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Department of Health and Human Services

Centers for Medicare & Medicaid Services

42 CFR Parts 410 and 419

Medicare Program: Proposed Changes to the Hospital Outpatient Prospective Payment System and CY 2009 Payment Rates; Proposed Changes to the Ambulatory Surgical Center Payment System and CY 2009 Payment Rates; Proposed Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 410 and 419

[CMS–1404–P]

RIN 0938–AP17

Medicare Program: Proposed Changes to the Hospital Outpatient Prospective Payment System and CY 2009 Payment Rates; Proposed Changes to the Ambulatory Surgical Center Payment System and CY 2009 Payment Rates

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

ACTION: Proposed rule.

SUMMARY: This proposed rule would revise the Medicare hospital outpatient prospective payment system to implement applicable statutory requirements and changes arising from our continuing experience with this system. In this proposed rule, we describe the proposed changes to the amounts and factors used to determine the payment rates for Medicare hospital outpatient services paid under the prospective payment system. These changes would be applicable to services furnished on or after January 1, 2009.

In addition, this proposed rule would update the revised Medicare ambulatory surgical center (ASC) payment system to implement applicable statutory requirements and changes arising from our continuing experience with this system. In this proposed rule, we propose the applicable relative payment weights and amounts for services furnished in ASCs, specific HCPCS codes to which these proposed changes would apply, and other pertinent ratesetting information for the CY 2009 ASC payment system. These changes would be applicable to services furnished on or after January 1, 2009.

DATES: To be assured consideration, comments on all sections of the preamble of this proposed rule must be received at one of the addresses provided in the **ADDRESSES** section no later than 5 p.m. EST on September 2, 2008.

ADDRESSES: In commenting, please refer to file code CMS–1404–P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

You may submit comments in one of four ways (no duplicates, please):

1. *Electronically*. You may submit electronic comments on this regulation to *http://www.regulations.gov*. Follow the instructions for ''Comment or Submission'' and enter the filecode to find the document accepting comments.

2. *By regular mail*. You may mail written comments (one original and two copies) to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1404–P, P.O. Box 8013, Baltimore, MD 21244–1850.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By express or overnight mail*. You may send written comments (one original and two copies) to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1404–P, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

4. *By hand or courier*. If you prefer, you may deliver (by hand or courier) your written comments (one original and two copies) before the close of the comment period to one of the following addresses:

a. Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201.

(Because access to the interior of the HHH Building is not readily available to persons without Federal Government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

b. 7500 Security Boulevard, Baltimore, MD 21244–1850.

If you intend to deliver your comments to the Baltimore address, please call the telephone number (410) 786–9994 in advance to schedule your arrival with one of our staff members.

Comments mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and received after the comment period.

Submission of comments on paperwork requirements. You may submit comments on this document's paperwork requirements by following the instructions at the end of the ''Collection of Information Requirements'' section in this document.

For information on viewing public comments, see the beginning of the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT: Alberta Dwivedi, (410) 786–0378—Hospital outpatient prospective payment issues; Dana Burley, (410) 786–0378—Ambulatory surgical center issues; Suzanne Asplen, (410) 786–4558—Partial hospitalization and community mental health center issues; Sheila Blackstock, (410) 786–3502—Reporting of quality data issues.

SUPPLEMENTARY INFORMATION:

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following Web site as soon as possible after they have been received: *http://www.regulations.gov*. Follow the search instructions on that Web site to view public comments.

Comments received timely will also be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244, on Monday through Friday of each week from 8:30 a.m. to 4 p.m. EST. To schedule an appointment to view public comments, phone 1–800–743–3951.

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Alphabetical List of Acronyms Appearing in This Proposed Rule

ACEP American College of Emergency Physicians
AHA American Hospital Association
AHIMA American Health Information Management Association
AMA American Medical Association
APC Ambulatory payment classification
AMP Average manufacturer price
ASC Ambulatory Surgical Center
ASP Average sales price
AWP Average wholesale price

BBA Balanced Budget Act of 1997, Pub. L. 105–33
BBRA Medicare, Medicaid, and SCHIP [State Children's Health Insurance Program] Balanced Budget Refinement Act of 1999, Pub. L. 106–113
BCA Blue Cross Association
BCBSA Blue Cross and Blue Shield Association
BIPA Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, Pub. L. 106–554
CAH Critical access hospital
CAP Competitive Acquisition Program
CBSA Core-Based Statistical Area
CCR Cost-to-charge ratio
CERT Comprehensive Error Rate Testing
CMHC Community mental health center
CMS Centers for Medicare & Medicaid Services
CoP Condition of participation
CORF Comprehensive outpatient rehabilitation facility
CPT [Physicians'] Current Procedural Terminology, Fourth Edition, 2007, copyrighted by the American Medical Association
CRNA Certified registered nurse anesthetist
CY Calendar year
DMEPOS Durable medical equipment, prosthetics, orthotics, and supplies
DMERC Durable medical equipment regional carrier
DRA Deficit Reduction Act of 2005, Pub. L. 109–171
DSH Disproportionate share hospital
EACH Essential Access Community Hospital
E/M Evaluation and management
EPO Erythropoietin
ESRD End-stage renal disease
FACA Federal Advisory Committee Act, Pub. L. 92–463
FAR Federal Acquisition Regulations
FDA Food and Drug Administration
FFS Fee-for-service
FSS Federal Supply Schedule
FTE Full-time equivalent
FY Federal fiscal year
GAO Government Accountability Office
GME Graduate medical education
HCPCS Healthcare Common Procedure Coding System
HCRIS Hospital Cost Report Information System
HHA Home health agency
HIPAA Health Insurance Portability and Accountability Act of 1996, Pub. L. 104–191
HOPD Hospital outpatient department
HOP QDRP Hospital Outpatient Quality Data Reporting Program
ICD–9–CM International Classification of Diseases, Ninth Edition, Clinical Modification
IDE Investigational device exemption
IME Indirect medical education
I/OCE Integrated Outpatient Code Editor
IOL Intraocular lens
IPPS [Hospital] Inpatient prospective payment system
IVIG Intravenous immune globulin
MAC Medicare Administrative Contractors
MedPAC Medicare Payment Advisory Commission
MDH Medicare-dependent, small rural hospital
MIEA–TRHCA Medicare Improvements and Extension Act under Division B, Title I of the Tax Relief Health Care Act of 2006, Pub. L. 109–432
MMA Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. 108–173
MMSEA Medicare, Medicaid, and SCHIP Extension Act of 2007, Pub. L. 110–173
MPFS Medicare Physician Fee Schedule
MSA Metropolitan Statistical Area
NCCI National Correct Coding Initiative
NCD National Coverage Determination
NTIOL New technology intraocular lens
OMB Office of Management and Budget
OPD [Hospital] Outpatient department
OPPS [Hospital] Outpatient prospective payment system
PHP Partial hospitalization program
PM Program memorandum
PPI Producer Price Index
PPS Prospective payment system
PPV Pneumococcal pneumonia vaccine
PRA Paperwork Reduction Act
QIO Quality Improvement Organization
RFA Regulatory Flexibility Act
RHQDAPU Reporting Hospital Quality Data for Annual Payment Update [Program]
RHHI Regional home health intermediary
SBA Small Business Administration
SCH Sole community hospital
SDP Single Drug Pricer
SI Status indicator
TEFRA Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. 97–248
TOPS Transitional outpatient payments
USPDI United States Pharmacopoeia Drug Information
WAC Wholesale acquisition cost

In this document, we address two payment systems under the Medicare program: The hospital outpatient prospective payment system (OPPS) and the revised ambulatory surgical center (ASC) payment system. The provisions relating to the OPPS are included in sections I. through XIV., and XVI. through XXI. of this proposed rule and in Addenda A, B, C (Addendum C is available on the Internet only; see section XVIII. of this proposed rule), D1, D2, E, L, and M to this proposed rule. The provisions related to the revised ASC payment system are included in sections XV. and XVII. through XXI. of this proposed rule and in Addenda AA, BB, DD1, DD2, and EE (Addendum EE is available on the Internet only; see section XVIII. of this proposed rule) to this proposed rule.

Table of Contents

I. Background for the OPPS

A. Legislative and Regulatory Authority for the Hospital Outpatient Prospective Payment System

When the Medicare statute was originally enacted, Medicare payment for hospital outpatient services was based on hospital-specific costs. In an effort to ensure that Medicare and its beneficiaries pay appropriately for services and to encourage more efficient delivery of care, the Congress mandated replacement of the reasonable cost-based payment methodology with a prospective payment system (PPS). The Balanced Budget Act (BBA) of 1997 (Pub. L. 105–33) added section 1833(t) to the Social Security Act (the Act) authorizing implementation of a PPS for hospital outpatient services.

The Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act (BBRA) of 1999 (Pub. L. 106–113) made major changes in the hospital outpatient prospective payment system (OPPS). The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000 (Pub. L. 106–554) made further changes in the OPPS. Section 1833(t) of the Act was also amended by the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 (Pub. L. 108–173). The Deficit Reduction Act (DRA) of 2005 (Pub. L. 109–171), enacted on February 8, 2006, also made additional changes in the OPPS. In addition, the Medicare Improvements and Extension Act under Division B of Title I of the

Tax Relief and Health Care Act (MIEA-TRHCA) of 2006 (Pub. L. 109–432), enacted on December 20, 2006, made further changes in the OPPS. Further, the Medicare, Medicaid, and SCHIP Extension Act (MMSEA) of 2007 (Pub. L. 110–173), enacted on December 29, 2007, made additional changes in the OPPS. A discussion of these changes is included in sections I.E., II.C., V., and VII. of this proposed rule.

The OPPS was first implemented for services furnished on or after August 1, 2000. Implementing regulations for the OPPS are located at 42 CFR part 419.

Under the OPPS, we pay for hospital outpatient services on a rate-per-service basis that varies according to the ambulatory payment classification (APC) group to which the service is assigned. We use the Healthcare Common Procedure Coding System (HCPCS) codes (which include certain Current Procedural Terminology (CPT) codes) and descriptors to identify and group the services within each APC group. The OPPS includes payment for most hospital outpatient services, except those identified in section I.B. of this proposed rule. Section 1833(t)(1)(B)(ii) of the Act provides for Medicare payment under the OPPS for hospital outpatient services designated by the Secretary (which includes partial hospitalization services furnished by community mental health centers (CMHCs)) and hospital outpatient services that are furnished to inpatients who have exhausted their Part A benefits, or who are otherwise not in a covered Part A stay. Section 611 of Pub. L. 108–173 added provisions for Medicare coverage of an initial preventive physical examination, subject to the applicable deductible and coinsurance, as an outpatient department service, payable under the OPPS.

The OPPS rate is an unadjusted national payment amount that includes the Medicare payment and the beneficiary copayment. This rate is divided into a labor-related amount and a nonlabor-related amount. The labor-related amount is adjusted for area wage differences using the hospital inpatient wage index value for the locality in which the hospital or CMHC is located.

All services and items within an APC group are comparable clinically and with respect to resource use (section 1833(t)(2)(B) of the Act). In accordance with section 1833(t)(2) of the Act, subject to certain exceptions, services and items within an APC group cannot be considered comparable with respect to the use of resources if the highest median (or mean cost, if elected by the Secretary) for an item or service in the APC group is more than 2 times greater than the lowest median cost for an item or service within the same APC group (referred to as the ''2 times rule''). In implementing this provision, we generally use the median cost of the item or service assigned to an APC group.

For new technology items and services, special payments under the OPPS may be made in one of two ways. Section 1833(t)(6) of the Act provides for temporary additional payments, which we refer to as ''transitional pass-through payments,'' for at least 2 but not more than 3 years for certain drugs, biological agents, brachytherapy devices used for the treatment of cancer, and categories of other medical devices. For new technology services that are not eligible for transitional pass-through payments, and for which we lack sufficient data to appropriately assign them to a clinical APC group, we have established special APC groups based on costs, which we refer to as New Technology APCs. These New Technology APCs are designated by cost bands which allow us to provide appropriate and consistent payment for designated new procedures that are not yet reflected in our claims data. Similar to pass-through payments, an assignment to a New Technology APC is temporary; that is, we retain a service within a New Technology APC until we acquire sufficient data to assign it to a clinically appropriate APC group.

B. Excluded OPPS Services and Hospitals

Section 1833(t)(1)(B)(i) of the Act authorizes the Secretary to designate the hospital outpatient services that are paid under the OPPS. While most hospital outpatient services are payable under the OPPS, section 1833(t)(1)(B)(iv) of the Act excludes payment for ambulance, physical and occupational therapy, and speech-language pathology services, for which payment is made under a fee schedule. Section 614 of Pub. L. 108–173 amended section 1833(t)(1)(B)(iv) of the Act to exclude payment for screening and diagnostic mammography services from the OPPS. The Secretary exercised the authority granted under the statute to also exclude from the OPPS those services that are paid under fee schedules or other payment systems. Such excluded services include, for example, the professional services of physicians and nonphysician practitioners paid under the Medicare Physician Fee Schedule (MPFS); laboratory services paid under the clinical diagnostic laboratory fee schedule (CLFS); services for beneficiaries with end-stage renal disease (ESRD) that are paid under the ESRD composite rate; and services and procedures that require an inpatient stay that are paid under the hospital inpatient prospective payment system (IPPS). We set forth the services that are excluded from payment under the OPPS in § 419.22 of the regulations.

Under § 419.20(b) of the regulations, we specify the types of hospitals and entities that are excluded from payment under the OPPS. These excluded entities include Maryland hospitals, but only for services that are paid under a cost containment waiver in accordance with section 1814(b)(3) of the Act; critical access hospitals (CAHs); hospitals located outside of the 50 States, the District of Columbia, and Puerto Rico; and Indian Health Service hospitals.

C. Prior Rulemaking

On April 7, 2000, we published in the **Federal Register** a final rule with comment period (65 FR 18434) to implement a prospective payment system for hospital outpatient services. The hospital OPPS was first implemented for services furnished on or after August 1, 2000. Section 1833(t)(9) of the Act requires the Secretary to review certain components of the OPPS, not less often than annually, and to revise the groups, relative payment weights, and other adjustments that take into account changes in medical practices, changes in technologies, and the addition of new services, new cost data, and other relevant information and factors.

Since initially implementing the OPPS, we have published final rules in the **Federal Register** annually to implement statutory requirements and changes arising from our continuing experience with this system. We published in the **Federal Register** on November 27, 2007 the CY 2008 OPPS/ASC final rule with comment period (72 FR 66580). In that final rule with comment period, we revised the OPPS to update the payment weights and conversion factor for services payable under the CY 2008 OPPS on the basis of claims data from January 1, 2006, through December 31, 2006, and to implement certain provisions of Pub. L. 108–173 and Pub. L. 109–171. In addition, we responded to public comments received on the provisions of the November 26, 2006 final rule with comment period (71 FR 67960) pertaining to the APC assignment of HCPCS codes identified in Addendum B to that rule with the new interim (NI) comment indicator; and public comments received on the August 2,

2007 OPPS/ASC proposed rule for CY 2008 (72 FR 42628).

Subsequent to publication of the CY 2008 OPPS/ASC final rule with comment period, we published in the **Federal Register** on February 22, 2008, a correction notice (73 FR 9860) to correct certain technical errors in the CY 2008 OPPS/ASC final rule with comment period.

D. APC Advisory Panel

1. Authority of the APC Panel

Section 1833(t)(9)(A) of the Act, as amended by section 201(h) of the BBRA, and redesignated by section 202(a)(2) of the BBRA, requires that we consult with an outside panel of experts to review the clinical integrity of the payment groups and their weights under the OPPS. The Act further specifies that the panel will act in an advisory capacity. The Advisory Panel on Ambulatory Payment Classification (APC) Groups (the APC Panel), discussed under section I.D.2. of this proposed rule, fulfills these requirements. The APC Panel is not restricted to using data compiled by CMS, and it may use data collected or developed by organizations outside the Department in conducting its review.

2. Establishment of the APC Panel

On November 21, 2000, the Secretary signed the initial charter establishing the APC Panel. This expert panel, which may be composed of up to 15 representatives of providers subject to the OPPS (currently employed full-time, not as consultants, in their respective areas of expertise), reviews clinical data and advises CMS about the clinical integrity of the APC groups and their payment weights. For purposes of this APC Panel, consultants or independent contractors are not considered to be full-time employees. The APC Panel is technical in nature, and is governed by the provisions of the Federal Advisory Committee Act (FACA). Since its initial chartering, the Secretary has renewed the APC Panel's charter three times: on November 1, 2002; on November 1, 2004; and effective November 21, 2006. The current charter specifies, among other requirements, that the APC Panel continues to be technical in nature; is governed by the provisions of the FACA; may convene up to three meetings per year; has a Designated Federal Officer (DFO); and is chaired by a Federal official designated by the Secretary.

The current APC Panel membership and other information pertaining to the APC Panel, including its charter, **Federal Register** notices, membership, meeting dates, agenda topics, and meeting reports can be viewed on the CMS Web site at: *http://www.cms.hhs.gov/FACA/05_AdvisoryPanelonAmbulatoryPaymentClassificationGroups.asp#TopOfPage.*

3. APC Panel Meetings and Organizational Structure

The APC Panel first met on February 27, February 28, and March 1, 2001. Since the initial meeting, the APC Panel has held 13 subsequent meetings, with the last meeting taking place on March 5, and March 6, 2008. Prior to each meeting, we publish a notice in the **Federal Register** to announce the meeting, and when necessary, to solicit nominations for APC Panel membership, and to announce new members.

The APC Panel has established an operational structure that, in part, includes the use of three subcommittees to facilitate its required APC review process. At its March 2008 meeting, the APC Panel recommended that the Observation and Visit Subcommittee's name be changed to the ''Visits and Observation Subcommittee.'' We are accepting this recommendation and will refer to the subcommittee by its new name, as appropriate, throughout this proposed rule. Thus, the three current subcommittees are the Data Subcommittee, the Visits and Observation Subcommittee, and the Packaging Subcommittee. The Data Subcommittee is responsible for studying the data issues confronting the APC Panel, and for recommending options for resolving them. The Visits and Observation Subcommittee reviews and makes recommendations to the APC Panel on all technical issues pertaining to observation services and hospital outpatient visits paid under the OPPS (for example, APC configurations and APC payment weights). The Packaging Subcommittee studies and makes recommendations on issues pertaining to services that are not separately payable under the OPPS, but whose payments are bundled or packaged into APC payments. Each of these subcommittees was established by a majority vote from the full APC Panel during a scheduled APC Panel meeting, and their continuation as subcommittees was last approved at the March 2008 APC Panel meeting. All subcommittee recommendations are discussed and voted upon by the full APC Panel.

Discussions of the recommendations resulting from the APC Panel's March 2008 meeting are included in the sections of this proposed rule that are specific to each recommendation. For discussions of earlier APC Panel meetings and recommendations, we refer readers to previously published hospital OPPS final rules or the Web site mentioned earlier in this section.

E. Provisions of the Medicare, Medicaid, and SCHIP Extension Act of 2007

The Medicare, Medicaid and SCHIP Extension Act (MMSEA) of 2007, (Pub. L. 110–173), enacted on December 29, 2007, included the following provisions that affect the OPPS and the revised APC payment system:

1. Increase in Physician Payment Update

Section 101 of the MMSEA provides a 0.5 percent increase in the physician payment update from January 1, 2008 through June 30, 2008; revises the Physician Assistance and Quality Initiative Fund, and extends through 2009 the physician quality reporting system. We refer readers to section XV. of this proposed rule for discussion of the effect of this provision on services paid under the revised ASC payment system.

2. Extended Expiration Date for Cost-Based OPPS Payment for Brachytherapy Sources and Therapeutic Radiopharmaceuticals

Section 106 of the MMSEA amended section 1833(t)(16)(C) of the Act, as amended by section 107 of the MIEA–TRCHA to extend for an additional 6 months, through June 30, 2008, payment for brachytherapy devices at hospitals' charges adjusted to costs and to mandate that the same cost-based payment methodology apply to therapeutic radiopharmaceuticals for the same extended payment period. We refer readers to sections V. and VII of this proposed rule for discussion of this provision.

3. Alternative Volume Weighting in Computation of Average Sales Price (ASP) for Medicare Part B Drugs

Section 112 of the MMSEA amended section 1847A(b) to provide for application of alternative volume weighting in computing the average sales price (ASP) for payment of Part B multiple source and single source drugs furnished after April 1, 2008, and for a special rule, beginning April 1, 2008, for payment of single source drugs or biologicals treated as a multiple source drug. This provision is discussed in section V. of this proposed rule.

