sections 553(b)(B) and 553(d)(3) of the APA provide for exceptions from the notice and comment and delay in effective date of the APA requirements; in cases in which these exceptions apply, sections 1871(b)(2)(C) and 1871(e)(1)(B)(ii) of the Act provide exceptions from the notice and 60-day comment period and delay in effective date requirements of the Act as well. Section 553(b)(B) of the APA and section 1871(b)(2)(C) of the Act authorize an agency to dispense with normal rulemaking requirements for good cause if the agency makes a finding that the notice and comment process is impracticable, unnecessary, or contrary to the public interest. In addition, both section 553(d)(3) of the APA and section 1871(e)(1)(B)(ii) of the Act allow the agency to avoid the 30-day delay in effective date where such delay is contrary to the public interest and an agency includes a statement of support.

We believe that this correcting document does not constitute a rulemaking that would be subject to the notice and comment or delayed effective date requirements. This correcting document corrects technical and typographical errors in the preamble, addenda, payment rates, and tables included or referenced in the CY 2019 OPPTS/ASC final rule with comment period but does not make substantive changes to the policies or payment methodologies that were adopted in the final rule with comment period. The corrections made through this correcting document are intended to ensure that the information in the CY 2019 OPPTS/ASC final rule with comment period accurately reflects the policies adopted in that rule.

In addition, even if this were a rule to which the notice and comment procedures and delayed effective date requirements applied, we find that there is good cause to waive such requirements. Undertaking further notice and comment procedures to incorporate the corrections in this document into the final rule with comment period or delaying the effective date would be contrary to the public interest because it is in the public’s interest for providers to receive appropriate payments in as timely a manner as possible, and to ensure that the CY 2019 OPPTS/ASC final rule with comment period accurately reflects our methodologies and policies as of the date they take effect and are applicable.

Furthermore, such procedures would be unnecessary, as we are not making substantive changes to our payment methodologies or policies, but rather, we are simply implementing correctly

the methodologies and policies that we previously proposed, received comment on, and subsequently finalized. This correcting document is intended solely to ensure that the CY 2019 OPPTS/ASC final rule with comment period accurately reflects these methodologies and policies. Therefore, we believe we have good cause to waive the notice and comment and effective date requirements.

IV. Correction of Errors

In FR Doc. 2018–24243 of November 21, 2018 (83 FR 58818), make the following corrections:

1. On page 58822, third column, second bullet point, in the section titled “Payment of Drugs, Biologicals, and Radiopharmaceuticals If Average Sales Price (ASP) Data Are Not Available,” in lines 3 through 11, the sentence “For CY 2019, we are making payment for separately payable drugs and biologicals that do not have pass-through payment status and are not acquired under the 340B Program at wholesale acquisition cost (WAC)+3 percent instead of WAC+6 percent if ASP data are not available” is replaced with “For CY 2019, we are making payment for separately payable drugs and biologicals that have partial quarter wholesale acquisition cost (WAC)-based pricing and are not acquired under the 340B Program at WAC+3 percent instead of WAC+6 percent if ASP data are not available.”

2. On page 58825, first column, a. The first section heading “c. Impact of the Changes to the Hospital OQR Program” is corrected to read “g. Impact of the Changes to the Hospital OQR Program”.

b. The second section heading “d. Impact of the Changes to the ASCQR Program” is corrected to read “h. Impact of the Changes to the ASCQR Program”.

3. On page 58833, last column, last partial paragraph, in line 8, the code “P9072” is corrected to read “P9073”.

4. On page 58834, first column, first partial paragraph, in lines 3 and 7, the code “P9073” is corrected to read “P9037”.

5. On page 58880, Table 12.—New Level II HCPCS Codes Effective April 1, 2018, in the last row, last column, titled “Final CY 2019 APC” for CY 2018 and CY 2019 HCPCS Code C9749, the figure “5164” is corrected to read “5165”.