4. Extended Expiration Date for Certain IPPS Wage Index Geographic Reclassifications and Special Exceptions

Section 117 of the MMSEA extended through September 30, 2008, both the reclassifications that were extended by section 106 of MIEA–TRCHA as well as certain special exception wage indices referenced in the FY 2005 IPPS final rule (69 FR 49105 and 49107). This provision also amended section 508 of Pub. L. 108–173 to specify conditions specific to the reclassification of a group of hospitals in a geographic area for discharges occurring during FY 2008. In addition, for hospital reclassifications extended by section 106(a) of the MIEA–TRCHA, that resulted in a lower wage index for the second half of FY 2007 than applicable to such hospitals during the first half of FY 2007, section 117 of the MMSEA directs the Secretary to apply a higher wage index to such hospitals for the entire FY 2007. We refer readers to section II.C. of this proposed rule for discussion of this provision.

F. Summary of the Major Contents of This Proposed Rule

In this proposed rule, we are setting forth proposed changes to the Medicare hospital OPPS for CY 2009. These changes would be effective for services furnished on or after January 1, 2009. We are also setting forth proposed changes to the Medicare revised ASC payment system for CY 2009. These changes would be effective for services furnished on or after January 1, 2009. The following is a summary of the major changes that we are proposing to make:

1. Proposed Updates Affecting OPPS Payments

In section II. of this proposed rule, we set forth—

- The methodology used to recalibrate the proposed APC relative payment weights.
- The proposed changes to packaged services.
- The proposed update to the conversion factor used to determine payment rates under the OPPS. In this section we set forth changes in the amounts and factors for calculating the full annual update increase to the conversion factor.
- The proposed retention of our current policy to use the IPPS wage indices to adjust, for geographic wage differences, the portion of the OPPS payment rate and the copayment standardized amount attributable to labor-related cost.
- The proposed update of statewide average default CCRs.
- The proposed application of hold harmless transitional outpatient payments (TOPs) for certain small rural hospitals.
- The proposed payment adjustment for rural SCHs.
- The proposed calculation of the hospital outpatient outlier payment.
- The calculation of the proposed national unadjusted Medicare OPPS payment.
- The proposed beneficiary copayments for OPPS services.

2. Proposed OPPS Ambulatory Payment Classification (APC) Group Policies

In section III. of this proposed rule, we discuss the proposed additions of new procedure codes to the APCs; our proposal to establish a number of new APCs; and our analyses of Medicare claims data and certain recommendations of the APC Panel. We also discuss the application of the 2 times rule and proposed exceptions to it; proposed changes to specific APCs; and the proposed movement of procedures from New Technology APCs to clinical APCs.

3. Proposed OPPS Payment for Devices

In section IV. of this proposed rule, we discuss proposed pass-through payment for specific categories of devices and the proposed adjustment for devices furnished at no cost or with partial or full credit.

4. Proposed OPPS Payment Changes for Drugs, Biologicals, and Radiopharmaceuticals

In section V. of this proposed rule, we discuss proposed CY 2009 OPPS payment for drugs, biologicals, and radiopharmaceuticals, including the proposed payment for drugs, biologicals, and radiopharmaceuticals with and without pass-through status.

5. Proposed Estimate of OPPS Transitional Pass-Through Spending for Drugs, Biologicals, Radiopharmaceuticals, and Devices

In section VI. of this proposed rule, we discuss the estimate of CY 2009 OPPS transitional pass-through spending for drugs, biologicals, and devices.

6. Proposed OPPS Payment for Brachytherapy Sources

In section VII. of this proposed rule, we discuss our proposal concerning coding and payment for brachytherapy sources.

7. Proposed OPPS Payment for Drug Administration Services

In section VIII. of this proposed rule, we set forth our proposed policy concerning payment and coding for drug administration services.

8. Proposed OPPS Payment for Hospital Outpatient Visits

In section IX. of this proposed rule, we set forth our proposed policies for the payment of clinic and emergency department visits and critical care services based on claims paid under the OPPS.

9. Proposed Payment for Partial Hospitalization Services

In section X. of this proposed rule, we set forth our proposed payment for partial hospitalization services, including the proposed separate threshold for outlier payments for CMHCs.

10. Proposed Procedures That Will Be Paid Only as Inpatient Procedures

In section XI. of this proposed rule, we discuss the procedures that we are proposing to remove from the inpatient list and assign to APCs.

11. OPPS Nonrecurring Technical and Policy Clarifications

In section XII. of this proposed rule, we set forth our nonrecurring technical and policy clarifications.

12. Proposed OPPS Payment Status and Comment Indicators

In section XIII. of this proposed rule, we discuss our proposed changes to the definitions of status indicators assigned to APCs and present our proposed comment indicators for the CY 2009 OPPS/ASC final rule with comment period.

13. OPPS Policy and Payment Recommendations

In section XIV. of this proposed rule, we address recommendations made by the Medicare Payment Advisory Commission (MedPAC) in its June 2007 and March 2008 reports to Congress, by the APC Panel regarding the OPPS for CY 2009, and by the Office of the Inspector General (OIG) in its June 2007 report.

14. Proposed Update of the Revised Ambulatory Surgical Center Payment System

In section XV. of this proposed rule, we discuss the proposed update of the revised ASC payment system payment rates for CY 2009.

15. Proposed Reporting of Hospital Outpatient Quality Data for Annual Hospital Payment Rate Updates and CY 2009 Payment Reduction

In section XVI. of this proposed rule, we discuss the proposed quality

measures for reporting hospital outpatient quality data for CY 2010 and subsequent calendar years, set forth the requirements for data collection and submission for the annual payment update, and propose a reduction in the OPPS payment for hospitals that fail to meet the HOP QDRP requirements for CY 2009.

16. Healthcare-Associated Conditions

In section XVII. of this proposed rule, we discuss considerations related to potentially extending the principle of Medicare not paying more for the preventable healthcare-associated conditions acquired during inpatient stays paid under the IPPS to other Medicare payment systems for healthcare-associated conditions that occur or result from care in other settings.

17. Regulatory Impact Analysis

In section XXI. of this proposed rule, we set forth an analysis of the impact the proposed changes would have on affected entities and beneficiaries.

II. Proposed Updates Affecting OPPS Payments

A. Proposed Recalibration of APC Relative Weights

1. Database Construction

a. Database Source and Methodology

Section 1833(t)(9)(A) of the Act requires that the Secretary review and revise the relative payment weights for APCs at least annually. In the April 7, 2000 OPPS final rule with comment period (65 FR 18482), we explained in detail how we calculated the relative payment weights that were implemented on August 1, 2000 for each APC group. As discussed in the November 13, 2000 interim final rule (65 FR 67824 through 67827), except for some reweighting due to a small number of APC changes, these relative payment weights continued to be in effect for CY 2001.

We are proposing to use the same basic methodology that we described in the April 7, 2000 OPPS final rule with comment period to recalibrate the APC relative payment weights for services furnished on or after January 1, 2009, and before January 1, 2010 (CY 2009). That is, we are proposing to recalibrate the relative payment weights for each APC based on claims and cost report data for outpatient services. We are proposing to use the most recent available data to construct the database for calculating APC group weights. For the purpose of recalibrating the proposed APC relative payment weights for CY 2009, we used approximately 130 million final action claims for hospital outpatient department (HOPD) services furnished on or after January 1, 2007, and before January 1, 2008. (For exact counts of claims used, we refer readers to the claims accounting narrative under supporting documentation for this proposed rule on the CMS Web site at: *http://www.cms.hhs.gov/HospitalOutpatientPPS/HORD/*).

Of the 130 million final action claims for services provided in hospital outpatient settings used to calculate the CY 2009 OPPS payment rates for this proposed rule, approximately 100 million claims were of the type of bill potentially appropriate for use in setting rates for OPPS services (but did not necessarily contain services payable under the OPPS). Of the 100 million claims, approximately 45 million were not for services paid under the OPPS or were excluded as not appropriate for use (for example, erroneous cost-to-charge ratios (CCRs) or no HCPCS codes reported on the claim). We were able to use approximately 52 million whole claims of the approximately 54 million claims that remained to set the OPPS APC relative weights that we are proposing for the CY 2009 OPPS. From the 52 million whole claims, we created approximately 90 million single records, of which approximately 60 million were ''pseudo'' single claims (created from multiple procedure claims using the process we discuss in this section). Approximately 627,000 claims trimmed out on cost or units in excess of +/−3 standard deviations from the geometric mean, yielding approximately 89 million single bills used for median setting. Ultimately, we were able to use for proposed CY 2009 ratesetting some portion of the data from 96 percent of the CY 2007 claims containing services payable under the OPPS.

The proposed APC relative weights and payments for CY 2009 in Addenda A and B to this proposed rule were calculated using claims from CY 2007 that were processed before January 1, 2008, and continue to be based on the median hospital costs for services in the APC groups. We selected claims for services paid under the OPPS and matched these claims to the most recent cost report filed by the individual hospitals represented in our claims data. We continue to believe that it is appropriate to use the most current full calendar year claims data and the most recently submitted cost reports to calculate the median costs which we are proposing to convert to relative payment weights for purposes of calculating the CY 2009 payment rates.

b. Proposed Use of Single and Multiple Procedure Claims

For CY 2009, in general, we are proposing to continue to use single procedure claims to set the medians on which the APC relative payment weights would be based, with some exceptions as discussed below. We generally use single procedure claims to set the median costs for APCs because we believe that it is important that the OPPS relative weights on which payment rates are based be appropriate when one and only one procedure is furnished and because we are, so far, unable to ensure that packaged costs can be appropriately allocated across multiple procedures performed on the same date of service. We agree that, optimally, it is desirable to use the data from as many claims as possible to recalibrate the APC relative payment weights, including those claims for multiple procedures. As we have for several years, we continued to use date of service stratification and a list of codes to be bypassed to convert multiple procedure claims to ''pseudo'' single procedure claims. Through bypassing specified codes that we believe do not have significant packaged costs, we are able to use more data from multiple procedure claims. In many cases, this enables us to create multiple ''pseudo'' single claims from claims that, as submitted, contained numerous separately paid procedures reported on the same date on one claim. We refer to these newly created single procedure claims as ''pseudo'' single claims because they were submitted by providers as multiple procedure claims. The history of our use of a bypass list to generate ''pseudo'' single claims is well documented, most recently in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66590 through 66597). In addition, for CY 2008, we increased packaging and created composite APCs, which also increased the number of bills we were able to use for median calculation by enabling us to use claims that contained multiple major procedures that previously would not have been usable. We refer readers to section II.A.2.e. of this proposed rule for discussion of the use of claims to establish median costs for composite APCs.

We are proposing to continue to apply these processes to enable us to use as much claims data as possible for ratesetting for the CY 2009 OPPS. Application of these processes in development of this proposed rule data resulted in our being able to use some or all of the data from 96 percent of the total claims that are eligible for use in

the OPPS ratesetting and modeling for this proposed rule. This process enabled us to create, for this proposed rule, approximately 60 million ''pseudo'' single claims, including multiple imaging composite ''single session'' bills (we refer readers to section II.A.2.e.(5) of this proposed rule for further discussion), and approximately 30 million ''natural'' single bills. For this proposed rule, ''pseudo'' single procedure bills represent 67 percent of all single bills used to calculate median costs. This compares favorably to the CY 2008 OPPS/ASC final rule with comment period data in which ''pseudo'' single bills represented 66 percent of all single bills used to calculate the median costs on which the CY 2008 OPPS payment rates were based.

For CY 2009, we are proposing to bypass 452 HCPCS codes that are identified in Table 1 of this proposed rule. We are proposing to continue the use of the codes on the CY 2008 OPPS bypass list. Since the inception of the bypass list, we have calculated the percent of ''natural'' single bills that contained packaging for each HCPCS code and the amount of packaging in each ''natural'' single bill for each code. We have generally retained the codes on the previous year's bypass list and used the update year's data (for CY 2009, data available for the first CY 2008 APC Panel meeting for services furnished on and after January 1, 2007 through and including September 30, 2007) to determine whether it would be appropriate to add additional codes to the previous year's bypass list. The entire list (including the codes that remained on the bypass list from prior years) is open to public comment. We removed two HCPCS codes from the CY 2008 bypass list for this CY 2009 proposal because the codes were deleted on December 31, 2005, specifically C8951 (Intravenous infusion for therapy/diagnosis; each additional hour (List separately in addition to C8950)) and C8955 (Chemotherapy administration, intravenous; infusion technique, each additional hour (List separately in addition to C8954)). We updated HCPCS codes on the CY 2008 bypass list that were mapped to new HCPCS codes for CY 2009 ratesetting. We are proposing to add to the bypass list all HCPCS codes not on the CY 2008 bypass list that, using the APC Panel data, meet the same previously established empirical criteria for the bypass list that are summarized below. We assume that the representation of packaging in the single claims for any given code is comparable to packaging for that code in the multiple claims. The proposed criteria for the bypass list are:

- There are 100 or more single claims for the code. This number of single claims ensures that observed outcomes are sufficiently representative of packaging that might occur in the multiple claims.
- Five percent or fewer of the single claims for the code have packaged costs on that single claim for the code. This criterion results in limiting the amount of packaging being redistributed to the separately payable procedure remaining on the claim after the bypass code is removed and ensures that the costs associated with the bypass code represent the cost of the bypassed service.
- The median cost of packaging observed in the single claims is equal to or less than $50. This limits the amount of error in redistributed costs.
- The code is not a code for an unlisted service.

In addition, we are proposing to add to the bypass list HCPCS codes that CMS medical advisors believe have minimal associated packaging based on their clinical assessment of the complete CY 2009 OPPS proposal. To ensure clinical consistency in our treatment of related services, we are also proposing to add the other CPT add-on codes for drug administration services to the CY 2009 bypass list, in addition to the CPT codes for additional hours of infusion that were previously included on the CY 2008 bypass list, because adding them enables us to use many correctly coded claims for initial drug administration services that would otherwise not be available for ratesetting. The result of this proposal is that the packaged costs associated with add-on drug administration services are packaged into payment for the initial administration service, as has been our payment policy for the past 2 years for the CPT codes for additional hours of infusion. We are also proposing to add HCPCS code G0390 (Trauma response team activation associated with hospital critical care service) because we think it is appropriate to attribute all of the packaged costs that appear on a claim with HCPCS code G0390 and CPT code 99291 (Critical care, evaluation and management of the critically ill or critically injured patient; first 30–74 minutes) to CPT code 99291. If we did not add HCPCS code G0390 to the bypass list, we would have many fewer claims to use to set the median costs for APCs 0617 (Critical Care) and 0618 (Trauma Response with Critical Care). By definition, we could not have any properly coded ''natural'' single bills for HCPCS code G0390. Including HCPCS code G0390 on the bypass list allows us to create more ''pseudo'' single bills for CPT code 99291 and HCPCS code G0390, and, therefore, to improve the accuracy of the median costs of APCs 0617 and 0618 to which the two codes are assigned, respectively. The Integrated Outpatient Code Editor (I/OCE) logic rejects a line for HCPCS code G0390 if CPT code 99291 is not also reported on the claim. Therefore, we cannot assess whether HCPCS code G0390 would meet the empirical criteria for inclusion on the bypass list because we have no ''natural'' single claims for HCPCS code G0390.

As a result of the multiple imaging composite APCs that we are proposing to establish for CY 2009 as discussed in section II.A.2.e.(5) of this proposed rule, the ''pseudo'' single converter logic for bypassed codes that are also members of multiple imaging composite APCs would change. When creating the set of ''pseudo'' single claims, claims that contain ''overlap bypass codes,'' that is, those HCPCS codes that are both on the bypass list and are members of the multiple imaging composite APCs, are identified first. These HCPCS codes are then processed to create multiple imaging composite ''single'' bills, that is, claims containing HCPCS codes from only one imaging family, thus suppressing the initial use of these codes as bypass codes. However, these ''overlap bypass codes'' are retained on the bypass list because single unit occurrences of these codes are identified as single bills at the end of the ''pseudo'' single processing logic. The net effect of using these HCPCS codes in building multiple imaging composite ''single session'' claims rather than for bypass purposes is a slight reduction in the number of ''pseudo'' single claims available for the ''overlap bypass codes'' and a handful of services that would be frequently billed with an ''overlap bypass code.'' This process also creates multiple imaging composite ''single session'' bills that can be used for calculating composite APC median costs. ''Overlap bypass codes'' that would be members of the proposed multiple imaging composite APCs are identified by asterisks (*) in Table 1.

We note that this list contains bypass codes that were appropriate to claims for services in CY 2007 and, therefore, includes codes that were deleted for CY 2008. Moreover, there are codes on the proposed bypass list that are new for CY 2008 and which are appropriate additions to the bypass list in preparation for use of the CY 2008 claims for creation of the CY 2010 OPPS. Table 1 below includes a list of the bypass codes that we are proposing

for CY 2009. We specifically request public comment on this proposed list of bypass codes for CY 2009.

TABLE 1.—PROPOSED CY 2009 BYPASS CODES FOR CREATING "PSEUDO" SINGLE CLAIMS FOR CALCULATING MEDIAN COSTS

HCPCS code	Short descriptor	"Overlap bypass codes"
11056	Trim skin lesions, 2 to 4.	
11057	Trim skin lesions, over 4.	
11300	Shave skin lesion	
11301	Shave skin lesion	
11719	Trim nail(s)	
11720	Debride nail, 1–5	
11721	Debride nail, 6 or more.	
11954	Therapy for contour defects.	
17000	Destruct premalg lesion.	
17003	Destruct premalg les, 2–14.	
29220	Strapping of low back.	
31231	Nasal endoscopy, dx.	
31579	Diagnostic laryngoscopy.	
51798	Us urine capacity measure.	
53661	Dilation of urethra	
54240	Penis study	
56820	Exam of vulva w/ scope.	
57150	Treat vagina infection.	
67820	Revise eyelashes	
69210	Remove impacted earwax.	
69220	Clean out mastoid cavity.	
70030	X-ray eye for foreign body.	
70100	X-ray exam of jaw	
70110	X-ray exam of jaw	
70120	X-ray exam of mastoids.	
70130	X-ray exam of mastoids.	
70140	X-ray exam of facial bones.	
70150	X-ray exam of facial bones.	
70160	X-ray exam of nasal bones.	
70200	X-ray exam of eye sockets.	
70210	X-ray exam of sinuses.	
70220	X-ray exam of sinuses.	
70250	X-ray exam of skull	
70260	X-ray exam of skull	
70328	X-ray exam of jaw joint.	
70330	X-ray exam of jaw joints.	
70336	Magnetic image, jaw joint.	*
70355	Panoramic x-ray of jaws.	
70360	X-ray exam of neck	
70370	Throat x-ray & fluoroscopy.	
70371	Speech evaluation, complex.	
70450	Ct head/brain w/o dye.	*
70480	Ct orbit/ear/fossa w/ o dye.	*
70486	Ct maxillofacial w/o dye.	*
70490	Ct soft tissue neck w/o dye.	*
70544	Mr angiography head w/o dye.	*
70551	Mri brain w/o dye	*
71010	Chest x-ray	
71015	Chest x-ray	
71020	Chest x-ray	
71021	Chest x-ray	
71022	Chest x-ray	
71023	Chest x-ray and fluoroscopy.	
71030	Chest x-ray	
71034	Chest x-ray and fluoroscopy.	
71035	Chest x-ray	
71100	X-ray exam of ribs	
71101	X-ray exam of ribs/ chest.	
71110	X-ray exam of ribs	
71111	X-ray exam of ribs/ chest.	
71120	X-ray exam of breastbone.	
71130	X-ray exam of breastbone.	
71250	Ct thorax w/o dye	*
72010	X-ray exam of spine.	
72020	X-ray exam of spine.	
72040	X-ray exam of neck spine.	
72050	X-ray exam of neck spine.	
72052	X-ray exam of neck spine.	
72069	X-ray exam of trunk spine.	
72070	X-ray exam of thoracic spine.	
72072	X-ray exam of thoracic spine.	
72074	X-ray exam of thoracic spine.	
72080	X-ray exam of trunk spine.	
72090	X-ray exam of trunk spine.	
72100	X-ray exam of lower spine.	
72110	X-ray exam of lower spine.	
72114	X-ray exam of lower spine.	
72120	X-ray exam of lower spine.	
72125	Ct neck spine w/o dye.	*
72128	Ct chest spine w/o dye.	*
72131	Ct lumbar spine w/o dye.	*
72141	Mri neck spine w/o dye.	*
72146	Mri chest spine w/o dye.	*
72148	Mri lumbar spine w/ o dye.	*
72170	X-ray exam of pelvis.	
72190	X-ray exam of pelvis.	
72192	Ct pelvis w/o dye	*
72202	X-ray exam sacroiliac joints.	
72220	X-ray exam of tailbone.	
73000	X-ray exam of collar bone.	
73010	X-ray exam of shoulder blade.	
73020	X-ray exam of shoulder.	
73030	X-ray exam of shoulder.	
73050	X-ray exam of shoulders.	
73060	X-ray exam of humerus.	
73070	X-ray exam of elbow.	
73080	X-ray exam of elbow.	
73090	X-ray exam of forearm.	
73100	X-ray exam of wrist	
73110	X-ray exam of wrist	
73120	X-ray exam of hand	
73130	X-ray exam of hand	
73140	X-ray exam of finger(s).	
73200	Ct upper extremity w/o dye.	*
73218	Mri upper extremity w/o dye.	*
73221	Mri joint upr extrem w/o dye.	*
73510	X-ray exam of hip	
73520	X-ray exam of hips	
73540	X-ray exam of pelvis & hips.	
73550	X-ray exam of thigh	
73560	X-ray exam of knee, 1 or 2.	
73562	X-ray exam of knee, 3.	

TABLE 1.—PROPOSED CY 2009 BYPASS CODES FOR CREATING "PSEUDO" SINGLE CLAIMS FOR CALCULATING MEDIAN COSTS—Continued

HCPCS code	Short descriptor	"Overlap bypass codes"
73564	X-ray exam, knee, 4 or more.	
73565	X-ray exam of knees.	
73590	X-ray exam of lower leg.	
73600	X-ray exam of ankle.	
73610	X-ray exam of ankle.	
73620	X-ray exam of foot	
73630	X-ray exam of foot	
73650	X-ray exam of heel	
73660	X-ray exam of toe(s).	
73700	Ct lower extremity w/o dye.	*
73718	Mri lower extremity w/o dye.	*
73721	Mri jnt of lwr extre w/o dye.	*
74000	X-ray exam of abdomen.	
74010	X-ray exam of abdomen.	
74020	X-ray exam of abdomen.	
74022	X-ray exam series, abdomen.	
74150	Ct abdomen w/o dye.	*
74210	Contrst x-ray exam of throat.	
74220	Contrast x-ray, esophagus.	
74230	Cine/vid x-ray, throat/esoph.	
74246	Contrst x-ray uppr gi tract.	
74247	Contrst x-ray uppr gi tract.	
74249	Contrst x-ray uppr gi tract.	
76100	X-ray exam of body section.	
76510	Ophth us, b & quant a.	
76511	Ophth us, quant a only.	
76512	Ophth us, b w/non-quant a.	
76513	Echo exam of eye, water bath.	
76514	Echo exam of eye, thickness.	
76516	Echo exam of eye	
76519	Echo exam of eye	
76536	Us exam of head and neck.	
76645	Us exam, breast(s)	
76700	Us exam, abdom, complete.	*
76705	Echo exam of abdomen.	*
76770	Us exam abdo back wall, comp.	*
76775	Us exam abdo back wall, lim.	*
76776	Us exam k transpl w/doppler.	*
76801	Ob us <14 wks, single fetus.	
76805	Ob us ≥14 wks, sngl fetus.	
76811	Ob us, detailed, sngl fetus.	
76816	Ob us, follow-up, per fetus.	
76817	Transvaginal us, obstetric.	
76830	Transvaginal us, non-ob.	
76856	Us exam, pelvic, complete.	*
76857	Us exam, pelvic, limited.	*
76870	Us exam, scrotum	*
76880	Us exam, extremity	
76970	Ultrasound exam follow-up.	
76977	Us bone density measure.	
76999	Echo examination procedure.	
77072	X-rays for bone age	
77073	X-rays, bone length studies.	
77074	X-rays, bone survey, limited.	
77075	X-rays, bone survey complete.	
77076	X-rays, bone survey, infant.	
77077	Joint survey, single view.	
77078	Ct bone density, axial.	
77079	Ct bone density, peripheral.	
77080	Dxa bone density, axial.	
77081	Dxa bone density/peripheral.	
77082	Dxa bone density, vert fx.	
77083	Radiographic absorptiometry.	
77084	Magnetic image, bone marrow.	
77280	Set radiation therapy field.	
77285	Set radiation therapy field.	
77290	Set radiation therapy field.	
77295	Set radiation therapy field.	
77300	Radiation therapy dose plan.	
77301	Radiotherapy dose plan, imrt.	
77315	Teletx isodose plan complex.	
77326	Brachytx isodose calc simp.	
77327	Brachytx isodose calc interm.	
77328	Brachytx isodose plan compl.	
77331	Special radiation dosimetry.	
77332	Radiation treatment aid(s).	
77333	Radiation treatment aid(s).	
77334	Radiation treatment aid(s).	
77336	Radiation physics consult.	
77370	Radiation physics consult.	
77401	Radiation treatment delivery.	
77402	Radiation treatment delivery.	
77403	Radiation treatment delivery.	
77404	Radiation treatment delivery.	
77407	Radiation treatment delivery.	
77408	Radiation treatment delivery.	
77409	Radiation treatment delivery.	
77411	Radiation treatment delivery.	
77412	Radiation treatment delivery.	
77413	Radiation treatment delivery.	
77414	Radiation treatment delivery.	
77416	Radiation treatment delivery.	
77418	Radiation tx delivery, imrt.	
77470	Special radiation treatment.	
77520	Proton trmt, simple w/o comp.	
77523	Proton trmt, intermediate.	
80500	Lab pathology consultation.	
80502	Lab pathology consultation.	
85097	Bone marrow interpretation.	
86510	Histoplasmosis skin test.	
86850	RBC antibody screen.	
86870	RBC antibody identification.	
86880	Coombs test, direct	

TABLE 1.—PROPOSED CY 2009 BYPASS CODES FOR CREATING "PSEUDO" SINGLE CLAIMS FOR CALCULATING MEDIAN COSTS—Continued

HCPCS code	Short descriptor	"Overlap bypass codes"
86885	Coombs test, indirect, qual.	
86886	Coombs test, indirect, titer.	
86890	Autologous blood process.	
86900	Blood typing, ABO	
86901	Blood typing, Rh (D).	
86903	Blood typing, antigen screen.	
86904	Blood typing, patient serum.	
86905	Blood typing, RBC antigens.	
86906	Blood typing, Rh phenotype.	
86930	Frozen blood prep	
86970	RBC pretreatment	
86977	RBC pretreatment, serum.	
88104	Cytopath fl nongyn, smears.	
88106	Cytopath fl nongyn, filter.	
88107	Cytopath fl nongyn, sm/fltr.	
88108	Cytopath, concentrate tech.	
88112	Cytopath, cell enhance tech.	
88160	Cytopath smear, other source.	
88161	Cytopath smear, other source.	
88162	Cytopath smear, other source.	
88172	Cytopathology eval of fna.	
88173	Cytopath eval, fna, report.	
88182	Cell marker study ..	
88184	Flowcytometry/ tc, 1 marker.	
88185	Flowcytometry/tc, add-on.	
88300	Surgical path, gross	
88302	Tissue exam by pathologist.	
88304	Tissue exam by pathologist.	
88305	Tissue exam by pathologist.	
88307	Tissue exam by pathologist.	
88311	Decalcify tissue	
88312	Special stains	
88313	Special stains	
88321	Microslide consultation.	
88323	Microslide consultation.	
88325	Comprehensive review of data.	
88331	Path consult intraop, 1 bloc.	
88342	Immunohistochemistry.	
88346	Immunofluorescent study.	
88347	Immunofluorescent study.	
88348	Electron microscopy.	
88358	Analysis, tumor	
88360	Tumor immunohistochem/manual.	
88361	Tumor immunohistochem/comput.	
88365	In situ hybridization (FISH).	
88368	Insitu hybridization, manual.	
88399	Surgical pathology procedure.	
89049	Chct for mal hyperthermia.	
89230	Collect sweat for test.	
89240	Pathology lab procedure.	
90472	Immunization admin, each add.	
90474	Immune admin oral/nasal addl.	
90761	Hydrate iv infusion, add-on.	
90766	Ther/proph/dg iv inf, add-on.	
90767	Tx/proph/dg addl seq iv inf.	
90770	Sc ther infusion, addl hr.	
90771	Sc ther infusion, reset pump.	
90775	Tx/pro/dx inj new drug add-on.	
90801	Psy dx interview	
90802	Intac psy dx interview.	
90804	Psytx, office, 20–30 min.	
90805	Psytx, off, 20–30 min w/e&m.	
90806	Psytx, off, 45–50 min.	
90807	Psytx, off, 45–50 min w/e&m.	
90808	Psytx, office, 75–80 min.	
90809	Psytx, off, 75–80, w/e&m.	
90810	Intac psytx, off, 20–30 min.	
90811	Intac psytx, 20–30, w/e&m.	
90812	Intac psytx, off, 45–50 min.	
90816	Psytx, hosp, 20–30 min.	
90818	Psytx, hosp, 45–50 min.	
90826	Intac psytx, hosp, 45–50 min.	
90845	Psychoanalysis	
90846	Family psytx w/o patient.	
90847	Family psytx w/patient.	
90853	Group psychotherapy.	
90857	Intac group psytx ...	
90862	Medication management.	
90899	Psychiatric service/therapy.	
92002	Eye exam, new patient.	
92004	Eye exam, new patient.	
92012	Eye exam established pat.	
92014	Eye exam & treatment.	
92020	Special eye evaluation.	
92025	Corneal topography	
92081	Visual field examination(s).	
92082	Visual field examination(s).	
92083	Visual field examination(s).	
92135	Ophth dx imaging post seg.	
92136	Ophthalmic biometry.	
92225	Special eye exam, initial.	
92226	Special eye exam, subsequent.	
92230	Eye exam with photos.	
92240	Icg angiography	
92250	Eye exam with photos.	
92275	Electroretinography	
92285	Eye photography ...	
92286	Internal eye photography.	
92520	Laryngeal function studies.	
92541	Spontaneous nystagmus test.	
92546	Sinusoidal rotational test.	
92548	Posturography	
92552	Pure tone audiometry, air.	
92553	Audiometry, air & bone.	
92555	Speech threshold audiometry.	
92556	Speech audiometry, complete.	

TABLE 1.—PROPOSED CY 2009 BYPASS CODES FOR CREATING "PSEUDO" SINGLE CLAIMS FOR CALCULATING MEDIAN COSTS—Continued

HCPCS code	Short descriptor	"Overlap bypass codes"
92557	Comprehensive hearing test.	
92567	Tympanometry	
92582	Conditioning play audiometry.	
92585	Auditor evoke potent, compre.	
92603	Cochlear implt f/up exam 7 >.	
92604	Reprogram cochlear implt 7 >.	
92626	Eval aud rehab status.	
93005	Electrocardiogram, tracing.	
93017	Cardiovascular stress test.	
93225	ECG monitor/record, 24 hrs.	
93226	ECG monitor/report, 24 hrs.	
93231	Ecg monitor/record, 24 hrs.	
93232	ECG monitor/report, 24 hrs.	
93236	ECG monitor/report, 24 hrs.	
93270	ECG recording	
93271	Ecg/monitoring and analysis.	
93278	ECG/signal-averaged.	
93727	Analyze ilr system	
93731	Analyze pacemaker system.	
93732	Analyze pacemaker system.	
93733	Telephone analy, pacemaker.	
93734	Analyze pacemaker system.	
93735	Analyze pacemaker system.	
93736	Telephonic analy, pacemaker.	
93741	Analyze ht pace device sngl.	
93742	Analyze ht pace device sngl.	
93743	Analyze ht pace device dual.	
93744	Analyze ht pace device dual.	
93786	Ambulatory BP recording.	
93788	Ambulatory BP analysis.	
93797	Cardiac rehab	
93798	Cardiac rehab/monitor.	
93875	Extracranial study ..	
93880	Extracranial study ..	
93882	Extracranial study ..	
93886	Intracranial study ...	
93888	Intracranial study ...	
93922	Extremity study	
93923	Extremity study	
93924	Extremity study	
93925	Lower extremity study.	
93926	Lower extremity study.	
93930	Upper extremity study.	
93931	Upper extremity study.	
93965	Extremity study	
93970	Extremity study	
93971	Extremity study	
93975	Vascular study	
93976	Vascular study	
93978	Vascular study	
93979	Vascular study	
93990	Doppler flow testing	
94015	Patient recorded spirometry.	
94690	Exhaled air analysis	
95115	Immunotherapy, one injection.	
95117	Immunotherapy injections.	
95165	Antigen therapy services.	
95250	Glucose monitoring, cont.	
95805	Multiple sleep latency test.	
95806	Sleep study, unattended.	
95807	Sleep study, attended.	
95808	Polysomnography, 1–3.	
95812	Eeg, 41–60 minutes	
95813	Eeg, over 1 hour ...	
95816	Eeg, awake and drowsy.	
95819	Eeg, awake and asleep.	
95822	Eeg, coma or sleep only.	
95869	Muscle test, thor paraspinal.	
95872	Muscle test, one fiber.	
95900	Motor nerve conduction test.	
95921	Autonomic nerv function test.	
95925	Somatosensory testing.	
95926	Somatosensory testing.	
95930	Visual evoked potential test.	
95950	Ambulatory eeg monitoring.	
95953	EEG monitoring/computer.	
95970	Analyze neurostim, no prog.	
95972	Analyze neurostim, complex.	
95974	Cranial neurostim, complex.	
95978	Analyze neurostim brain/1h.	
96000	Motion analysis, video/3d.	
96101	Psycho testing by psych/phys.	
96111	Developmental test, extend.	
96116	Neurobehavioral status exam.	
96118	Neuropsych tst by psych/phys.	
96119	Neuropsych testing by tec.	
96150	Assess hlth/behave, init.	
96151	Assess hlth/behave, subseq.	
96152	Intervene hlth/behave, indiv.	
96153	Intervene hlth/behave, group.	
96402	Chemo hormon antineopl sq/im.	
96411	Chemo, iv push, addl drug.	
96415	Chemo, iv infusion, addl hr.	
96417	Chemo iv infus each addl seq.	
96423	Chemo ia infuse each addl hr.	
96900	Ultraviolet light therapy.	
96910	Photochemotherapy with UV–B.	
96912	Photochemotherapy with UV–A.	
96913	Photochemotherapy, UV–A or B.	
96920	Laser tx, skin <250 sq cm.	
98925	Osteopathic manipulation.	
98926	Osteopathic manipulation.	
98927	Osteopathic manipulation.	
98940	Chiropractic manipulation.	
98941	Chiropractic manipulation.	
98942	Chiropractic manipulation.	
99204	Office/outpatient visit, new.	
99212	Office/outpatient visit, est.	
99213	Office/outpatient visit, est.	
99214	Office/outpatient visit, est.	

TABLE 1.—PROPOSED CY 2009 BYPASS CODES FOR CREATING ''PSEUDO'' SINGLE CLAIMS FOR CALCULATING MEDIAN COSTS—Continued

HCPCS code	Short descriptor	''Overlap bypass codes''
99241	Office consultation	
99242	Office consultation	
99243	Office consultation	
99244	Office consultation	
99245	Office consultation	
0144T	CT heart wo dye; qual calc.	
G0008	Admin influenza virus vac.	
G0101	CA screen; pelvic/breast exam.	
G0127	Trim nail(s)	
G0130	Single energy x-ray study.	
G0166	Extrnl counterpulse, per tx.	
G0175	OPPS Service,sched team conf.	
G0340	Robt lin-radsurg fractx 2–5.	
G0344	Initial preventive exam.	
G0365	Vessel mapping hemo access.	
G0367	EKG tracing for initial prev.	
G0376	Smoke/tobacco counseling >10.	
G0389	Ultrasound exam AAA screen.	
G0390	Trauma response w/hosp criti.	
M0064	Visit for drug monitoring.	
Q0091	Obtaining screen pap smear.	

c. Proposed Calculation of CCRs

(1) Development of the CCRs

We calculated hospital-specific overall CCRs and hospital-specific departmental CCRs for each hospital for which we had CY 2007 claims data. For CY 2009 OPPS ratesetting, we used the set of claims processed during CY 2007. We applied the hospital-specific CCR to the hospital's charges at the most detailed level possible, based on a revenue code-to-cost center crosswalk that contains a hierarchy of CCRs used to estimate costs from charges for each revenue code. That crosswalk is available for review and continuous comment on the CMS Web site at: *http://www.cms.hhs.gov/HospitalOutpatientPPS/03_crosswalk.asp#TopOfPage.* We calculated CCRs for the standard and nonstandard cost centers accepted by the electronic cost report database. In general, the most detailed level at which we calculated CCRs was the hospital-specific departmental level.

We are proposing to make a change to the revenue code-to-cost center crosswalk for the CY 2009 OPPS. Specifically, for revenue code 0904 (Activity Therapy), we are proposing to make cost center 3550 (Psychiatric/Psychological Services) the primary cost center and to make cost center 6000 (Clinic services) the secondary cost center. For CY 2008, for revenue code 0904, the primary cost center is 3580 (Recreational Therapy), cost center 3550 is secondary; and cost center 6000 is tertiary. We are proposing this change to conform the OPPS methodology for hospital claims to the crosswalk that is being used to calculate partial hospitalization costs for CMHCs.

We would like to affirm that the longstanding Medicare principles of cost apportionment at § 413.53 convey that, under the departmental method of apportionment, the cost of each ancillary department is to be apportioned separately rather than being combined with another department. However, CMS does not specify a revenue code-to-cost center crosswalk that hospitals must adopt to prepare the cost report, but instead, requires hospitals to submit their individual crosswalk to the Medicare contractor when the cost report is filed. The proposed CY 2009 OPPS revenue code-to-cost center crosswalk contains several potential cost center locations for a revenue code because it is an attempt to best represent the association of revenue codes with cost centers across all hospitals for modeling purposes. Assignment to cost centers is mutually exclusive and only defaults to the next level when the cost center with higher priority is unavailable. The changes to the crosswalk for revenue code 0904 mentioned above are used by CMS for modeling purposes only, and we fully expect hospitals to comply with the Medicare reimbursement policies when reporting their costs and charges on the cost report.

At the March 2008 APC Panel meeting, we reviewed with the APC Panel's Data Subcommittee the current revenue code-to-cost center crosswalk, as well as other data in preparation for the CY 2009 rulemaking cycle. At this meeting, the APC Panel recommended that the Data Subcommittee continue its work and we are accepting that recommendation. We will continue to work with the APC Panels' Data Subcommittee to prepare and review data and analyses relevant to the APC configurations and OPPS payment policies for hospital outpatient items and services.

(2) Charge Compression

Since the implementation of the OPPS, some commenters have raised concerns about potential bias in the OPPS cost-based weights due to ''charge compression,'' which is the practice of applying a lower charge markup to higher-cost services and a higher charge markup to lower-cost services. As a result, the cost-based weights suffer from aggregation bias, undervaluing high cost items and overvaluing low cost items if an estimate of average markup embodied in a single CCR is applied to items of widely varying costs in the same cost center. Commenters expressed increased concern about the impact of charge compression when, partially in response to recommendations of the Medicare Payment Advisory Commission (MedPAC), CMS proposed to set the relative weights for payment under the IPPS based on the costs of inpatient hospital services, rather than the charges for the services.

To explore this issue, in August 2006 we awarded a contract to RTI International (RTI) to study the effects of charge compression in calculating the IPPS relative weights, particularly with regard to the impact on inpatient diagnosis-related group (DRG) payments, and to consider methods to reduce the variation in the CCRs used to calculate costs for the IPPS relative weights across services within cost centers. Of specific note was RTI's analysis of a regression-based methodology estimating an average adjustment for CCR by type of revenue code from an observed relationship between provider cost center CCRs and proportional billing of high and low cost services in the cost center. RTI issued a report in March 2007 with its findings on charge compression. The report is available on the CMS Web site at: *http://www.cms.hhs.gov/reports/downloads/Dalton.pdf.* Although this report was focused largely on charge compression in the context of the IPPS cost-based relative weights, several of the findings were relevant to the OPPS. Therefore, we discussed the findings and our responses to that interim draft report in the CY 2008 OPPS/ASC proposed rule (72 FR 42641 through 42643) and reiterated them in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66599 through 66602).

As RTI noted in its 2007 report that its research was limited to IPPS DRG cost-based weights and that it did not examine potential areas of charge compression specific to hospital outpatient services, we were concerned

that the analysis was too limited in scope because typically hospital cost report CCRs encompass both inpatient and outpatient services for each cost center. Further, because both the IPPS and OPPS rely on cost-based weights, we preferred to introduce any methodological adjustments to both payment systems at the same time. We believe that because charge compression affects the cost estimates for services paid under both IPPS and OPPS in the same way, it is appropriate that we would use the same approach to address the issue. Finally, we noted that we wished to assess the educational activities being undertaken by the hospital community to improve cost reporting accuracy in response to RTI's findings, either as an adjunct to or in lieu of regression-based adjustments to CCRs.