6. On page 58894, first column, last paragraph, in the fourth line from the bottom of the paragraph, in the phrase “In addition, we proposed to continue to assign the services described by HCPCS code C9734 . . .”, the words “continue to” are removed.

7. On page 58895, last column, last paragraph, in line 13, the reference to “APC 5114” is corrected to read “APC 5115”.

8. On page 58897, in Table 17.—CY 2019 Status Indicator (SI), APC Assignment, and Payment Rate for the Magnetic Resonance Image Guided High Intensity Focused Ultrasound (MRgFUS) Procedures, in the row for CPT/HCPCS Code C9734, in the column “CY 2018 OPPTS APC,” the figure “5115” is corrected to read “5114”.

9. On page 58909, third column, after the first full paragraph that ends with “. . . at each level and clinical homogeneity.” and before the following paragraph, which begins with “Comment: Several commenters believed that the current structure” the following text is added:

In addition, we received a comment related to CPT code 33274 (Transcatheter insertion or replacement of permanent leadless pacemaker, right ventricular, including imaging guidance (for example, fluoroscopy, venous ultrasound, ventriculography, femoral venography) and device evaluation (for example, interrogation or programming), when performed). We note that in Addendum B to the CY 2019 OPPTS/ASC proposed rule, we proposed to assign CPT code 33274 to APC 5194 (Level 4 Endovascular Procedures), which is the same APC assignment as its predecessor code 0387T (Transcatheter insertion or replacement of permanent leadless pacemaker, ventricular), which was effective January 1, 2015 and deleted on December 31, 2018. CPT code 33274 was listed as 33X05 (the 5-digit CMS placeholder code) in Addendum B with the short descriptor and Addendum O with the long descriptor of the CY 2019 OPPTS/ASC proposed rule. We also assigned the code to comment indicator “NP” in Addendum B to the proposed rule to indicate that the code is new for CY 2019 with a proposed APC assignment and that public comments would be accepted on the proposed APC assignment. We note that CPT code 33274 will be effective January 1, 2019. Although the code is new for CY 2019, the service associated with CPT code 33274 was previously described by CPT codes 0387T, which will be deleted on December 31, 2018.

Comment: We received a comment to the CY 2019 OPPTS/ASC proposed rule requesting the assignment of CPT code 33274 from APC 5194 (Level 4 Endovascular Procedures) to APC 5224 (Level 4 Pacemaker and Similar Procedures).

Response: We appreciate the suggestion, however, as noted above, CPT code 33274 is assigned to the same

APC as its predecessor code 0387T. Accordingly, we do not believe that a change in APC is warranted at this time.

10. On page 58928, third column, after the first full paragraph ending with “Addendum B is available via the internet on the CMS website.” and before Table 35, the following section and text are added:

21. Other Procedures/Services

For CY 2019, we proposed to continue to assign CPT code 47382 (Ablation, 1 or more liver tumor(s), percutaneous, radiofrequency) to APC 5361.

Comment: A commenter requested the reassignment of CPT code 47382 from APC 5361 (Level 1 Laparoscopy and Related Services) to APC 5362 (Level 2 Laparoscopy and Related Services).

Response: Based on the latest hospital outpatient claims data used for this final rule with comment period, we disagree that CPT code 47382 should be assigned to APC 5362 for CY 2019. Our analysis of the claims data show a geometric mean cost of approximately \$6,063 for CPT code 47382, based on 2,220 single claims (out of 2,242 total claims), which is significantly less than the geometric mean cost of about \$7,809 for APC 5362. We believe that APC 5361 is the most appropriate APC assignment for CPT code 47382 based on its clinical and resource homogeneity to the other procedures assigned to this APC.

Therefore, after consideration of the public comment we received, we are finalizing our proposal, without modification, to assign CPT code 47382 to APC 5361 for CY 2019. The final CY 2019 payment rate for the code can be found in Addendum B to this final rule with comment period (which is available via the internet on the CMS website).