We have since expanded RTI's analysis of charge compression to incorporate outpatient services. In August 2007, we again contracted with RTI. Under this contract, we asked RTI to evaluate the cost estimation process for the OPPS relative weights. This research included a reassessment of the regression-based CCR models using hospital outpatient and inpatient charge data, as well as a detailed review of the OPPS revenue code-to-cost center crosswalk and the OPPS' hospital-specific CCR methodology. In evaluating cost-based estimation, in general, the results of RTI's analyses impact both the OPPS APC relative weights and the IPPS MS–DRG (Medicare-Severity) relative weights. With the release of the IPPS FY 2009 proposed rule in April 2008, CMS also posted an interim report discussing RTI's research findings for the IPPS MS–DRG relative weights to be available during the public comment period on the FY 2009 IPPS proposed rule. This report can be found on RTI's Web site at: *http://www.rti.org/reports/cms/HHSM–500–2005–0029I/PDF/Refining_Cost_to_Charge_Ratios_200804.pdf.* The IPPS-specific chapters, which were separately displayed in the April 2008 interim report, as well as the more recent OPPS chapters, are included in the July 2008 RTI final report entitled, ''Refining Cost to Charge Ratios for Calculating APC and DRG Relative Payment Weights,'' that became available at the time of the development of this proposed rule. The RTI final report can be found on RTI's Web site at: *http://www.rti.org.*

RTI's final report distinguished between two types of research findings and recommendations, those pertaining to the accounting or cost report data itself and those related to statistical regression analysis. Because the OPPS uses a hospital-specific CCR methodology, employs detailed cost report data, and estimates costs at the claim level, CMS asked RTI to closely evaluate the accounting component of the cost-based weight methodology, specifically the revenue code-to-cost center crosswalk. In reviewing the cost report data for nonstandard cost centers used in the crosswalk, RTI discovered some problems concerning the classification of nonstandard cost centers, and reclassified nonstandard cost centers by reading providers' cost center labels. Standard cost centers are preprinted in the CMS-approved cost report software, while nonstandard cost centers are identified and updated periodically through analysis of frequently used labels. RTI also evaluated the revenue code-to-cost center crosswalk after examining hospitals' cost report and revenue code billing patterns in order to reduce aggregation bias inherent in defaulting to the overall ancillary CCR and generally to improve the empirical accuracy of the crosswalk.

With regard to the statistical adjustments, RTI confirmed the findings of its March 2007 report that regression models are a valid approach for diagnosing potential aggregation bias within selected services for the IPPS and found that regression models are equally valid for setting payments under the OPPS. RTI also suggested that regression-based CCRs could provide a short-term correction until accounting data could be refined to support more accurate CCR estimates under both the IPPS and the OPPS. RTI again found aggregation bias in devices, drugs, and radiology and, using combined outpatient and inpatient claims, expanded the number of recommended regression-adjusted CCRs.

In almost all cases, RTI observed that potential distortions in the APC relative weights were proportionally much greater than for MS–DRGs for both accounting-based and statistical adjustments because APC groups are small and generally price a single service. However, just as the overall impacts on MS–DRGs were more moderate because MS–DRGs experienced offsetting effects of changes in cost estimation, a given hospital outpatient visit might include more than one service, leading to offsetting effects in cost estimation for services provided in the outpatient episode as a whole. In general, APC relative weights are more volatile than MS–DRG relative weights from year to year yet OPPS provider impacts are typically quite modest and, in light of this experience, we expect that overall provider impacts could be much more moderate than those suggested by individual APC impacts from the RTI analysis.

Notwithstanding likely offsetting effects at the provider-level, RTI asserted that, while some averaging is appropriate for a prospective payment system, extreme distortions in APC payments for individual services bias perceptions of service profitability and may lead hospitals to inappropriately set their charge structure. RTI noted that this may not be true for ''core'' hospital services, such as oncology, but has a greater impact in evolving areas with greater potential for provider-induced demand, such as specialized imaging services. RTI also noted that cost-based weights are only one component of a final prospective payment rate. There are other rate adjustments (wage index, indirect medical education (IME), and disproportionate share hospital (DSH)) to payment derived from the revised cost-based weights and the cumulative effect of these components may not improve the ability of final payment to reflect resource cost. With regard to APCs and MS–DRGs that contain substantial device costs, RTI cautioned that other prospective payment system adjustments (wage index, IME, and DSH) largely offset the effects of charge compression among hospitals that receive these adjustments. RTI endorsed short-term regression-based adjustments, but also concluded that more refined and accurate accounting data are the preferred long-term solution to mitigate charge compression and related bias in hospital cost-based weights.

As a result of this research, RTI made 11 recommendations, 2 of which are specific to IPPS MS–DRGs and are not discussed in this proposed rule. The first set of non-IPPS-specific recommendations concentrates on short-term accounting changes to current cost report data; the second set addresses short-term regression-based and other statistical adjustments. RTI concluded its recommendations with longer-term accounting changes to the cost report. (RTI report, ''Refining Cost to Charge Ratios for Calculating APC and MS–DRG Relative Payment Weights,'' July 2008). Given the magnitude and scope of impacts on APC relative weights that would result from adopting both accounting and statistical changes, as specifically observed in Chapter 6 of RTI's July 2008 final report and Attachments 4a, 4b, and 5 (RTI report, ''Refining Cost to Charge Ratios for Calculating APC and MS–DRG Relative Payment Weights,'' July 2008), we are not proposing to adopt any short-term adjustments to OPPS payment rate

calculations for CY 2009. Furthermore, the numerous and substantial changes that RTI recommends have significantly complex interactions with one another and we believe that we should proceed cautiously. In a budget neutral payment system, increases in payment for some services must be countered by reductions to payment for other services.

We are, however, specifically seeking public comments on several of RTI's recommended accounting-based changes pertaining to the cost report as discussed below because we plan to consider these public comments in our current revision to the Medicare hospital cost report and in our decisions pertaining to the CY 2010 OPPS. We believe that improved and more precise cost reporting is the best way to improve the accuracy of all cost-based payment weights, including relative weights for the IPPS MS–DRGs. Because both the IPPS and the OPPS rely on cost-based weights derived, in part, from data on the Medicare hospital cost report form, public comments on recommended changes to the cost report should address any impact on both the inpatient and outpatient payment systems.

We noted in the FY 2009 IPPS proposed rule that we are updating the cost report form to eliminate outdated requirements in conjunction with the Paperwork Reduction Act (PRA), and that we plan to propose actual changes to the cost reporting form, the attending cost reporting software, and the cost report instructions in Chapter 36 of the Medicare Provider Reimbursement Manual (PRM), Part II (73 FR 23546 through 23547). We anticipate proposing these revisions shortly. We would consider any public comments on our proposals for cost report changes, as well as any public comments on RTI's cost estimation findings and recommendations for revising the cost report in general, in updating the cost report. We expect the revised cost report may be available for hospitals to use when submitting cost reports during FY 2010, that is, for cost reporting periods beginning after October 1, 2008, and we expect that we would be able to use some of these data for setting payment rates for future OPPS updates.

RTI's first set of four recommendations for accounting changes addressed improved use of existing cost report and claims data. RTI recommended: (1) Immediately using text searches of providers' line descriptions to more appropriately classify nonstandard cost centers in current hospital cost report data; (2) changing cost report preparation software to impose fixed descriptions on nonstandard cost centers; (3) slightly revising CMS' cost center aggregation table to eliminate duplicative or misplaced nonstandard cost centers and to add nonstandard cost centers for common services without one; and (4) adopting RTI's recommended changes to the revenue code-to-cost center crosswalk.

Given the magnitude and scope of impacts resulting from RTI's recommended revisions, we are not proposing to adopt any of the short-term accounting changes, including text searches of providers' line descriptions to more appropriately classify nonstandard cost centers and recommended changes to the revenue code-to-cost center crosswalk. We will modify the cost report preparation software that will accompany the revised Medicare cost report form to print a brief fixed description with a nonstandard cost center number, while continuing to allow the hospital to enter a line description.

With regard to revisions to the cost center aggregation table, we are specifically inviting public comment on whether several identified cost centers are duplicative (RTI report, ''Refining Cost to Charge Ratios for Calculating APC and MS–DRG Relative Payment Weights,'' July 2008). We are also specifically requesting public comment on creation of new nonstandard cost centers for services that are well represented in line descriptions associated with ''other ancillary services'' cost centers, but for which no distinct nonstandard cost center currently exists and for which UB–04 revenue codes do exist, including cardiac rehabilitation, hyperbaric oxygen therapy, and patient education (RTI report, ''Refining Cost to Charge Ratios for Calculating APC and MS–DRG Relative Payment Weights,'' July 2008). We will consider these comments as we continue our work on revising the Medicare hospital cost report form.

Furthermore, we are interested in public comment on RTI's recommended changes to the OPPS revenue code-to-cost center crosswalk, and we may propose to adopt crosswalk changes for CY 2010 based on RTI's analyses and related public comments received on this issue. Although available on the CMS Web site for continuous public comment, we have received relatively few public comments over the last several years on the OPPS revenue code-to-cost center crosswalk, which has undergone only minimal change since the inception of the OPPS. RTI's revised crosswalk in Attachment 2b of its final report reflected all accounting changes, including reclassification of nonstandard cost centers from text searches, removal of duplicative cost centers, and addition of new nonstandard cost centers for common services. Throughout the July 2008 final report, RTI used a subscripting nomenclature developed from CMS' aggregation table to identify cost centers. To disentangle the combined impact of these changes and clearly communicate RTI's recommended changes in current cost center numbers, we have made available on the CMS Web site a revised (RTI-recommended) crosswalk using current standard and nonstandard cost centers in the same format as the crosswalk proposed for the CY 2009 OPPS. This revised (RTI-recommended) crosswalk may be found on the CMS Web site under supporting documentation for this proposed rule at: *http://www.cms.hhs.gov/HospitalOutpatientPPS/HORD/list.asp#TopOfPage.* We did not include RTI's recommended new or collapsed nonstandard cost centers in this revised crosswalk.

We are specifically inviting public comment on the numerous changes included in this crosswalk. Areas of specific interest include the addition of ''default'' CCRs for clinic, cardiology, and therapy services before defaulting to the overall ancillary CCR, as is our current policy. The overall ancillary CCR is charge-weighted and heavily influenced by the relationship between costs and charges for surgical and imaging services. RTI also introduced cost center 4300 (Radioisotope) as a primary cost converter for the nuclear medicine revenue codes (034X). Further, RTI added secondary and tertiary crosswalk maps for services that frequently appear together, such as CCRs for Computed Tomography (CT) Scan as a secondary cost converter for the Magnetic Resonance Imaging (MRI) revenue codes (061X) (RTI report, ''Refining Cost to Charge Ratios for Calculating APC and MS–DRG Relative Payment Weights,'' July 2008).

RTI's second set of recommendations concentrated on short-term statistical regression-based adjustments to address aggregation bias. RTI recommended: (1) Adopting regression-adjusted OPPS CCRs for Devices, Other Supplies Sold, Additional Detail Coded Drugs, and Intravenous (IV) Solutions and Other Drugs Sold; and (2) adopting a set of CCRs that blend corrected cost report and regression-adjusted CCRs for CT scanning, MRI, therapeutic radiology, nuclear medicine, and other diagnostic radiology services for hospitals that did not report these standard and nonstandard cost centers. We agree that

improved data for cost estimation in these areas is a desirable goal. However, we have chosen to concentrate our efforts on concrete steps to improve the quality of cost report accounting data that ultimately would be used to calculate both hospital inpatient and outpatient prospective payment system relative weights. In the proposed rule for the FY 2009 IPPS (73 FR 23544), for which the public comment period closed on June 13, 2008, we emphasize this fundamental goal of improving cost report accounting data rather than making short-term statistical adjustments.

RTI's third and final set of recommendations focused on long-term accounting revisions to the cost report and educational efforts to improve the overall accuracy of accounting data. RTI recommended: (1) Clarifying cost report instructions and requiring hospitals to use all standard lines in the cost report if their facility offers the described services; (2) creating new standard lines on the cost report for CT Scanning, MRI, Cardiac Catheterization, Devices, and Drugs Requiring Additional Coding; and (3) educating hospitals through industry-led educational initiatives directed at methods for capital cost finding, specifically encouraging providers to use direct assignment of equipment depreciation and lease costs wherever possible, or at least to allocate moveable equipment depreciation based on dollar value of assigned depreciation costs.

We will consider the best means to clarify the principle of departmental apportionment of costs at § 413.53, which states that hospitals should apportion separately the costs and charges of each ancillary department for which charges are customarily made separately rather than combining those costs and charges with another ancillary department. RTI noted that many hospitals combine costs and charges for therapeutic radiology and nuclear medicine services under the diagnostic radiology cost center, when these are services with their own specific and distinct charges and cost centers (RTI report, ''Refining Cost to Charge Ratios for Calculating APC and MS–DRG Relative Payment Weights,'' July 2008). We seek to better understand the reason for this aggregation and other relatively common scenarios, such as a failure to report the standard cost center 4700 (Blood Storing, Processing & Transp.) when the hospital bills Medicare for blood products that always have storage and processing costs and charges, as well as any concerns hospitals may have about reporting all appropriate standard cost centers.

With regard to creating new standard lines on the cost report, we are proposing standard lines on the cost report for Devices and Drugs Requiring Additional Coding. In the FY 2009 IPPS proposed rule (73 FR 23546), we proposed to create two new cost centers, Medical Supplies Charged to Patients and Implantable Devices Charged to Patients, to replace the current cost center called Supplies Charged to Patients as part of our initiative to revise and update the Medicare hospital cost report form. In our discussion of pharmacy overhead cost in section V.B.3. of this proposed rule, we are proposing to create two other new cost centers, Drugs with High Overhead Costs Charged to Patients and Drugs with Low Overhead Costs Charged to Patients, to replace the current cost center called Drugs Charged to Patient. Public comment on the proposal for these two other new cost centers included in this proposed rule should be made in reference to that detailed discussion.

We believe that standard cost centers for CT Scanning, MRI, and Cardiac Catheterization also may be appropriate as we revise the Medicare hospital cost report form. CMS already has established nonstandard cost centers for these services and many, but not all, hospitals currently report costs and charges in these cost centers. As noted earlier in this section, cost center coding is a way to standardize cost reporting across hospitals. Standard cost centers are preprinted through CMS-approved cost report software, and nonstandard cost centers are identified and updated periodically through analysis of frequently used labels. While we currently use available nonstandard cost center CCRs for cost estimation under the OPPS, creating standard lines for CT Scanning, MRI, and Cardiac Catheterization would do more to require hospitals to break out their costs and charges for services in these clinical areas, especially as we pursue clarifying our departmental apportionment regulations requiring reporting of distinct charge types in separate ancillary cost centers. We are specifically inviting public comment on the appropriateness of creating standard cost centers for CT Scanning, MRI, and Cardiac Catheterization, rather than continuing the established nonstandard cost centers for these services.

The accuracy of capital cost allocation under Medicare allocation methods remains an issue when discussing the accuracy of CCRs for radiology and other capital-intensive services. We are supportive of industry-led educational initiatives to improve the quality of reporting capital costs on the cost report and, as we explained in the FY 2008 IPPS final rule with comment period (72 FR 47196), we are willing to work with the hospital industry to further such initiatives.

In summary, for CY 2009, we are proposing to adopt or support several of RTI's accounting recommendations that would improve the accuracy of cost report data, including educational initiatives on reporting capital costs, additional standard cost centers on the cost report for Drugs with High Overhead Costs and Drugs with Low Overhead Costs, adding fixed descriptions to the cost report software, and clarifying instructions requiring hospitals to report all standard cost centers if they offer services of the appropriate type. We are interested in significant public discussion of some of RTI's short-term and long-term recommendations, including RTI's suggested revisions to the revenue code-to-cost center crosswalk and recommended creation of standard cost centers for CT Scanning, MRI, and Cardiac Catheterization. We believe our CY 2009 proposals and certain short-term and long-term recommendations included in RTI's July 2008 final report would further our pursuit of concrete steps for CY 2009 and future years to improve the overall accuracy of cost report accounting data and, therefore, hospital cost-based relative weights.

2. Proposed Calculation of Median Costs

In this section of this proposed rule, we discuss the use of claims to calculate the proposed OPPS payment rates for CY 2009. The hospital OPPS page on the CMS Web site on which this proposed rule is posted provides an accounting of claims used in the development of the proposed rates at: *http://www.cms.hhs.gov/HospitalOutpatientPPS.* The accounting of claims used in the development of this proposed rule is included on the Web site under supplemental materials for the CY 2009 proposed rule. That accounting provides additional detail regarding the number of claims derived at each stage of the process. In addition, below we discuss the files of claims that comprise the data sets that are available for purchase under a CMS data user contract. Our CMS Web site, *http://www.cms.hhs.gov/HospitalOutpatientPPS,* includes information about purchasing the following two OPPS data files: ''OPPS Limited Data Set'' and ''OPPS Identifiable Data Set.'' These files are available for the claims that were used to calculate the proposed payment rates for the CY 2009 OPPS.

We used the following methodology to establish the relative weights used in calculating the proposed OPPS payment rates for CY 2009 shown in Addenda A and B to this proposed rule.

a. Claims Preparation

We used the CY 2007 hospital outpatient claims processed before January 1, 2008, to set the proposed relative weights for CY 2009. To begin the calculation of the relative weights for CY 2009, we pulled all claims for outpatient services furnished in CY 2007 from the national claims history file. This is not the population of claims paid under the OPPS, but all outpatient claims (including, for example, CAH claims and hospital claims for clinical laboratory services for persons who are neither inpatients nor outpatients of the hospital).

We then excluded claims with condition codes 04, 20, 21, and 77. These are claims that providers submitted to Medicare knowing that no payment would be made. For example, providers submit claims with a condition code 21 to elicit an official denial notice from Medicare and document that a service is not covered. We then excluded claims for services furnished in Maryland, Guam, the U.S. Virgin Islands, American Samoa, and the Northern Mariana Islands because hospitals in those geographic areas are not paid under the OPPS.

We divided the remaining claims into the three groups shown below. Groups 2 and 3 comprise the 100 million claims that contain hospital bill types paid under the OPPS.

1. Claims that were not bill types 12X, 13X (hospital bill types), or 76X (CMHC bill types). Other bill types are not paid under the OPPS and, therefore, these claims were not used to set OPPS payment. In prior years, we also used claims of bill type 14X to set payment rates under the OPPS. However, bill type 14X ceased to be used to report any services for which payment is made under the OPPS effective April 1, 2006. Therefore, we did not use these claims in development of the proposed CY 2009 OPPS rates.

2. Claims that were bill types 12X or 13X (hospital bill types). These claims are hospital outpatient claims.

3. Claims that were bill type 76X (CMHC). (These claims are later combined with any claims in item 2 above with a condition code 41 to set the per diem partial hospitalization rate determined through a separate process.)

For the CCR calculation process, we used the same general approach as we used in developing the final APC rates for CY 2007 using the revised CCR calculation which excluded the costs of paramedical education programs and weighted the outpatient charges by the volume of outpatient services furnished by the hospital. We refer readers to the CY 2007 OPPS/ASC final rule with comment period for more information (71 FR 67983 through 67985). We first limited the population of cost reports to only those for hospitals that filed outpatient claims in CY 2007 before determining whether the CCRs for such hospitals were valid.

We then calculated the CCRs for each cost center and the overall CCR for each hospital for which we had claims data. We did this using hospital-specific data from the Healthcare Cost Report Information System (HCRIS). We used the most recent available cost report data, in most cases, cost reports for CY 2006. For this proposed rule, we used the most recently submitted cost reports to calculate the CCRs to be used to calculate median costs for the proposed CY 2009 OPPS rates. If the most recent available cost report was submitted but not settled, we looked at the last settled cost report to determine the ratio of submitted to settled cost using the overall CCR, and we then adjusted the most recent available submitted but not settled cost report using that ratio. We calculated both an overall CCR and cost center-specific CCRs for each hospital. We used the overall CCR calculation discussed in section II.A.1.c. of this proposed rule for all purposes that require use of an overall CCR.

We then flagged CAH claims, which are not paid under the OPPS, and claims from hospitals with invalid CCRs. The latter included claims from hospitals without a CCR; those from hospitals paid an all-inclusive rate; those from hospitals with obviously erroneous CCRs (greater than 90 or less than .0001); and those from hospitals with overall CCRs that were identified as outliers (3 standard deviations from the geometric mean after removing error CCRs). In addition, we trimmed the CCRs at the cost center (that is, departmental) level by removing the CCRs for each cost center as outliers if they exceeded ± 3 standard deviations from the geometric mean. We used a four-tiered hierarchy of cost center CCRs to match a cost center to every possible revenue code appearing in the outpatient claims, with the top tier being the most common cost center and the last tier being the default CCR. If a hospital's cost center CCR was deleted by trimming, we set the CCR for that cost center to ''missing'' so that another cost center CCR in the revenue center hierarchy could apply. If no other cost center CCR could apply to the revenue code on the claim, we used the hospital's overall CCR for the revenue code in question. For example, if a visit was reported under the clinic revenue code, but the hospital did not have a clinic cost center, we mapped the hospital-specific overall CCR to the clinic revenue code. The hierarchy of CCRs is available for inspection and comment on the CMS Web site: *http://www.cms.hhs.gov/HospitalOutpatientPPS.* We note that as discussed in section II.A.1.c.(1) of this proposed rule, we are proposing to remove cost center 3580 (Recreational Therapy) from the hierarchy of CCRs for revenue code 0904 (Activity Therapy).

We then converted the charges to costs on each claim by applying the CCR that we believed was best suited to the revenue code indicated on the line with the charge. Table 2 of this proposed rule contains a list of the revenue codes we are proposing to package. Revenue codes not included in Table 2 are those not allowed under the OPPS because their services could not be paid under the OPPS (for example, inpatient room and board charges), and thus charges with those revenue codes were not packaged for creation of the OPPS median costs. One exception to this general methodology for converting charges to costs on each claim is the calculation of median blood costs, as discussed in section II.A.2.d.(2) of this proposed rule.

Thus, we applied CCRs as described above to claims with bill type 12X or 13X, excluding all claims from CAHs and hospitals in Maryland, Guam, the U.S. Virgin Islands, American Samoa, and the Northern Mariana Islands and claims from all hospitals for which CCRs were flagged as invalid.

We identified claims with condition code 41 as partial hospitalization services of hospitals and moved them to another file. These claims were combined with the 76X claims identified previously to calculate the partial hospitalization per diem rate.

We then excluded claims without a HCPCS code. We moved to another file claims that contained nothing but influenza and pneumococcal pneumonia (PPV) vaccines. Influenza and PPV vaccines are paid at reasonable cost and, therefore, these claims are not used to set OPPS rates. We note that the separate file containing partial hospitalization claims is included in the files that are available for purchase as discussed above.

We next copied line-item costs for drugs, blood, and brachytherapy sources (the lines stay on the claim, but are copied onto another file) to a separate file. No claims were deleted when we copied these lines onto another file.

These line-items are used to calculate a per unit mean and median cost and a per day mean and median cost for drugs, radiopharmaceutical agents, blood and blood products, and brachytherapy sources, as well as other information used to set payment rates, such as a unit-to-day ratio for drugs.

b. Splitting Claims and Creation of ''Pseudo'' Single Claims

We then split the remaining claims into five groups: single majors, multiple majors, single minors, multiple minors, and other claims. (Specific definitions of these groups follow below.) We are proposing to continue our current policy of defining major procedures as any procedure having a status indicator of ''S,'' ''T,'' ''V,'' or ''X;'' defining minor procedures as any code having a status indicator of ''F,'' ''G,'' ''H,'' ''K,'' ''L,'' ''R,'' ''U,'' or ''N,'' and classifying ''other'' procedures as any code having a status indicator other than one that we have classified as major or minor. For CY 2009, we are proposing that status indicator ''R'' would be assigned to blood and blood products; status indicator ''U'' would be assigned to brachytherapy sources; status indicator ''Q1'' would be assigned to all ''STVX-packaged codes;'' status indicator ''Q2'' would be assigned to all ''T-packaged codes;'' and status indicator ''Q3'' would be assigned to all codes that may be paid through a composite APC based on composite-specific criteria or paid separately through single code APCs when the criteria are not met. The codes with proposed status indicators ''Q1,'' ''Q2,'' and ''Q3'' were previously assigned status indicator ''Q'' for the CY 2008 OPPS. As we discuss in section XIII.A.1. of this proposed rule, we are proposing to assign these new status indicators to facilitate identification of the different categories of codes. We are proposing to treat these codes in the same manner for data purposes for CY 2009 as we treated them for CY 2008. Specifically, we are proposing to continue to evaluate whether the criteria for separate payment of codes with status indicator ''Q1'' or ''Q2'' are met in determining whether they are treated as major or minor codes. Codes with status indicator ''Q1'' or ''Q2'' are carried through the data either with status indicator ''N'' as packaged or, if they meet the criteria for separate payment, they are given the status indicator of the APC to which they are assigned and are considered as ''pseudo'' single major codes. Codes assigned status indicator ''Q3'' are paid under individual APCs unless they occur in the combinations that qualify for payment as composite APCs and, therefore, they carry the status indicator of the individual APC to which they are assigned through the data process and are treated as major codes during both the split and ''pseudo'' single creation process. The calculation of the median costs for composite APCs from multiple major claims is discussed in section II.A.2.e. of this proposed rule.

Specifically, we divided the remaining claims into the following five groups:

1. *Single Major Claims:* Claims with a single separately payable procedure (that is, status indicator ''S,'' ''T,'' ''V,'' or ''X,'' which includes codes with status indicator ''Q3''); claims with one unit of a status indicator ''Q1'' code (''STVX-packaged'') where there was no code with status indicator ''S,'' ''T,'' ''V,'' or ''X'' on the same claim on the same date; or claims with one unit of a status indicator ''Q2'' code (''T-packaged'') where there was no code with a status indicator ''T'' on the same claim on the same date.

2. *Multiple Major Claims:* Claims with more than one separately payable procedure (that is, status indicator ''S,'' ''T,'' ''V,'' or ''X,'' which includes codes with status indicator ''Q3''), or multiple units of one payable procedure. These claims include those codes with a status indicator ''Q2'' code (''T-packaged'') where there was no procedure with a status indicator ''T'' on the same claim on the same date of service but where there was another separately paid procedure on the same claim with the same date of service (that is, another code with status indicator ''S,'' ''V,'' or ''X''). We also include in this set claims that contained one unit of one code when the bilateral modifier was appended to the code and the code was conditionally or independently bilateral. In these cases, the claims represented more than one unit of the service described by the code, notwithstanding that only one unit was billed.

3. *Single Minor Claims:* Claims with a single HCPCS code that was assigned status indicator ''F,'' ''G,'' ''H,'' ''K,'' ''L,'' ''R,'' ''U,'' or ''N'' and not status indicator ''Q1'' (''STVX-packaged'') or status indicator ''Q2'' (''T-packaged'') code.

4. *Multiple Minor Claims:* Claims with multiple HCPCS codes that are assigned status indicator ''F,'' ''G,'' ''H,'' ''K,'' ''L,'' ''R,'' ''U,'' or ''N;'' claims that contain more than one code with status indicator ''Q1'' (''STVX-packaged'') or more than one unit of a code with status indicator ''Q1'' but no codes with status indicator ''S,'' ''T,'' ''V,'' or ''X'' on the same date of service; or claims that contain more than one code with status indicator ''Q2'' (T-packaged), or ''Q2'' and ''Q1,'' or more than one unit of a code with status indicator ''Q2'' but no code with status indicator ''T'' on the same date of service.

5. *Non-OPPS Claims:* Claims that contain no services payable under the OPPS (that is, all status indicators other than those listed for major or minor status). These claims were excluded from the files used for the OPPS. Non-OPPS claims have codes paid under other fee schedules, for example, durable medical equipment or clinical laboratory tests, and do not contain either a code for a separately paid OPPS service or a code for a packaged service. Non-OPPS claims include claims for ''sometimes'' therapy HCPCS codes for wound care paid sometimes under the OPPS but billed, in these non-OPPS cases, with revenue codes indicating that the therapy services would be paid under the Medicare Physician Fee Schedule (MPFS).

The claims listed in numbers 1, 2, 3, and 4 above are included in the data files that can be purchased as described above. Claims that contain codes to which we are proposing to assign status indicators ''Q1'' (''STVX-packaged'') and ''Q2'' (''T-packaged'') appear in the data for the single major file, the multiple major file, and the multiple minor file used in this proposed rule. Claims that contain codes to which we are proposing to assign status indicator ''Q3'' (composite APC members) appear in both the data of the single and multiple major files used in this proposed rule, depending on the specific composite calculation.

To develop ''pseudo'' single claims for this proposed rule, we examined both the multiple major claims and the multiple minor claims. We first examined the multiple major claims for dates of service to determine if we could break them into ''pseudo'' single procedure claims using the dates of service for all lines on the claim. If we could create claims with single major procedures by using dates of service, we created a single procedure claim record for each separately paid procedure on a different date of service (that is, a ''pseudo'' single).

We also used the bypass codes listed earlier in Table 1 and discussed in section II.A.1.b. of this proposed rule to remove separately payable procedures that we determined contained limited or no packaged costs or that were otherwise suitable for inclusion on the bypass list from a multiple procedure bill. When one of the two separately payable procedures on a multiple procedure claim was on the bypass list, we split the claim into two ''pseudo''

single procedure claim records. The single procedure claim record that contained the bypass code did not retain packaged services. The single procedure claim record that contained the other separately payable procedure (but no bypass code) retained the packaged revenue code charges and the packaged HCPCS code charges. We also removed lines that contained multiple units of codes on the bypass list and treated them as ''pseudo'' single claims by dividing the cost for the multiple units by the number of units on the line. Where one unit of a single, separately paid procedure code remained on the claim after removal of the multiple units of the bypass code, we created a ''pseudo'' single claim from that residual claim record, which retained the costs of packaged revenue codes and packaged HCPCS codes. This enabled us to use claims that would otherwise be multiple procedure claims and could not be used.

However, where only one unit of one of an ''overlap bypass code'' appeared on a claim with only one unit of another separately paid code, we used the line-item cost of the ''overlap bypass code'' to create a ''pseudo'' single procedure claim for the ''overlap bypass code'' but did not use the remaining costs on the claim for the other separately paid procedure. We did not incorporate the changes to create ''pseudo'' single claims from the remaining information on these claims in the data development process for this proposed rule. We believe this simplifies our communication of the claims development process to the public by not adding unnecessary complexity. Furthermore, the limited increase of only 1 percent in the number of ''pseudo'' single claims that would be created from the remaining data made it impractical to include the changes to the data development process that would be required, taking into consideration the complexity of making such changes.

We also examined the multiple minor claims to determine whether we could create ''pseudo'' single procedure claims. Specifically, where the claim contained multiple codes with status indicator ''Q1'' (''STVX-packaged'') on the same date of service or contained multiple units of a single code with status indicator ''Q1,'' we selected the status indicator ''Q1'' HCPCS code that had the highest CY 2008 relative weight, moved the units to one on that HCPCS code, and packaged all costs for other codes with status indicator ''Q1,'' as well as all other packaged HCPCS code and packaged revenue code costs, into a total single cost for the claim to create a ''pseudo'' single claim for the selected code. We changed the status indicator for selected codes from the data status indicator of ''N'' to the status indicator of the APC to which the selected procedure was assigned for further data processing and considered this claim as a major procedure claim. We used this claim in the calculation of the APC median cost for the status indicator ''Q1'' HCPCS code.

Similarly, where a multiple minor claim contained multiple codes with status indicator ''Q2'' (''T-packaged'') or multiple units of a single code with status indicator ''Q2,'' we selected the status indicator ''Q2'' HCPCS code that had the highest CY 2008 relative weight, moved the units to one on that HCPCS code, and packaged all costs for other codes with status indicator ''Q2,'' as well as all other packaged HCPCS code and packaged revenue code costs into a total single cost for the claim to create a ''pseudo'' single claim for the selected code. We changed the status indicator for the selected code from a data status indicator of ''N'' to the status indicator of the APC to which the selected code was assigned, and we considered this claim as a major procedure claim.

Lastly, where a multiple minor claim contained multiple codes with status indicator ''Q2'' (''T-packaged'') and status indicator ''Q1'' (''STVX-packaged''), we selected the status indicator ''Q2'' HCPCS code (''T-packaged'') that had the highest relative weight for CY 2008, moved the units to one on that HCPCS code, and packaged all costs for other codes with status indicator ''Q2,'' costs of all codes with status indicator ''Q1'' (''STVX-packaged''), other packaged HCPCS code and packaged revenue code costs into a total single cost for the claim to create a ''pseudo'' single claim for the selected (''T-packaged'') code. We favor status indicator ''Q2'' over ''Q1'' HCPCS codes because ''Q2'' HCPCS codes have higher CY 2008 relative weights. If a status indicator ''Q1'' HCPCS code had a higher CY 2008 relative weight, it would become the primary code for the simulated single bill process. We changed the status indicator for the selected status indicator ''Q2'' (''T-packaged'') code from a data status indicator of ''N'' to the status indicator of the APC to which the selected code was assigned and we considered this claim as a major procedure claim.

After we assessed the conditional packaging of HCPCS codes with proposed status indicators ''Q1'' and ''Q2,'' we then assessed the claims to determine if the proposed criteria for the multiple imaging composite APCs, discussed in section II.A.2.e.(5) of this proposed rule, were met. Where the criteria for the proposed imaging composite APCs were met, we created a ''single session'' claim for the applicable imaging composite service and determined whether we could use the claim in ratesetting. For HCPCS codes that are both conditionally packaged and are proposed members of a multiple imaging composite APC, we first assessed whether the code would be packaged and if so, the code ceased to be available for further assessment as part of the composite APC. Because the code would not be a separately payable procedure, we considered it to be unavailable for use in setting the composite APC median cost.

We excluded those claims that we were not able to convert to single claims even after applying all of the techniques for creation of ''pseudo'' singles to multiple majors and to multiple minors. As has been our practice in recent years, we also excluded claims that contained codes that were viewed as independently or conditionally bilateral and that contained the bilateral modifier (Modifier 50 (Bilateral procedure)) because the line-item cost for the code represented the cost of two units of the procedure, notwithstanding that the code appeared with a unit of one.

c. Completion of Claim Records and Median Cost Calculations

We then packaged the costs of packaged HCPCS codes (codes with status indicator ''N'' listed in Addendum B to this proposed rule and the costs of those lines for codes with status indicator ''Q1'' or ''Q2'' when they are not separately paid) and packaged revenue codes into the cost of the single major procedure remaining on the claim.

The list of packaged revenue codes is shown in Table 2 below. As noted in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66606), for the CY 2008 OPPS, we adopted an APC Panel recommendation that requires CMS to review the final list of packaged revenue codes for consistency with OPPS policy and ensure that future versions of the I/OCE edit accordingly. We compared the packaged revenue codes in the I/OCE to the final list of packaged revenue codes for the CY 2008 OPPS (72 FR 66608 through 66609) that we used for packaging costs in median calculation. As a result of that analysis, we are proposing to use the packaged revenue codes for CY 2009 displayed in Table 2 below.

We also excluded (1) claims that had zero costs after summing all costs on the claim and (2) claims containing packaging flag number 3. Effective for

services furnished on or after July 1, 2004, the I/OCE assigned packaging flag number 3 to claims on which hospitals submitted token charges for a service with status indicator ''S'' or ''T'' (a major separately paid service under the OPPS) for which the fiscal intermediary was required to allocate the sum of charges for services with a status indicator equaling ''S'' or ''T'' based on the weight of the APC to which each code was assigned. We do not believe that these charges, which were token charges as submitted by the hospital, are valid reflections of hospital resources. Therefore, we deleted these claims. We also deleted claims for which the charges equaled the revenue center payment (that is, the Medicare payment) on the assumption that where the charge equaled the payment, to apply a CCR to the charge would not yield a valid estimate of relative provider cost.

For the remaining claims, we then standardized 60 percent of the costs of the claim (which we have previously determined to be the labor-related portion) for geographic differences in labor input costs. We made this adjustment by determining the wage index that applied to the hospital that furnished the service and dividing the cost for the separately paid HCPCS code furnished by the hospital by that wage index. As has been our policy since the inception of the OPPS, we are proposing to use the pre-reclassified wage indices for standardization because we believe that they better reflect the true costs of items and services in the area in which the hospital is located than the post-reclassification wage indices and, therefore, would result in the most accurate unadjusted median costs.

We also excluded claims that were outside 3 standard deviations from the geometric mean of units for each HCPCS code on the bypass list (because, as discussed above, we used claims that contain multiple units of the bypass codes).

After removing claims for hospitals with error CCRs, claims without HCPCS codes, claims for immunizations not covered under the OPPS, and claims for services not paid under the OPPS, approximately 54 million claims were left for this proposed rule. Of these 54 million claims, we were able to use some portion of approximately 52 million whole claims (96 percent of approximately 54 million potentially usable claims) to create approximately 90 million single and ''pseudo'' single claims, of which we used 89 million single bills (after trimming out approximately 627,000 claims as discussed below) in the CY 2009 median development and ratesetting.

We used the remaining claims to calculate the proposed CY 2009 median costs for each separately payable HCPCS code and each APC. The comparison of HCPCS and APC medians determines the applicability of the 2 times rule. Section 1833(t)(2) of the Act provides that, subject to certain exceptions, the items and services within an APC group cannot be considered comparable with respect to the use of resources if the highest median (or mean cost, if elected by the Secretary) for an item or service in the group is more than 2 times greater than the lowest median cost for an item or service within the same group (the 2 times rule). Finally, we reviewed the medians and reassigned HCPCS codes to different APCs where we believed that it was appropriate. Section III. of this proposed rule includes a discussion of certain proposed HCPCS code assignment changes that resulted from examination of the medians and for other reasons. The APC medians were recalculated after we reassigned the affected HCPCS codes. Both the HCPCS medians and the APC medians were weighted to account for the inclusion of multiple units of the bypass codes in the creation of ''pseudo'' single bills.

In some cases, APC median costs are calculated using variations of the process outlined above. Section II.A.2.d. of this proposed rule that follows addresses the calculation of single APC criteria-based median costs. Section II.A.2.e. of this proposed rule discusses the calculation of composite APC criteria-based median costs.

Section X.B. of this proposed rule addresses the methodology for calculating the median cost for partial hospitalization services.

TABLE 2.—PROPOSED CY 2009 PACKAGED REVENUE CODES

Revenue code	Description
0250	PHARMACY.
0251	GENERIC.
0252	NONGENERIC.
0254	PHARMACY INCIDENT TO OTHER DIAGNOSTIC.
0255	PHARMACY INCIDENT TO RADIOLOGY.
0257	NONPRESCRIPTION DRUGS.
0258	IV SOLUTIONS.
0259	OTHER PHARMACY.
0260	IV THERAPY, GENERAL CLASS.
0262	IV THERAPY/PHARMACY SERVICES.
0263	SUPPLY/DELIVERY.
0264	IV THERAPY/SUPPLIES.
0269	OTHER IV THERAPY.
0270	M&S SUPPLIES.
0271	NONSTERILE SUPPLIES.
0272	STERILE SUPPLIES.
0273	TAKE HOME SUPPLIES.
0275	PACEMAKER DRUG.
0276	INTRAOCULAR LENS SOURCE DRUG.
0278	OTHER IMPLANTS.
0279	OTHER M&S SUPPLIES.
0280	ONCOLOGY.
0289	OTHER ONCOLOGY.
0343	DIAGNOSTIC RADIOPHARMS.
0344	THERAPEUTIC RADIOPHARMS.
0370	ANESTHESIA.
0371	ANESTHESIA INCIDENT TO RADIOLOGY.
0372	ANESTHESIA INCIDENT TO OTHER DIAGNOSTIC.

TABLE 2.—PROPOSED CY 2009 PACKAGED REVENUE CODES—Continued

Revenue code	Description
0379	OTHER ANESTHESIA.
0390	BLOOD STORAGE AND PROCESSING.
0399	OTHER BLOOD STORAGE AND PROCESSING.
0560	MEDICAL SOCIAL SERVICES.
0569	OTHER MEDICAL SOCIAL SERVICES.
0621	SUPPLIES INCIDENT TO RADIOLOGY.
0622	SUPPLIES INCIDENT TO OTHER DIAGNOSTIC.
0624	INVESTIGATIONAL DEVICE (IDE).
0630	DRUGS REQUIRING SPECIFIC IDENTIFICATION, GENERAL CLASS.
0631	SINGLE SOURCE.
0632	MULTIPLE.
0633	RESTRICTIVE PRESCRIPTION.
0681	TRAUMA RESPONSE, LEVEL I.
0682	TRAUMA RESPONSE, LEVEL II.
0683	TRAUMA RESPONSE, LEVEL III.
0684	TRAUMA RESPONSE, LEVEL IV.
0689	TRAUMA RESPONSE, OTHER.
0700	CAST ROOM.
0709	OTHER CAST ROOM.
0710	RECOVERY ROOM.
0719	OTHER RECOVERY ROOM.
0720	LABOR ROOM.
0721	LABOR.
0732	TELEMETRY.
0762	OBSERVATION ROOM.
0801	HEMODIALYSIS.
0802	PERITONEAL DIALYSIS.
0803	CAPD.
0804	CCPD.
0809	OTHER INPATIENT DIALYSIS.
0810	ORGAN ACQUISITION.
0819	OTHER ORGAN ACQUISITION.
0821	HEMODIALYSIS COMP OR OTHER RATE.
0824	MAINTENANCE 100%.
0825	SUPPORT SERVICES.
0829	OTHER HEMO OUTPATIENT.
0942	EDUCATION/TRAINING.

d. Proposed Calculation of Single Procedure APC Criteria-Based Median Costs

(1) Device-Dependent APCs

Device-dependent APCs are populated by HCPCS codes that usually, but not always, require that a device be implanted or used to perform the procedure. For a full history of how we have calculated payment rates for device-dependent APCs in previous years, and a detailed discussion of how we developed the standard device-dependent APC ratesetting methodology, we refer readers to the CY 2008 OPPS/ASC final rule with comment period (72 FR 66739 through 66742). Overviews of the procedure-to-device edits and device-to-procedure edits used in ratesetting for device-dependent APCs are available in the CY 2005 OPPS final rule with comment period (69 FR 65761 through 65763) and the CY 2007 OPPS/ASC final rule with comment period (71 FR 68070 through 68071).