In addition, for CY 2019, we proposed to assign CPT code 95983 (Electronic analysis of implanted neurostimulator pulse generator/transmitter (for example, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with brain neurostimulator pulse generator/transmitter programming, first 15 minutes face-to-face time with physician or other qualified health care professional) to APC 5741 (Level 1 Electronic Analysis of Devices). We note that in Addendum B to the CY 2019 OPPTS/ASC proposed rule, CPT code 95983 was listed as 95X85 (the 5-digit CMS placeholder code) in Addendum B with the short descriptor and

Addendum O with the long descriptor of the CY 2019 OPPTS/ASC proposed rule. We also assigned the code to comment indicator “NP” in Addendum B to the proposed rule to indicate that the code is new for CY 2019 with a proposed APC assignment and that public comments would be accepted on the proposed APC assignment. We note that CPT code 95983 will be effective January 1, 2019.

Comment: A commenter requested the assignment of CPT code 95983 from APC 5741 (Level 1 Electronic Analysis of Devices) to APC 5742 (Level 2 Electronic Analysis of Devices).

Response: Based on input from our medical advisors and our review of the procedure, we believe that CPT code 95983 is appropriately placed in APC 5741 since it shares similar characteristics as other electronic analysis services in the APC. Therefore, after consideration of the public comment we received, we are finalizing our proposal, without modification, to assign CPT code 95983 to APC 5741 for CY 2019. The final CY 2019 payment rate for the code can be found in Addendum B to this final rule with comment period (which is available via the internet on the CMS website).

We will reevaluate the APC assignments for CPT code 47382 and 95983 for the next rulemaking cycle. We remind hospitals that we review, on an annual basis, the APC assignments for all items and services paid under the OPPTS.

11. On page 58954, Table 37, last column, the Pass-Through Payment Effective Date for CY 2019 HCPCS code Q5101 that reads “07/01/2015” is corrected to read “01/01/2016”.

12. On page 58958, Table 38, last column, the Pass-Through Payment Effective Date for CY 2018 and CY 2019 HCPCS code J7328 that reads “01/01/2016” is corrected to read “04/01/2017”.

13. On page 58969, second column, in line 3, the word “with” is corrected to read “without”.

14. On page 59079,
a. Second column, last partial paragraph, in line 4, the figure “0.8792” is corrected to read “0.8800”.

b. Third column, last partial paragraph, in line 4, the figure “1.0004” is corrected to read “1.0000”.

15. On page 59080,
a. First column, first partial paragraph,

(1) In line 2, the figure “\$46.551” is corrected to read “\$46.532”.

(2) In line 8, the figure “1.0004” is corrected to read “1.0000”.

(3) In line 13, the figure “\$45.639” is corrected to read “\$45.621”.

b. Second column, second full paragraph, in line 7, the figure "\$46.551" is corrected to read "\$46.532."

16. On page 59088, first column, first full paragraph, in line 12, the word

"retaining" is corrected to read "removing".

17. On pages 59100 and 59101, the un-numbered table—Hospital OQR Program Measure Set for the CY 2020 Payment Determination, and the

footnotes for the table, are corrected to read as follows:

Hospital OQR Program Measure Set for the CY 2020 Payment Determination	
NQF #	Measure Name
0288	OP-2: Fibrinolytic Therapy Received Within 30 Minutes of ED Arrival†
0290	OP-3: Median Time to Transfer to Another Facility for Acute Coronary Intervention
0289	OP-5: Median Time to ECG†
0514	OP-8: MRI Lumbar Spine for Low Back Pain†
None	OP-9: Mammography Follow-up Rates
None	OP-10: Abdomen CT – Use of Contrast Material
0513	OP-11: Thorax CT – Use of Contrast Material
None	OP-12: The Ability for Providers with HIT to Receive Laboratory Data Electronically Directly into their ONC-Certified EHR System as Discrete Searchable Data
0669	OP-13: Cardiac Imaging for Preoperative Risk Assessment for Non-Cardiac, Low-Risk Surgery
None	OP-14: Simultaneous Use of Brain Computed Tomography (CT) and Sinus Computed Tomography (CT)
0491	OP-17: Tracking Clinical Results between Visits†
0496	OP-18: Median Time from ED Arrival to ED Departure for Discharged ED Patients
0499	OP-22: Left Without Being Seen†
0661	OP-23: Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke who Received Head CT or MRI Scan Interpretation Within 45 minutes of ED Arrival
0658	OP-29: Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients*
0659	OP-30: Colonoscopy Interval for Patients with a History of Adenomatous Polyps – Avoidance of Inappropriate Use*
1536	OP-31: Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery**
2539	OP-32: Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy
1822	OP-33: External Beam Radiotherapy for Bone Metastases†
None	OP-35: Admissions and Emergency Department (ED) Visits for Patients Receiving Outpatient Chemotherapy
2687	OP-36: Hospital Visits after Hospital Outpatient Surgery
None	OP-37a: OAS CAHPS – About Facilities and Staff***
None	OP-37b: OAS CAHPS – Communication About Procedure***
None	OP-37c: OAS CAHPS – Preparation for Discharge and Recovery***
None	OP-37d: OAS CAHPS – Overall Rating of Facility***

Hospital OQR Program Measure Set for the CY 2020 Payment Determination	
NQF #	Measure Name
None	OP-37e: OAS CAHPS – Recommendation of Facility***

† We note that NQF endorsement for this measure was removed.

* We note that measure name was revised to reflect NQF title.

** Measure voluntarily collected as set forth in section XIII.D.3.b. of the CY 2015 OPPTS/ASC final rule with comment period (79 FR 66946 through 66947).

*** Measure reporting delayed beginning with CY 2018 reporting and for subsequent years as discussed in section XIII.B.5. of the CY 2018 OPPTS/ASC final rule with comment period (82 FR 59432 through 59433).

18. On page 59102, the un-numbered table—Hospital OQR Program Measure Set for the 2021 Payment Determination and Subsequent years, and the footnotes for the table, are corrected to read as follows:

Hospital OQR Program Measure Set for the CY 2021 Payment Determination and Subsequent Years	
NQF #	Measure Name
0288	OP-2: Fibrinolytic Therapy Received Within 30 Minutes of ED Arrival†
0290	OP-3: Median Time to Transfer to Another Facility for Acute Coronary Intervention
0514	OP-8: MRI Lumbar Spine for Low Back Pain†
None	OP-10: Abdomen CT – Use of Contrast Material
0669	OP-13: Cardiac Imaging for Preoperative Risk Assessment for Non-Cardiac, Low-Risk Surgery
0496	OP-18: Median Time from ED Arrival to ED Departure for Discharged ED Patients
0499	OP-22: Left Without Being Seen†
0661	OP-23: Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke who Received Head CT or MRI Scan Interpretation Within 45 minutes of ED Arrival
0658	OP-29: Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients*
1536	OP-31: Cataracts: Improvement in Patient’s Visual Function within 90 Days Following Cataract Surgery**
2539	OP-32: Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy
1822	OP-33: External Beam Radiotherapy for Bone Metastases†
None	OP-35: Admissions and Emergency Department (ED) Visits for Patients Receiving Outpatient Chemotherapy
2687	OP-36: Hospital Visits after Hospital Outpatient Surgery
None	OP-37a: OAS CAHPS – About Facilities and Staff***
None	OP-37b: OAS CAHPS – Communication About Procedure***
None	OP-37c: OAS CAHPS – Preparation for Discharge and Recovery***
None	OP-37d: OAS CAHPS – Overall Rating of Facility***
None	OP-37e: OAS CAHPS – Recommendation of Facility***

† We note that NQF endorsement for this measure was removed.

* We note that measure name was revised to reflect NQF title.

** Measure voluntarily collected as set forth in section XIII.D.3.b. of the CY 2015 OPPS/ASC final rule with comment period (79 FR 66946 through 66947).