For CY 2009, we are proposing to continue using our standard methodology for calculating median costs for device-dependent APCs, which utilizes claims data that generally represent the full cost of the required device. Specifically, we are proposing to calculate the medians for device-dependent APCs for CY 2009 using only the subset of single bills from CY 2007 claims data that pass the procedure-to-device edits; do not contain token charges for devices; and do not contain the ''FB'' modifier signifying that the device was furnished without cost to the provider, supplier, or practitioner, or where a full credit was received. We continue to believe that this methodology gives us the most appropriate median costs for device-dependent APCs in which the hospital incurs the full cost of the device.

While the median costs for the majority of device-dependent APCs show increases from CY 2008 based on the CY 2009 proposed rule claims data, the median costs for three APCs involving electrode/lead implantation decreased significantly compared to the CY 2008 final rule with comment period median costs. Specifically, APCs 0106 (Insertion/Replacement of Pacemaker Leads and/or Electrodes), 0225 (Implantation of Neurostimulator Electrodes, Cranial Nerve), and 0418 (Insertion of Left Ventricular Pacing Electrode), demonstrate median decreases of 26 percent, 52 percent, and 47 percent, respectively. We believe these decreases reflect hospitals' correction of inaccurate and incomplete billing practices for these services due to the implementation of device-to-procedure edits beginning in CY 2007. As discussed in the CY 2007 OPPS/ASC final rule with comment period (71 FR 68070 through 68071), in the course of examining claims data for calculation of the CY 2007 payment rates, we identified circumstances in which hospitals billed a device code but failed to bill any procedure code with which the device could be used correctly. For APCs 0106, 0225, and 0418 in particular, we saw that hospitals frequently billed a procedure code for

lead/electrode implantation with device HCPCS codes for a lead/electrode and the more expensive pulse generator, but failed to report a procedure code for generator implantation. These errors in billing led to the costs of the pulse generator being packaged incorrectly into the procedure codes for lead/electrode implantation. Hospitals that coded and billed in this manner received no payment for the procedure to implant the pulse generator, but these erroneous claims caused the payment rate for the lead/electrode implantation APCs to be inappropriately high. To address this problem, we implemented edits to correct the coding for CY 2007, and the decreases to the median costs of APCs 0106, 0225, and 0418 for CY 2009 are consistent with what we expect, based on what we understand to be the nature of the services and the costs of correctly coded devices. We also note an anticipated decrease in our frequency of single bills for the services assigned to APCs 0106, 0225, and 0418, most likely because the device-to-procedure edits led hospitals to include the pulse generator implantation HCPCS codes on the same claims, resulting in fewer single claims for the lead/electrode implantation procedures.

APC 0625 (Level IV Vascular Access Procedures) as configured for CY 2008 and calculated based on CY 2007 claims data also demonstrates a significant decrease in median cost (approximately 59 percent) relative to CY 2008 (based on CY 2006 claims data). We believe this decrease is attributable to the implementation of procedure-to-device edits on January 1, 2007, for the only CPT code assigned to this APC, specifically CPT code 36566 (Insertion of tunneled centrally inserted central venous access device, requiring two catheters via two separate venous access sites; with subcutaneous port(s)). Because the procedure described by CPT code 36566 involves the insertion of a dialysis access system, our edits require that the HCPCS code for that device be present on the claim any time a hospital bills CPT code 36566. Prior to January 1, 2007, we believe that hospitals often reported CPT code 36566 without also reporting the device HCPCS code for the dialysis access system, or incorrectly billed CPT code 36566 for procedures that do not require the use of the device. Therefore, with the implementation of procedure-to-device edits, the volume of total CY 2007 claims for CPT code 36566 decreased as hospitals corrected their claims to report this service only under the appropriate circumstances, while the correctly coded claims reporting the required device (and available for CY 2009 ratesetting) increased significantly from CY 2006 to CY 2007. We believe that the CY 2009 proposed rule median cost of $2,092 calculated for CPT code 36566 from those claims is accurate and appropriately reflects correct hospital reporting of the procedure and the associated device. Furthermore, because of the decrease in the median cost for CPT code 36566, we are proposing for CY 2009 to reassign the code to APC 0623 (Level III Vascular Access Procedures), which has a median cost of approximately $1,939. We also are proposing to delete APC 0625 because no other procedures would map to this APC once CPT code 36566 is reassigned.

In addition, we note a decrease of approximately 19 percent for APC 0681 (Knee Arthroplasty) relative to CY 2008, which we believe is attributable to a low volume of services being performed by a small number of providers. As we have stated in the past, some fluctuation in relative costs from year to year is to be expected in a prospective payment system for low volume device-dependent APCs such as APC 0681, for which the median cost increased approximately 37 percent from CY 2007 to CY 2008.

Table 3 lists the APCs for which we are proposing to use our standard device-dependent APC ratesetting methodology for CY 2009. We refer readers to Addendum A to this proposed rule for the proposed payment rates for these APCs.

TABLE 3.—PROPOSED CY 2009 DEVICE-DEPENDENT APCS

APC	Status indicator	APC title
0039	S	Level I Implantation of Neurostimulator.
0040	S	Percutaneous Implantation of Neurostimulator Electrodes, Excluding Cranial Nerve.
0061	S	Laminectomy, Laparoscopy, or Incision for Implantation of Neurostimulator Electrodes, Excluding Cranial Nerve.
0082	T	Coronary or Non Coronary Atherectomy.
0083	T	Coronary or Non Coronary Angioplasty and Percutaneous Valvuloplasty.
0084	S	Level I Electrophysiologic Procedures.
0085	T	Level II Electrophysiologic Procedures.
0086	T	Level III Electrophysiologic Procedures.
0089	T	Insertion/Replacement of Permanent Pacemaker and Electrodes.
0090	T	Insertion/Replacement of Pacemaker Pulse Generator.
0104	T	Transcatheter Placement of Intracoronary Stents.
0106	T	Insertion/Replacement of Pacemaker Leads and/or Electrodes.
0107	T	Insertion of Cardioverter-Defibrillator.
0108	T	Insertion/Replacement/Repair of Cardioverter-Defibrillator Leads.
0115	T	Cannula/Access Device Procedures.
0202	T	Level VII Female Reproductive Procedures.
0222	S	Level II Implantation of Neurostimulator.
0225	S	Implantation of Neurostimulator Electrodes, Cranial Nerve.
0227	T	Implantation of Drug Infusion Device.
0229	T	Transcatheter Placement of Intravascular Shunts.
0259	T	Level VII ENT Procedures.
0293	T	Level V Anterior Segment Eye Procedures.
0315	S	Level III Implantation of Neurostimulator.
0384	T	GI Procedures with Stents.
0385	S	Level I Prosthetic Urological Procedures.
0386	S	Level II Prosthetic Urological Procedures.
0418	T	Insertion of Left Ventricular Pacing Elect.
0425	T	Level II Arthroplasty with Prosthesis.
0427	T	Level II Tube or Catheter Changes or Repositioning.

TABLE 3.—PROPOSED CY 2009 DEVICE-DEPENDENT APCS—Continued

APC	Status indicator	APC title
0622	T	Level II Vascular Access Procedures.
0623	T	Level III Vascular Access Procedures.
0648	T	Level IV Breast Surgery.
0652	T	Insertion of Intraperitoneal and Pleural Catheters.
0653	T	Vascular Reconstruction/Fistula Repair with Device.
0654	T	Insertion/Replacement of a permanent dual chamber pacemaker.
0655	T	Insertion/Replacement/Conversion of a permanent dual chamber pacemaker.
0656	T	Transcatheter Placement of Intracoronary Drug-Eluting Stents.
0674	T	Prostate Cryoablation.
0680	S	Insertion of Patient Activated Event Recorders.
0681	T	Knee Arthroplasty.

(2) Blood and Blood Products

Since the implementation of the OPPS in August 2000, separate payments have been made for blood and blood products through APCs rather than packaging them into payments for the procedures with which they are administered. Hospital payments for the costs of blood and blood products, as well as the costs of collecting, processing, and storing blood and blood products, are made through the OPPS payments for specific blood product APCs.

For the CY 2009 OPPS, we are proposing to continue to establish payment rates for blood and blood products using our blood-specific CCR methodology, which utilizes actual or simulated CCRs from the most recently available hospital cost reports to convert hospital charges for blood and blood products to costs. This methodology has been our standard ratesetting methodology for blood and blood products since CY 2005. It was developed in response to data analysis indicating that there was a significant difference in CCRs for those hospitals with and without blood-specific cost centers, and past comments indicating that the former OPPS policy of defaulting to the overall hospital CCR for hospitals not reporting a blood-specific cost center often resulted in an underestimation of the true hospital costs for blood and blood products. Specifically, in order to address the difference in CCRs and to better reflect hospitals' costs, we are proposing to continue to simulate blood CCRs for each hospital that does not report a blood cost center by calculating the ratio of the blood-specific CCRs to hospitals' overall CCRs for those hospitals that do report costs and charges for blood cost centers. We would then apply this mean ratio to the overall CCRs of hospitals not reporting costs and charges for blood cost centers on their cost reports in order to simulate blood-specific CCRs for those hospitals. We calculated the proposed median costs upon which the proposed CY 2009 payment rates for blood and blood products are based using the actual blood-specific CCR for hospitals that reported costs and charges for a blood cost center and a hospital-specific simulated blood-specific CCR for hospitals that did not report costs and charges for a blood cost center.

We continue to believe that the blood-specific CCR methodology better responds to the absence of a blood-specific CCR for a hospital than alternative methodologies, such as defaulting to the overall hospital CCR or applying an average blood-specific CCR across hospitals. Because this methodology takes into account the unique charging and cost accounting structure of each provider, we believe that it yields more accurate estimated costs for these products. We believe that continuing with this methodology in CY 2009 would result in median costs for blood and blood products that accurately reflect the relative estimated costs of these products for hospitals without blood cost centers, and, therefore, for these products in general.

As discussed in section XIII.A.1. of this proposed rule, we are also proposing to create status indicator ''R'' (Blood and Blood Products), to denote blood and blood products for publication and payment purposes in CY 2009. We believe that it is necessary to create a status indicator that is specific to blood and blood products to facilitate development of blood product median costs under the blood-specific CCR methodology and to facilitate implementation of the reduced payments that would be made to hospitals that fail to report the hospital outpatient quality data, as discussed in section XVI.D.2. of this proposed rule.

We refer readers to Addendum B to this proposed rule for the CY 2009 proposed payment rates for blood and blood products, which are identified with proposed status indicator ''R.'' For more detailed discussion of the blood-specific CCR methodology, we refer readers to the CY 2005 OPPS proposed rule (69 FR 50524 through 50525). For a full history of OPPS payment for blood and blood products, we refer readers to the CY 2008 OPPS/ASC final rule with comment period (72 FR 66807 through 66810).

(3) Single Allergy Tests

We are proposing to continue with our methodology of differentiating single allergy tests (''per test'') from multiple allergy tests (''per visit'') by assigning these services to two different APCs to provide accurate payments for these tests in CY 2009. Multiple allergy tests are currently assigned to APC 0370 (Allergy Tests), with a median cost calculated based on the standard OPPS methodology. We provided billing guidance in CY 2006 in Program Transmittal 804 (issued on January 3, 2006) specifically clarifying that hospitals should report charges for the CPT codes that describe single allergy tests to reflect charges ''per test'' rather than ''per visit'' and should bill the appropriate number of units of these CPT codes to describe all of the tests provided. However, our CY 2007 claims data available for this CY 2009 proposed rule for APC 0381 do not reflect improved and more consistent hospital billing practices of ''per test'' for single allergy tests. The median cost of APC 0381, calculated for this proposed rule according to the standard single claims OPPS methodology, is approximately $51, significantly higher than the CY 2008 median cost of APC 0381 of approximately $17 calculated according to the ''per unit'' methodology, and greater than we would expect for these procedures that are to be reported ''per test'' with the appropriate number of units. Some claims for single allergy tests still appear to provide charges that represent a ''per visit'' charge, rather than a ''per test'' charge.

Therefore, consistent with our payment policy for CYs 2006, 2007, and

2008, we are proposing to calculate a ''per unit'' median cost for APC 0381, based upon 520 claims containing multiple units or multiple occurrences of a single CPT code. The CY 2009 proposed median cost for APC 0381 using the ''per unit'' methodology is approximately $25. For a full discussion of this methodology, we refer readers to the CY 2008 OPPS/ASC final rule with comment period (72 FR 66737).

(4) Echocardiography Services

For the CY 2009 OPPS, we are proposing to continue the packaging of payment for all contrast agents into the payment for the associated imaging procedure, as we did in CY 2008. For echocardiography services, we are proposing to estimate median costs using the same methodology that we used to set medians for these services for CY 2008. In CY 2008, we finalized a policy to package payment for all contrast agents into the payment for the associated imaging procedure regardless of whether the contrast agent met the OPPS drug packaging threshold. Section 1833(t)(2)(G) of the Act requires us to create additional APC groups of services for procedures that use contrast agents that classify them separately from those procedures that do not utilize contrast agents. To reconcile this statutory provision with our final policy of packaging all contrast agents, for CY 2008, we calculated HCPCS-specific median costs for all separately payable echocardiography procedures that may be performed with contrast agents by isolating single and ''pseudo'' single claims with the following CPT codes where a contrast agent was also billed on the claim: 93303 (Transthoracic echocardiography for congenital cardiac anomalies; complete), 93304 (Transthoracic echocardiography for congenital cardiac anomalies; follow-up or limited study), 93307 (Echocardiography, transthoracic, real-time with image documentation (2D) with or without M-mode recording; complete), 93308 (Echocardiography, transthoracic, real-time with image documentation (2D) with or without M-mode recording; follow-up or limited study), 93312 (Echocardiography, transesophageal, real time with image documentation (2D) (with or without M-mode recording); including probe placement, image acquisition, interpretation and report), 93315 (Transesophageal echocardiography for congenital cardiac anomalies; including probe placement, image acquisition, interpretation and report), 93318 (Echocardiography, transesophageal (TEE) for monitoring purposes, including probe placement, real time 2-dimensional image acquisition and interpretation leading to ongoing (continuous) assessment of (dynamically changing) cardiac pumping function and to therapeutic measures on an immediate time basis), and 93350 (Echocardiography, transthoracic, real-time with image documentation (2D), with or without M-mode recording, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report). As noted in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66644), our analysis indicated that all echocardiography procedures that may be performed with contrast agents are reasonably similar both clinically and in terms of resource use, as evidenced by similar HCPCS median costs.

Pursuant to the statute, for CY 2008, we created APC 0128 (Echocardiogram With Contrast) to provide payment for echocardiography procedures that are performed with a contrast agent. In addition, as discussed in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66644 through 66646), in order for hospitals to identify separately and receive appropriate payment for echocardiography procedures performed with contrast beginning in CY 2008, we created eight new HCPCS codes (C8921 through C8928) that corresponded to the related CPT echocardiography codes and assigned them to the newly created APC 0128. We instructed hospitals performing echocardiography procedures without contrast to continue to report the CPT codes and to report the new C-codes when performing echocardiography procedures with contrast or without contrast followed by with contrast.

Claims data from CY 2008 are not yet available for ratesetting, so we do not yet have claims data specific to HCPCS codes C8921 through C8928 in order to determine the CY 2009 payment rate for APC 0128. Therefore, for CY 2009, we are proposing to again use the methodology that we used to set the CY 2008 payment rate for APC 0128 (72 FR 66645). That is, we isolate single and ''pseudo'' single claims in our database that include those CPT codes in the range of 93303 through 93350 as described above that correspond to the contrast studies described by HCPCS codes C8921 through C8928. For claims where one of these echocardiography procedures was billed with a contrast agent, we packaged the cost of the contrast agent into the cost of the echocardiography procedure and then calculated a median cost for APC 0128 using this subset of claims to determine the proposed median cost for APC 0128 of approximately $563. As in CY 2008, the HCPCS code-specific median costs for echocardiography procedures performed with contrast are all similar, and we continue to believe these services share sufficient similarity to be assigned to the same APC.

For CY 2009, we also recalculated the median cost for APCs 0269 (Level II Echocardiogram Without Contrast Except Transesophageal); 0270 (Transesophageal Echocardiogram Without Contrast); and 0697 (Level I Echocardiogram Without Contrast Except Transesophageal), as we did in CY 2008 (72 FR 66645). We used claims for CPT codes 93303 through 93350 after removing claims from the ratesetting process that included contrast agents because these claims were used to set the median cost for APC 0128.

We continue to believe that these echocardiography APC medians accurately reflect hospital costs when performing echocardiography procedures, both with and without contrast. In addition, we believe that this coding and payment methodology allows us to both adhere to the statutory requirement to create additional groups of services for procedures that use contrast agents and to continue packaged payment for contrast agents.

(5) Nuclear Medicine Services

In CY 2008, we began packaging payment for diagnostic radiopharmaceuticals into the payment for the associated nuclear medicine procedure. (For a discussion regarding the distinction between diagnostic and therapeutic radiopharmaceuticals, we refer readers to the CY 2008 OPPS/ASC final rule at 72 FR 66636). Prior to the implementation of this policy, diagnostic radiopharmaceuticals were subject to the standard OPPS drug packaging methodology whereby payments are packaged when the estimated mean per day product costs fall at or below the annual packaging threshold for drugs, biologicals, and radiopharmaceuticals.

Packaging costs into a single aggregate payment for a service, encounter, or episode of care is a fundamental principle that distinguishes a prospective payment system from a fee schedule. In general, packaging the costs of supportive items and services into the payment for the independent procedure or service with which they are associated encourages hospital efficiencies and also enables hospitals to manage their resources with maximum flexibility. All nuclear medicine procedures require the use of at least

one radiopharmaceutical or other radiolabeled product, and there are only a small number of radiopharmaceuticals that may be appropriately billed with each diagnostic nuclear medicine procedure. For the OPPS, we distinguish diagnostic radiopharmaceuticals from therapeutic radiopharmaceuticals for payment purposes, and this distinction is recognized in the Level II HCPCS codes for diagnostic radiopharmaceuticals that include the term ''diagnostic'' along with a radiopharmaceutical in their HCPCS code descriptors. As we stated in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66635), we believe that our policy to package payment for diagnostic radiopharmaceuticals (other than those already packaged when their per day costs are below the packaging threshold for OPPS drugs, biologicals, and radiopharmaceuticals) is consistent with OPPS packaging principles, provides greater administrative simplicity for hospitals, and encourages hospitals to use the most clinically appropriate and cost efficient diagnostic radiopharmaceutical for each study. For more background on this policy, we refer readers to discussions in the CY 2008 OPPS/ASC proposed rule (72 FR 42667 through 42672) and the CY 2008 OPPS/ASC final rule with comment period (72 FR 66635 through 66641).

We continue to believe that it is most appropriate to package payment for some radiopharmaceuticals, specifically diagnostic radiopharmaceuticals, into the payment for diagnostic nuclear medicine procedures, and we are proposing to continue to package payment for diagnostic radiopharmaceuticals into the payment for the associated nuclear medicine procedure for CY 2009 as described in section V.B.2.b. of this proposed rule.

During the March 2008 APC Panel meeting, the APC Panel recommended that CMS continue to package payment for diagnostic radiopharmaceuticals for CY 2009. In addition, the APC Panel recommended that CMS present data at the first CY 2009 APC Panel meeting on usage and frequency, geographic distribution, and size and type of hospitals performing nuclear medicine studies using radioisotopes in order to ensure that access to diagnostic radiopharmaceuticals is preserved for Medicare beneficiaries. We are accepting both of these recommendations.

For CY 2008 ratesetting, we used only claims for nuclear medicine procedures that contained a diagnostic radiopharmaceutical in calculating the median costs for APCs including nuclear medicine procedures (72 FR 66639). This is similar to the established methodology used for device-dependent APCs before claims reflecting the procedure-to-device edits were included in our claims data. For CY 2008 we also implemented claims processing edits (called procedure-to-radiopharmaceutical edits) requiring the presence of a radiopharmaceutical (or other radiolabeled product) HCPCS code when a separately payable nuclear medicine procedure is present on a claim. Similar to our practice regarding the procedure-to-device edits that have been in place for some time, we continually review comments and requests for changes related to these edits and, based on our review, may update the edit list during our quarterly update process if necessary. The radiopharmaceutical (and other radiolabeled product) and procedure HCPCS codes that are included in these edits can be viewed on the OPPS Web site at: *http://www.cms.hhs.gov/HospitalOutpatientPPS/01_overview.asp.*

The CY 2008 OPPS claims that are subject to the procedure-to-radiopharmaceutical edits will not be available for setting payment rates until CY 2010 and, therefore, are not yet available to set payment rates for CY 2009. Therefore, we are proposing to continue our established CY 2008 methodology for setting the payment rates for APCs that include nuclear medicine procedures for CY 2009. We used an updated list of radiolabeled products from the procedure-to-radiopharmaceutical edit file to identify single and ''pseudo'' single claims for nuclear medicine procedures that also included at least one eligible radiolabeled product. Using this subset of claims, we followed our standard OPPS ratesetting methodology, discussed in section II.A. of this proposed rule, to calculate median costs for nuclear medicine procedures and their associated APCs.

We have identified those APCs containing nuclear medicine procedures that would be subject to this methodology under our CY 2009 proposal in Table 4 below. As in CY 2008, when we set APC median costs based on single and ''pseudo'' single claims that also included at least one radiolabeled product on our edit file, we observed an equivalent or higher median cost than that calculated from all single and ''pseudo'' single bills. We believe that this methodology appropriately ensures that the costs of diagnostic radiopharmaceuticals are included in the ratesetting process for these APCs.

TABLE 4.—PROPOSED APCS WHERE NUCLEAR MEDICINE PROCEDURES ARE ASSIGNED WITH MEDIAN COSTS CALCULATED FROM CLAIMS WITH AN ASSOCIATED RADIOLABELED PRODUCT

APC	APC title
0307	Myocardial Positron Emission Tomography (PET) imaging.
0308	Non-Myocardial Positron Emission Tomography (PET) imaging.
0377	Level II Cardiac Imaging.
0378	Level II Pulmonary Imaging.
0389	Level I Non-Imaging Nuclear Medicine.
0390	Level I Endocrine Imaging.
0391	Level II Endocrine Imaging.
0392	Level II Non-imaging Nuclear Medicine.
0393	Hematologic Processing & Studies.
0394	Hepatobiliary Imaging.
0395	GI Tract Imaging.
0396	Bone Imaging.
0397	Vascular Imaging.
0398	Level I Cardiac Imaging.
0400	Hematopoietic Imaging.
0401	Level I Pulmonary Imaging.
0402	Level II Nervous System Imaging.
0403	Level I Nervous System Imaging.

TABLE 4.—PROPOSED APCS WHERE NUCLEAR MEDICINE PROCEDURES ARE ASSIGNED WITH MEDIAN COSTS CALCULATED FROM CLAIMS WITH AN ASSOCIATED RADIOLABELED PRODUCT—Continued

APC	APC title
0404	Renal and Genitourinary Studies.
0406	Level I Tumor/Infection Imaging.
0408	Level III Tumor/Infection Imaging.
0414	Level II Tumor/Infection Imaging.

(6) Hyperbaric Oxygen Therapy

Since the implementation of OPPS in August 2000, the OPPS has recognized HCPCS code C1300 (Hyperbaric oxygen under pressure, full body chamber, per 30 minute interval) for hyperbaric oxygen therapy (HBOT) provided in the hospital outpatient setting. In the CY 2005 final rule with comment period (69 FR 65758 through 65759), we finalized a ''per unit'' median cost calculation for APC 0659 (Hyperbaric Oxygen) using only claims with multiple units or multiple occurrences of HCPCS code C1300 because delivery of a typical HBOT service requires more than 30 minutes. We observed that claims with only a single occurrence of the code were anomalies, either because they reflected terminated sessions or because they were incorrectly coded with a single unit. In the same rule, we also established that HBOT would not generally be furnished with additional services that might be packaged under the standard OPPS APC median cost methodology. This enabled us to use claims with multiple units or multiple occurrences. Finally, we also used each hospital's overall CCR to estimate costs for HCPCS code C1300 from billed charges rather than the CCR for the respiratory therapy or other departmental cost centers. Comments on the CY 2005 proposed rule effectively demonstrated that hospitals report the costs and charges for HBOT in a wide variety of cost centers. Since CY 2005, we have used this methodology to estimate the median cost for HBOT. The median costs of HBOT using this methodology have been relatively stable for the last 5 years. For CY 2009, we are proposing to continue using the same methodology to estimate a ''per unit'' median cost for HCPCS code C1300 of approximately $103 using 71,866 claims with multiple units or multiple occurrences for this proposed rule.

(7) Payment for Ancillary Outpatient Services When Patient Expires (–CA Modifier)

In the November 1, 2002 final rule with comment period (67 FR 66798), we discussed the creation of the new HCPCS–CA modifier to address situations where a procedure on the OPPS inpatient list must be performed to resuscitate or stabilize a patient (whose status is that of an outpatient) with an emergent, life-threatening condition, and the patient dies before being admitted as an inpatient. In Program Transmittal A–02–129, issued on January 3, 2003, we instructed hospitals on the use of this modifier. For a complete description of the history of the policy and development of the payment methodology for these services, we refer readers to the CY 2007 OPPS/ASC final rule with comment period (71 FR 68157 through 68158).

For CY 2009, we are proposing to continue to use our established ratesetting methodology for calculating the median cost of APC 0375 (Ancillary Outpatient Services When Patient Expires), and we are proposing to continue to make one payment under APC 0375 for the services that meet the specific conditions for using modifier –CA. We would calculate the relative payment weight for APC 0375 by using all claims reporting a status indicator ''C'' procedure appended with the –CA modifier, using estimated costs from claims data for line-items with a HCPCS code assigned status indicator ''G,'' ''H,'' ''K,'' ''N,'' ''Q1,'' ''Q2,'' ''Q3,'' ''R,'' ''S,'' ''T,'' ''U,'' ''V,'' and ''X'' and charges for packaged revenue codes without a HCPCS code. We continue to believe that this methodology results in the most appropriate aggregate median cost for the ancillary services provided in these unusual clinical situations.

Also, we believe that hospitals are reporting the –CA modifier according to the policy initially established in CY 2003. The claims frequency for APC 0375 has been relatively stable over the past few years. Although the proposed median cost for APC 0375 is slightly lower for CY 2009 than for CY 2008, generally it has increased significantly in recent years. Variation in the median cost for APC 0375 is expected because of the small number of claims and because the specific cases are grouped by the presence of the –CA modifier appended to an inpatient procedure and not according to the standard APC criteria of clinical and resource homogeneity. Cost variation for APC 0375 from year to year is anticipated and acceptable so long as hospitals continue judicious reporting of the –CA modifier.

Table 5 shows the number of claims and the median cost for APC 0375 from CY 2006 to CY 2008. For CY 2009, we are proposing a median cost for APC 0375 of approximately $4,762.

TABLE 5.—CLAIMS FOR ANCILLARY OUTPATIENT SERVICES WHEN PATIENT EXPIRES (–CA MODIFIER) FOR CYS 2006 THROUGH 2008

Prospective payment year	Number of claims	Median cost ($)
CY 2006	370	2,717
CY 2007	260	3,549
CY 2008	183	4,945

e. Proposed Calculation of Composite APC Criteria-Based Median Costs

As discussed in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66613), we believe it is important that the OPPS enhance incentives for hospitals to provide only necessary, high quality care and to provide that care as efficiently as possible. For CY 2008, we developed composite APCs to provide a single payment for groups of services that are typically performed together during a single clinical encounter and that result in the provision of a complete service. Bundling payment for multiple independent services into a single OPPS payment in this way enables hospitals to manage their resources with maximum flexibility by monitoring and adjusting the volume and efficiency of services themselves. An additional advantage to the composite APC model is that we can use data from correctly coded multiple procedure claims to calculate payment rates for the specified combinations of services, rather than relying upon single procedure claims which typically are low in volume and/or incorrectly coded. We refer readers to section II.A.4. of the CY 2008 OPPS/ASC final rule with comment period for a full discussion of the development of the composite APC methodology (72 FR

66611 through 66614 and 66650 through 66652).

We continue to consider the development and implementation of larger payment bundles, such as composite APCs, a long-term policy objective for the OPPS and continue to explore other areas where this payment model may be utilized. In developing this proposed rule, we followed the same methodology for identifying possible composite APCs as we did for CY 2008. Specifically, we examined the multiple procedure claims that we could not convert to single procedure claims to identify common combinations of services for which we have relatively few single procedure claims. We then performed a clinical assessment of the combinations that we identified to determine whether our findings were consistent with our understanding of the services furnished. In addition, consistent with our stated intention to involve the APC Panel in our future exploration of how we can develop encounter-based and episode-based payment groups (72 FR 66614), we also specifically explored a possible composite APC for radioimmunotherapy in response to a recommendation of the APC Panel from its September 2007 meeting.

After performing claims analysis and clinical assessments as described above, and taking into consideration the recommendation of the APC Panel from its March 2008 meeting that we continue pursing a radioimmunotherapy composite APC, we are not proposing a composite APC payment for radioimmunotherapy for CY 2009, as discussed further in section V.B.4. of this proposed rule. However, we are proposing to expand the composite APC model to one new clinical area for CY 2009, multiple imaging services, as described in detail in section II.A.2.e.(5) of this proposed rule. We also are proposing to continue our established composite APC policies for extended assessment and management, low dose rate (LDR) prostate brachytherapy, cardiac electrophysiologic evaluation and ablation, and mental health services for CY 2009, as discussed in sections II.A.2.e.(1), II.A.2.e.(2), II.A.2.e.(3), and II.A.2.e.(4), respectively, of this proposed rule.

(1) Extended Assessment and Management Composite APCs (APCs 8002 and 8003)

For the CY 2009 OPPS we are proposing to continue to include composite APC 8002 (Level I Extended Assessment and Management Composite) and composite APC 8003 (Level II Extended Assessment and Management Composite) in the OPPS. In addition, we are proposing to include HCPCS code G0384 (Level 5 hospital emergency department visit provided in a type B emergency department) in the criteria that determine eligibility for payment for composite APC 8003. For CY 2008, we created these two new composite APCs to provide payment to hospitals in certain circumstances when extended assessment and management of a patient occur (an extended visit). In most circumstances, observation services are supportive and ancillary to the other services provided to a patient. In the circumstances when observation care is provided in conjunction with a high level visit or direct admission and is an integral part of a patient's extended encounter of care, payment is made for the entire care encounter through one of two composite APCs as appropriate.

As defined for the CY 2008 OPPS, composite APC 8002 describes an encounter for care provided to a patient that includes a high level (Level 5) clinic visit or direct admission to observation in conjunction with observation services of substantial duration (72 FR 66648 through 66649). Composite APC 8003 describes an encounter for care provided to a patient that includes a high level (Level 4 or 5) emergency department visit or critical care services in conjunction with observation services of substantial duration. HCPCS code G0378 (Observation services, per hour) is assigned status indicator ''N,'' signifying that its payment is always packaged. As noted in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66648 through 66649), the I/OCE evaluates every claim received to determine if payment through a composite APC is appropriate. If payment through a composite APC is inappropriate, the I/OCE, in conjunction with the PRICER, determines the appropriate status indicator, APC, and payment for every code on a claim. The specific criteria that must be met for the two extended assessment and management composite APCs to be paid are provided below in the description of the claims that were selected for the calculation of the proposed CY 2009 median costs for these composite APCs. The general composite APC logic and observation care reporting criteria have also been included in updates to the Claims Processing and Benefit Policy Manuals through Change Request 5916 (Program Transmittals 82 and 1145), dated February 8, 2008, and we are not proposing to change these criteria for the CY 2009 OPPS.

When we created composite APCs 8002 and 8003 for CY 2008, we retained as general reporting requirements for all observation services those criteria related to physician order and evaluation; documentation; and observation beginning and ending time as listed in section XI. of the CY 2008 final rule with comment period (72 FR 66812). We are not proposing to change these reporting requirements for the CY 2009 OPPS. These are more general requirements that encourage hospitals to provide medically reasonable and necessary care and help to ensure the proper reporting of observation services on correctly coded hospital claims that reflect the full charges associated with all hospital resources utilized to provide the reported services.

As noted in detail in sections IX.C and XI. of the CY 2008 OPPS/ASC final rule with comment period (72 FR 66802 through 66805 and 66814), we saw a normal and stable distribution of clinic and emergency department visit levels. We do not expect to see an increase in the proportion of visit claims for high level visits as a result of the new composite APCs adopted for CY 2008 and proposed for CY 2009. Similarly, we expect that hospitals will not purposely change their visit guidelines or otherwise upcode clinic and emergency department visits reported with observation care solely for the purpose of composite payment. As stated in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66648), we expect to carefully monitor any changes in billing practices on a service-specific and hospital-specific level to determine whether there is reason to request that Quality Improvement Organizations (QIOs) review the quality of care furnished, or to request that Benefit Integrity contractors or other contractors review the claims against the medical record. However, we will not have claims available for analysis that reflect the new CY 2008 payment policy for the extended assessment and management composite APCs until the CY 2010 annual OPPS rulemaking cycle.

At the March 2008 meeting of the APC Panel, we discussed with the Visits and Observation Subcommittee, as well as with the full APC Panel, the extended assessment and management composite APCs and observation-related data previously requested by the APC Panel at its September 2007 meeting. At its March 2008 meeting, the APC Panel recommended that CMS provide them with additional data related to the frequency and median cost for the extended assessment and management composite APCs and length-of-stay

frequency distribution data for observation services, with additional detail at the 24–48 hour and greater than 48 hour levels. We are accepting those recommendations and will provide additional data as requested at the next APC Panel meeting in 2008. In addition, the APC Panel recommended continuation of the Visits and Observation Subcommittee's work. We also are accepting that recommendation.

For CY 2009, we are proposing to continue the extended assessment and management composite APC payment methodology for APCs 8002 and 8003. As stated above, we are also proposing to continue the general reporting requirements for observation services reported with HCPCS code G0378. We continue to believe that the composite APCs 8002 and 8003 and the related policies provide the most appropriate means of paying for these services. We are proposing to calculate the median costs for APCs 8002 and 8003 using all single and ''pseudo single'' procedure claims for CY 2007 that meet the criteria for payment of each composite APC.

Specifically, to calculate the proposed median costs for composite APCs 8002 and 8003, we selected single and ''pseudo'' single claims that met each of the following criteria:

1. Did not contain a HCPCS code to which we have assigned status indicator ''T'' with a date of service 1 day earlier than the date of service associated with HCPCS code G0378. (By selecting these claims from single and ''pseudo'' single claims, we had already assured that they would not contain a code for a service with status indicator ''T'' on the same date of service.);

2. Contained 8 or more units of HCPCS code G0378; and

3. Contained one of the following codes:

- In the case of composite APC 8002, HCPCS code G0379 (Direct admission of patient for hospital observation care) on the same date of service as G0378; or CPT code 99205 (Office or other outpatient visit for the evaluation and management of a new patient (Level 5)); or CPT code 99215 (Office or other outpatient visit for the evaluation and management of an established patient (Level 5)) provided on the same date of service or one day before the date of service for HCPCS code G0378.
- In the case of composite APC 8003, CPT code 99284 (Emergency department visit for the evaluation and management of a patient (Level 4)); CPT code 99285 (Emergency department visit for the evaluation and management of a patient (Level 5)); CPT code 99291 (Critical care, evaluation and management of the critically ill or critically injured patient; first 30–74 minutes); or HCPCS code G0384 provided on the same date of service or one day before the date of service for HCPCS code G0378. (As discussed in detail below, we are proposing to add HCPCS code G0384 to the eligibility criteria for composite APC 8003 for CY 2009.)

We applied the standard packaging and trimming rules to the claims before calculating the proposed median costs. The proposed CY 2009 median cost resulting from this process for composite APC 8002 is $364, which was calculated from 14,968 single and ''pseudo'' single bills that met the required criteria. The proposed median cost for composite APC 8003 is $670, which was calculated from 83,491 single and ''pseudo'' single bills that met the required criteria. This is the same methodology we used to calculate the medians for composite APCs 8002 and 8003 for the CY 2008 OPPS (72 FR 66649).

As discussed in more detail in section IX.B. of this proposed rule, we are proposing to reassign HCPCS code G0384 from APC 0608 (Level 5 Hospital Clinic Visits) to APC 0616 (Level 5 Emergency Visits). Consistent with this change for CY 2009, we are also proposing to add HCPCS code G0384 to the eligibility criteria for payment of composite APC 8003. Because these visits are rare, we would not expect that adding HCPCS code G0384 to the eligibility criteria for payment for extended assessment and management composite APC 8003 would significantly increase the relative frequency of the Type B emergency department Level 5 visits reported using HCPCS code G0384.

As discussed further in sections III.D and IX. of this proposed rule and consistent with our CY 2008 final policy, when calculating the median costs for the clinic, Type A emergency department visit, Type B emergency department visit, and critical care APCs (0604 through 0617 and 0626 through 0629), we would utilize our methodology that excludes those claims for visits that are eligible for payment through the two extended assessment and management composite APCs, that is APC 8002 or APC 8003. We believe that this approach would result in the most accurate cost estimates for APCs 0604 through 0617 and 0626 through 0629 for CY 2009.

Also as discussed in section XIII.A.1. of this proposed rule, for CY 2009, we are proposing to replace current status indicator ''Q'' with three new separate status indicators: ''Q1,'' ''Q2,'' and ''Q3.'' We believe that this proposed change would make our policy more transparent to hospitals and would facilitate the use of status indicator-driven logic in our ratesetting calculations, and in hospital billing and accounting systems. Under this proposal, status indicator ''Q3'' would be assigned to all codes that may be paid through a composite APC based on composite-specific criteria or separately through single code APCs when the criteria are not met. Therefore, we are proposing that each of the direct admission, clinic, and emergency department visit codes that may be paid through composite APCs 8002 and 8003 be assigned status indicator ''Q3'' for CY 2009. We are proposing that HCPCS code G0378 would continue to be always packaged by assigning the HCPCS code status indicator ''N,'' its current status indicator under the CY 2008 OPPS.

We are also proposing that the payment policy for separate payment of HCPCS code G0379 that was finalized for the CY 2008 OPPS (72 FR 66814 through 66815) would continue to apply for CY 2009 when the criteria for payment of this service through composite APC 8002 are not met. The criteria for payment of HCPCS code G0379 under either composite APC 8002, as part of the extended assessment and management composite service or APC 0604, as a separately payable individual service are: (1) both HCPCS codes G0378 and G0379 are reported with the same date of service; and (2) no service with a status indicator of ''T'' or ''V'' or Critical Care (APC 0617) is provided on the same date of service as HCPCS code G0379. If either of the above criteria is not met, HCPCS code G0379 is assigned status indicator ''N'' and its payment is packaged into the payment for other separately payable services provided in the same encounter.

In summary, for CY 2009, we are proposing to continue the extended assessment and management composite APC payment methodology and the general reporting requirements for observation services reported with HCPCS code G0378. We are proposing to base the CY 2009 OPPS payment for composite APC 8002 on a median cost of $364 and to base the payment for composite APC 8003 on a median cost of $670. For CY 2009, we are also proposing to add HCPCS code G0384 to the eligibility criteria for payment of composite APC 8003. Furthermore, we are proposing to assign status indicator ''Q3'' to each of the visit codes that may be paid through the Level I and Level II extended assessment and management composite APCs.

(2) Low Dose Rate (LDR) Prostate Brachytherapy Composite APC (APC 8001)

LDR prostate brachytherapy is a treatment for prostate cancer in which needles or catheters are inserted into the prostate, followed by permanent implantation of radioactive sources into the prostate through the hollow needles or catheters. At least two CPT codes are used to report the composite treatment service because there are separate codes that describe placement of the needles/catheters and the application of the brachytherapy sources: CPT code 55875 (Transperineal placement of needles or catheters into prostate for interstitial radioelement application, with or without cystoscopy) and CPT code 77778 (Interstitial radiation source application; complex). Generally, the component services represented by both codes are provided in the same operative session in the same hospital on the same date of service to the Medicare beneficiary treated with LDR brachytherapy for prostate cancer. As discussed in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66653), OPPS payment rates for CPT code 77778, in particular, have fluctuated over the years. We were frequently informed by the public that reliance on single procedure claims to set the median costs for these services resulted in use of only incorrectly coded claims for LDR prostate brachytherapy because a correctly coded claim should include, for the same date of service, CPT codes for both needle/catheter placement and application of radiation sources, as well as separately coded imaging and radiation therapy planning services (that is, a multiple procedure claim).