*** Measure reporting delayed beginning with CY 2018 reporting and for subsequent years as discussed in section XIII.B.5. of the CY 2018 OPPS/ASC final rule with comment period (82 FR 59432 through 59433).

19. On page 59117, the word “retaining” is corrected to read “removing”.

20. On page 59129, first column, first full paragraph,

a. In lines 1 through 10, the following text is removed: “Furthermore, this is the only measure in the ASCQR Program measure set that deals with cataract surgery, which is commonly performed in the ASC setting. If it is

removed, the program will have a gap in coverage for this clinical area. As a result, we now believe that meaningful information can be provided to consumers regarding those facilities.”

b. In Lines 10 through 16, the following text is moved to the end of the previous paragraph: “In addition, when this measure was made voluntary in the CY 2015 OPPS/ASC final rule with comment period (79 FR 66984)

commenters stated that the measure would promote and improve care coordination among providers.”

21. On page 59169, first column,

a. First full paragraph, in line 10, the figure “0.8792” is corrected to read “0.8800”.

b. Last paragraph, in line 26, the figure “1.0004” is corrected to read “1.0000”.

c. Last paragraph, in the third line from the bottom, the figure “\$46.555” is corrected to read “\$46.532”.

22. On page 59170,

a. Third column, first partial paragraph, in line 5, the figure “79 percent” is corrected to read “68 percent”.

b. In Table 63.—Estimated Impact of the CY 2019 Update to the ASC Payment System on Aggregate CY 2019 Medicare Program Payments by Surgical Speciality or Ancillary Items and Services Group, in the last row, third column, titled “Estimated CY 2019 Percent Change” for Ancillary items and

services, the figure “79” is corrected to read “68”.

23. On page 59171, Table 64.—Estimated Impact of the CY 2019 Update to the ASC Payment System on Aggregate Payments for Selected Procedures, the fourth column, “Estimated CY 2019 Percent Change,” is corrected to read as follows:

Estimated CY 2019 Percent Change (4)
-1
3
-1
1
-3
3
11
4
-1
0
1
1
11
8
3
4
4
4
0
-2
-2
2
-2
0
-2
-5
-2
5
-2
8

Dated: December 20, 2018.

Ann C. Agnew,

*Executive Secretary to the Department,
Department of Health and Human Services.*

[FR Doc. 2018-28348 Filed 12-21-18; 4:15 pm]

BILLING CODE 4120-01-P

DEPARTMENT OF HOMELAND SECURITY

Federal Emergency Management Agency

44 CFR Part 64

[Docket ID FEMA-2018-0002; Internal Agency Docket No. FEMA-8561]

Suspension of Community Eligibility

AGENCY: Federal Emergency Management Agency, DHS.

ACTION: Final rule.

SUMMARY: This rule identifies communities where the sale of flood insurance has been authorized under the National Flood Insurance Program (NFIP) that are scheduled for suspension on the effective dates listed within this rule because of noncompliance with the floodplain management requirements of the program. If the Federal Emergency Management Agency (FEMA) receives documentation that the community has adopted the required floodplain management measures prior to the effective suspension date given in this rule, the suspension will not occur and a notice of this will be provided by publication in the **Federal Register** on a subsequent date. Also, information identifying the current participation status of a community can be obtained from FEMA's Community Status Book (CSB). The CSB is available at <https://www.fema.gov/national-flood-insurance-program-community-status-book>.

DATES: The effective date of each community's scheduled suspension is the third date ("Susp.") listed in the third column of the following tables.

FOR FURTHER INFORMATION CONTACT: If you want to determine whether a particular community was suspended on the suspension date or for further information, contact Adrienne L. Sheldon, PE, CFM, Federal Insurance and Mitigation Administration, Federal Emergency Management Agency, 400 C Street SW, Washington, DC 20472, (202) 212-3966.