In order to base payment on claims for the most common clinical scenario, and to contribute to our goal of providing payment under the OPPS for a larger bundle of component services provided in a single hospital encounter, beginning in CY 2008 we provide a single payment for LDR prostate brachytherapy when the composite service, billed as CPT codes 55875 and 77778, is furnished in a single hospital encounter. We base the payment for composite APC 8001 (LDR Prostate Brachytherapy Composite) on the median cost derived from claims for the same date of service that contain both CPT codes 55875 and 77778 and that do not contain other separately paid codes that are not on the bypass list. In uncommon occurrences in which the services are billed individually, hospitals continue to receive separate payments for the individual services. We refer readers to the CY 2008 OPPS/ASC final rule with comment period (72 FR 66652 through 66655) for a full history of OPPS payment for LDR prostate brachytherapy and a detailed description of how we developed the LDR prostate brachytherapy composite APC.

For CY 2009, we are proposing to continue paying for LDR prostate brachytherapy services using the composite APC methodology proposed and implemented for CY 2008. That is, we are proposing to use CY 2007 claims on which both CPT codes 55875 and 77778 were billed on the same date of service with no other separately paid procedure codes (other than those on the bypass list) to calculate the payment rate for composite APC 8001. Consistent with our CY 2008 practice, we would not use the claims that meet these criteria in the calculation of the median costs for APCs 0163 (Level IV Cystourethroscopy and Other Genitourinary Procedures) and 0313 (Brachytherapy) to which HCPCS codes 55875 and 77778 are assigned respectively; median costs for APCs 0163 and 0313 would continue to be calculated using single procedure claims. As discussed in section XIII.A.1. of this proposed rule, we also are proposing to use new status indicator ''Q3'' (Codes that May be Paid Through a Composite APC), to denote HCPCS codes such as CPT codes 55875 and 77778 that may be paid through a composite APC for publication and payment purposes for CY 2009, rather than status indicator ''Q'' that is being used in CY 2008. We are proposing the status indicator change to facilitate identification of HCPCS codes that may be paid through composite APCs and to facilitate development of the composite APC median costs.

We continue to believe that this composite APC contributes to our goal of creating hospital incentives for efficiency and cost containment, while providing hospitals with the most flexibility to manage their resources. We also continue to believe that data from claims reporting both services required for LDR prostate brachytherapy provide the most accurate median cost upon which to base the composite APC payment rate.

Using partial year CY 2007 claims data available for the CY 2009 proposed rule, we were able to use 6,897 claims that contained both CPT code 77778 and 55875 to calculate the median cost upon which the CY 2009 proposed payment for composite APC 8001 is based. The proposed median cost for composite APC 8001 for CY 2009 is approximately $3,509. This is an increase compared to the CY 2008 OPPS/ASC final rule with comment period in which we calculated a final median cost for this composite APC of approximately $3,391 based on a full year of CY 2006 claims data. The CY 2009 proposed composite APC median is slightly less than $3,581, the sum of the proposed median costs for APCs 0163 (Level IV Cystourethroscopy and other Genitourinary Procedures) and 0651 (Complex Interstitial Radiation Source Application) ($2,388 + $1,193), the APCs to which CPT codes 77778 and 55875 map if one service is billed on a claim without the other. We believe that the proposed median cost for composite APC 8001 of approximately $3,509, which is calculated from claims we believe to be correctly coded, would result in a reasonable and appropriate payment rate for this service in CY 2009.

(3) Cardiac Electrophysiologic Evaluation and Ablation Composite APC (APC 8000)

Cardiac electrophysiologic evaluation and ablation services frequently are performed in varying combinations with one another during a single episode of care in the HOPD. Therefore, correctly coded claims for these services often include multiple codes for component services that are reported with different CPT codes and that, prior to CY 2008, were always paid separately through different APCs (specifically, APC 0085 (Level II Electrophysiologic Evaluation), APC 0086 (Ablate Heart Dysrhythm Focus), and APC 0087 (Cardiac Electrophysiologic Recording/Mapping)). As a result, there would never be many single bills for cardiac electrophysiologic evaluation and ablation services, and those that are reported as single bills would often represent atypical cases or incorrectly coded claims. As described in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66655 through 66659), the APC Panel and the public expressed persistent concerns regarding the limited and reportedly unrepresentative single bills available for use in calculating the median cost for these services according to our standard OPPS methodology.

Effective January 1, 2008, we established APC 8000 (Cardiac Electrophysiologic Evaluation and Ablation Composite) to pay for a composite service made up of at least one specified electrophysiologic evaluation service and one electrophysiologic ablation service. Calculating a composite APC for these services allowed us to utilize many more claims than were available to establish the individual APC median

costs for these services, and we also saw this composite APC as an opportunity to advance our stated goal of promoting hospital efficiency through larger payment bundles. In order to calculate the median cost upon which the payment rate for composite APC 8000 is based, we used multiple procedure claims that contained at least one CPT code from group A for evaluation services and at least one CPT code from group B for ablation services reported on the same date of service on an individual claim. We refer readers to Table 6 for identification of the CPT codes that are assigned to groups A and B. For a full discussion of how we identified the group A and group B procedures and established the CY 2008 payment rate for the cardiac electrophysiologic evaluation and ablation composite APC, we refer readers to the CY 2008 OPPS/ASC final rule with comment period (72 FR 66655 through 66659). Where a service in group A is furnished on a date of service that is different from the date of service for a code in group B for the same beneficiary, payments are made under the appropriate single procedure APCs and the composite APC does not apply.

For CY 2009, we are proposing to continue paying for cardiac electrophysiologic evaluation and ablation services using the composite APC methodology established for CY 2008. Consistent with our CY 2008 practice, we would not use the claims that meet these criteria in the calculation of the median costs for APCs 0085 (Level II Electrophysiologic Procedures) and 0086 (Level III Electrophysiologic Procedures), to which the HCPCS codes in both groups A and B for composite APC 8000 are otherwise assigned. Median costs for APCs 0085 and 0086 would continue to be calculated using single procedure claims. As discussed in section XIII.A.1. of this proposed rule, we also are proposing to use new status indicator ''Q3'' (Codes that May be Paid Through a Composite APC) to denote HCPCS codes such as the cardiac electrophysiologic evaluation and ablation CPT codes that may be paid through a composite APC for publication and payment purposes for CY 2009, rather than the status indicator ''Q'' that is being used in CY 2008. We continue to believe that the composite APC for cardiac electrophysiologic evaluation and ablation services is the most efficient and effective way to use the claims data for the majority of these services and best represents the hospital resources associated with performing the common combinations of these services that are clinically typical. Further, this approach creates incentives for efficiency by providing a single payment for a larger bundle of major procedures when they are performed together, in contrast to continued separate payment for each of the individual procedures.

Using partial year CY 2007 claims data available for this proposed rule, we were able to use 5,603 claims containing a combination of group A and group B codes and calculated a proposed median cost of approximately $9,174 for composite APC 8000. This is an increase compared to the CY 2008 OPPS/ASC final rule with comment period in which we calculated a final median cost for this composite APC of approximately $8,438 based on a full year of CY 2006 claims data. We believe that the proposed median cost of $9,174 calculated from a high volume of correctly coded multiple procedure claims results in an accurate and appropriate proposed payment for cardiac electrophysiologic evaluation and ablation services when at least one evaluation service is furnished during the same clinical encounter as at least one ablation service. Table 6 below lists the groups of procedures upon which we are proposing to base composite APC 8000 for CY 2009.

TABLE 6.—GROUPS OF CARDIAC ELECTROPHYSIOLOGIC EVALUATION AND ABLATION PROCEDURES UPON WHICH WE BASE COMPOSITE APC 8000

Codes used in combinations: At least one in Group A and one in Group B	HCPCS code	Proposed single code CY 2009 APC	Proposed CY 2009 SI (composite)
Group A			
Electrophysiology evaluation	93619	0085	Q3
Electrophysiology evaluation	93620	0085	Q3
Group B			
Ablate heart dysrhythm focus	93650	0085	Q3
Ablate heart dysrhythm focus	93651	0086	Q3
Ablate heart dysrhythm focus	93652	0086	Q3

(4) Mental Health Services Composite APC (APC 0034)

For the CY 2009 OPPS, we are proposing to continue our longstanding policy of limiting the aggregate payment for specified less intensive mental health services furnished on the same date to the payment for a day of partial hospitalization, which we consider to be the most resource intensive of all outpatient mental health treatment. We refer readers to the April 7, 2000 OPPS final rule with comment period (65 FR 18455) for the initial discussion of this longstanding policy. We continue to believe that the costs associated with administering a partial hospitalization program represent the most resource intensive of all outpatient mental health treatment, and we do not believe that we should pay more for a day of individual mental health services under the OPPS than the partial hospitalization per diem payment.

For CY 2009, as discussed further in section X.B. of this proposed rule, we are proposing to create two new APCs, 0172 (Level I Partial Hospitalization (3 services)) and 0173 (Level II Partial Hospitalization (4 or more services)), to replace APC 0033 (Partial Hospitalization), which we are proposing to delete for CY 2009. In summary, when a community mental health center (CMHC) or hospital provides three units of partial hospitalization services and meets all other partial hospitalization payment criteria, the CMHC or hospital would be paid through APC 0172. When the CMHC or hospital provides four or more units of partial hospitalization services and meets all other partial hospitalization payment criteria, the hospital would be paid through APC 0173. For CY 2009, we are proposing to set the payment rate for mental health composite APC 0034 at the same rate as APC 0173, which is the maximum partial hospitalization per diem payment. We believe this APC payment

rate would provide the most appropriate payment for composite APC 0034, taking into consideration the intensity of the mental health services and the differences in the HCPCS codes for mental health services that could be paid through this composite APC compared with the HCPCS codes that could be paid through partial hospitalization APC 0173. Through the I/OCE, when the payment for specified mental health services provided by one hospital to a single beneficiary on one date of service based on the payment rates associated with the APCs for the individual services would exceed the maximum per diem partial hospitalization payment [listed as APC 0173 (Level II Partial Hospitalization (4 or more services))], those specified mental health services would be assigned to APC 0034 (Mental Health Services Composite), which has the same payment rate as APC 0173, and the hospital would be paid one unit of APC 0034. In the CY 2008 OPPS/ASC final rule with comment period (72 FR 66651), we clarified that this longstanding policy regarding payment of APC 0034 for combinations of independent mental health services provided in a single hospital encounter resembles the payment policy for composite APCs that we finalized for LDR prostate brachytherapy and cardiac electrophysiologic evaluation and ablation services for CY 2008. Similar to the logic for those two composite APCs, the I/OCE currently determines, and we are proposing for CY 2009 that it would continue to determine, whether to pay these specified mental health services individually or to make a single payment at the same rate as the APC 0173 per diem rate for partial hospitalization for all of the specified mental health services furnished on that date of service. However, we note that this established policy for payment of APC 0034 differs from the payment policies for the LDR prostate brachytherapy and cardiac electrophysiologic evaluation and ablation composite APCs because APC 0034 is only paid if the sum of the individual payment rates for the specified mental health services provided on one date of service exceeds the APC 0034 payment rate.

For CY 2008 (72 FR 66651), we changed the status indicator to ''Q'' for the HCPCS codes that describe the specified mental health services to which APC 0034 applies because those codes are conditionally packaged when the sum of the payment rates for the single code APCs to which they are assigned exceeds the per diem payment rate for partial hospitalization. For CY 2009, we are proposing to change the status indicator from ''Q'' (Packaged Services Subject to Separate Payment under OPPS Payment Criteria) to ''Q3,'' (Codes that May be Paid Through a Composite APC), for those HCPCS codes that describe the specified mental health services to which APC 0034 applies. This is consistent with our proposal to change the status indicator from ''Q'' to ''Q3'' for all HCPCS codes that may be paid through composite APCs, in order to further refine our identification of the different types of conditionally packaged HCPCS codes that were previously all assigned the same status indicator ''Q'' under the OPPS. We are proposing to apply this status indicator policy to the HCPCS codes that are assigned to composite APC 0034 in Addendum M to this proposed rule. We are also proposing to change the status indicator from ''P'' (Partial Hospitalization) to ''S'' (Significant Procedure, Not Discounted when Multiple), for APC 0034. Although APC 0034 has been historically assigned status indicator ''P'' under the OPPS, this APC provides payment for mental health services that are furnished in an HOPD outside of a partial hospitalization program. This proposed status indicator change should have no practical implications for hospitals from a billing or payment perspective. Rather, we believe that it is more appropriate to assign status indicator ''S'' to an APC that describes mental health services that are provided outside of a partial hospitalization program. We refer readers to section XIII.A. of this proposed rule for a complete discussion of status indicators and our proposed status indicator changes for CY 2009.

In summary, we are not proposing a change to the longstanding payment policy under which the OPPS pays one unit of APC 0034 in cases in which the total payments for specified mental health services provided on the same date of service would otherwise exceed the payment rate for APC 0173. However, we are proposing to change the status indicator to ''Q3'' for the HCPCS codes for the mental health services to which this policy applies, consistent with our belief that payment for these services should be packaged into a single payment made at the same rate as a day of partial hospitalization unless the sum of the individual payments for these codes would be less than the payment for composite APC 0034.

(5) Multiple Imaging Composite APCs (APCs 8004, 8005, 8006, 8007, and 8008)

Under current OPPS policy, hospitals receive a full APC payment for each imaging service on a claim, regardless of how many procedures are performed during a single session using the same imaging modality or whether the procedures are performed on contiguous body areas. In response to a 2005 MedPAC recommendation to reduce the technical component payment for multiple imaging services performed on contiguous body areas, CMS proposed a payment reduction policy for multiple imaging procedures performed on contiguous body areas in both the CY 2006 MPFS proposed rule (70 FR 45849 through 45851) and the CY 2006 OPPS proposed rule (70 FR 42748 through 42751). In the March 2005 MedPAC report entitled, ''Report to the Congress: Medicare Payment Policy,'' MedPAC concluded that Medicare's physician's office payment rates for imaging services were based on each service being provided independently and that the rates did not account for efficiencies that may be gained when multiple studies using the same imaging modality are performed in the same session. In both the CY 2006 MPFS proposed rule (70 FR 45849) and the CY 2006 OPPS proposed rule (70 FR 42751), we suggested that although each imaging procedure entails the use of hospital resources, including certain staff, equipment, and supplies, some of those resource costs are not incurred twice when the procedures are performed in the same session and thus, should not be paid as if they were incurred twice. Specifically, for CY 2006, for both the MPFS and the OPPS, we proposed to apply a 50-percent reduction in the payment for certain second and subsequent imaging procedures performed during the same session, similar to the longstanding OPPS policy of reducing payments for certain second and subsequent surgical procedures performed during the same operative session. We developed the 50-percent reduction estimate using MPFS input data to estimate the practice expense resources associated with equipment time and indirect costs that would not occur for the second and subsequent procedures. We proposed that the reduction would apply only to individual services within 11 designated imaging families, which were comprised of procedures utilizing similar modalities across contiguous body areas and developed based on MPFS billing data. The imaging modalities included in the proposal

were ultrasound, computed tomography (CT), computed tomographic angiography (CTA), magnetic resonance imaging (MRI), and magnetic resonance angiography (MRA). Prior to making the proposal for the OPPS, we confirmed that the CY 2004 OPPS claims for the CY 2006 OPPS update demonstrated comparable clustering of imaging procedures by modality and within family. The OPPS and MPFS imaging services provided across families would not be subject to the reduction policy as proposed for CY 2006. The proposed 11 families of imaging services were as follows:

- Ultrasound (Chest/Abdomen/Pelvis-Non-Obstetrical)
- CT and CTA (Chest/Thorax/Abd/Pelvis)
- CT and CTA (Head/Brain/Orbit/Maxillofacial/Neck)
- MRI and MRA (Chest/Abd/Pelvis)
- MRI and MRA (Head/Brain/Neck)
- MRI and MRA (Spine)
- CT (Spine)
- MRI and MRA (Lower Extremities)
- CT and CTA (Lower Extremities)
- MR and MRI (Upper Extremities and Joints)
- CT and CTA (Upper Extremities)

In response to the multiple imaging payment reduction policy proposed for the CY 2006 OPPS (70 FR 68707 through 68708), several commenters requested that we postpone implementation until we performed further analyses and were able to find more substantial, hospital-based data to support the 50-percent payment reduction rather than base the policy on MPFS data. Commenters argued that, unlike a relative value unit (RVU) estimate of the total resources associated with a single service for the MPFS, the OPPS cost-based methodology already incorporates the efficiencies of performing multiple procedures during the same session and that median cost estimates for single procedures reflect these savings. Specifically, an imaging CCR consists of the labor and allocated capital and overhead costs for all imaging provided in a department specified by each hospital on its cost report, divided by the total charges for all imaging services provided. In short, commenters stated that because the OPPS cost estimates used for setting the OPPS payment rates for imaging services already reflect costs for a department in general, the CCR used to adjust charges to costs currently incorporated savings from the imaging efficiencies associated with multiple procedures provided in a single session. By applying this CCR to every charge on a claim, commenters noted that CMS averages multiple imaging efficiencies for all imaging services across all service costs estimated with the departmental CCR. At its August 2005 meeting, the APC Panel heard this and other arguments and recommended that CMS postpone implementation of the policy for a year in order to gather more data on the impact of the proposed changes.

In the CY 2006 OPPS final rule with comment period (70 FR 68516), we acknowledged that, based on our analysis of how hospitals report charges and costs for diagnostic radiology services, it may be correct that the median costs from hospital claims data for the imaging services in the 11 families proposed for the reduction policy already reflect reduced median costs based, in part, on hospitals' provision of multiple imaging services in a single session. However, we expressed concern that the marginal effect of imaging efficiencies on a given CCR may be negligible, thereby underestimating the impact of multiple imaging efficiencies, especially where hospitals reported all diagnostic radiology services in one cost center and did not split the costs and charges for advanced imaging with CT, MRI, or ultrasound into separate cost centers. Because efficiencies are inherent in our cost methodology, our analysis did not provide a definitive answer regarding how much, on average, the OPPS median costs for single imaging services in the 11 families are reduced due to existing hospital efficiencies related to multiple services provided in a single session. Accordingly, we did not implement a multiple imaging payment reduction policy for the OPPS in CY 2006 (a modified MPFS multiple imaging payment reduction policy was implemented with a 25-percent reduction policy for certain second and subsequent imaging services for CY 2006, and that same reduction policy currently remains in effect under the MPFS). In the CY 2006 OPPS final rule with comment period (70 FR 68707 through 68708), we stated that, depending upon the results of future analyses, we might revisit this issue and propose revisions to the structure of our payment rates for imaging procedures in order to ensure that those rates properly reflect the relative costs of initial and subsequent imaging procedures. Since publication of the CY 2006 OPPS final rule with comment period, MedPAC has encouraged us to continue our analyses in order to improve payment accuracy for imaging services under the OPPS, including considering adopting a multiple procedure payment reduction policy.

In preparation for the CY 2009 OPPS proposed rule, we revisited the issue of how we could improve the accuracy of OPPS payment for multiple imaging services and incorporate the lower marginal cost for conducting second and subsequent imaging procedures in the same imaging session. As already noted, for CY 2008, we developed a composite APC methodology to provide a single payment for two or more major independent services that are typically performed together during a single operative session and that result in the provision of a complete service (72 FR 66650 through 66652). The composite APCs for LDR prostate brachytherapy services and cardiac electrophysiologic evaluation and ablation services discussed in sections II.A.2.e.(2) and (3), respectively, of this proposed rule are classic examples. Providing one payment for an entire session encourages hospitals to closely evaluate the resources they use for all components of the composite service in order to improve their payment relative to the costs of performing the composite service. We decided to explore capturing efficiencies for multiple imaging procedures through a composite APC payment methodology when a hospital provides more than one imaging procedure using the same modality during a single session.

We began by reexamining the 11 imaging families of HCPCS codes for contiguous body areas involving a single imaging modality that we had proposed for CY 2006 and that are currently in use under the MPFS for the multiple imaging procedure payment reduction policy. We based this code-specific analysis on the HCPCS codes recognized under the OPPS for the same services that are included in the 11 CY 2008 MPFS imaging families, and in addition, we incorporated the 10 HCPCS codes that are proposed for inclusion in these 11 families for the CY 2009 MPFS. We collapsed the 11 MPFS imaging families into 3 OPPS imaging families according to their modality—1 for ultrasound