SUPPLEMENTARY INFORMATION: The NFIP enables property owners to purchase Federal flood insurance that is not otherwise generally available from

private insurers. In return, communities agree to adopt and administer local floodplain management measures aimed at protecting lives and new construction from future flooding. Section 1315 of the National Flood Insurance Act of 1968, as amended, 42 U.S.C. 4022, prohibits the sale of NFIP flood insurance unless an appropriate public body adopts adequate floodplain management measures with effective enforcement measures. The communities listed in this document no longer meet that statutory requirement for compliance with program regulations, 44 CFR part 59. Accordingly, the communities will be suspended on the effective date in the third column. As of that date, flood insurance will no longer be available in the community. We recognize that some of these communities may adopt and submit the required documentation of legally enforceable floodplain management measures after this rule is published but prior to the actual suspension date. These communities will not be suspended and will continue to be eligible for the sale of NFIP flood insurance. A notice withdrawing the suspension of such communities will be published in the **Federal Register**.

In addition, FEMA publishes a Flood Insurance Rate Map (FIRM) that identifies the Special Flood Hazard Areas (SFHAs) in these communities. The date of the FIRM, if one has been published, is indicated in the fourth column of the table. No direct Federal financial assistance (except assistance pursuant to the Robert T. Stafford Disaster Relief and Emergency Assistance Act not in connection with a flood) may be provided for construction or acquisition of buildings in identified SFHAs for communities not participating in the NFIP and identified for more than a year on FEMA's initial FIRM for the community as having flood-prone areas (section 202(a) of the Flood Disaster Protection Act of 1973, 42 U.S.C. 4106(a), as amended). This prohibition against certain types of Federal assistance becomes effective for the communities listed on the date shown in the last column. The Administrator finds that notice and public comment procedures under 5 U.S.C. 553(b), are impracticable and unnecessary because communities listed in this final rule have been adequately notified.

Each community receives 6-month, 90-day, and 30-day notification letters addressed to the Chief Executive Officer stating that the community will be suspended unless the required floodplain management measures are met prior to the effective suspension

date. Since these notifications were made, this final rule may take effect within less than 30 days.

National Environmental Policy Act. FEMA has determined that the community suspension(s) included in this rule is a non-discretionary action and therefore the National Environmental Policy Act of 1969 (42 U.S.C. 4321 *et seq.*) does not apply.

Regulatory Flexibility Act. The Administrator has determined that this rule is exempt from the requirements of the Regulatory Flexibility Act because the National Flood Insurance Act of 1968, as amended, Section 1315, 42 U.S.C. 4022, prohibits flood insurance coverage unless an appropriate public body adopts adequate floodplain management measures with effective enforcement measures. The communities listed no longer comply with the statutory requirements, and after the effective date, flood insurance will no longer be available in the communities unless remedial action takes place.

Regulatory Classification. This final rule is not a significant regulatory action under the criteria of section 3(f) of Executive Order 12866 of September 30, 1993, Regulatory Planning and Review, 58 FR 51735.

Executive Order 13132, Federalism. This rule involves no policies that have federalism implications under Executive Order 13132.

Executive Order 12988, Civil Justice Reform. This rule meets the applicable standards of Executive Order 12988.

Paperwork Reduction Act. This rule does not involve any collection of information for purposes of the Paperwork Reduction Act, 44 U.S.C. 3501 *et seq.*

List of Subjects in 44 CFR Part 64

Flood insurance, Floodplains.

Accordingly, 44 CFR part 64 is amended as follows:

PART 64—[AMENDED]

■ 1. The authority citation for part 64 continues to read as follows:

Authority: 42 U.S.C. 4001 *et seq.*; Reorganization Plan No. 3 of 1978, 3 CFR, 1978 Comp.; p. 329; E.O. 12127, 44 FR 19367, 3 CFR, 1979 Comp.; p. 376.

§ 64.6 [Amended]

■ 2. The tables published under the authority of § 64.6 are amended as follows: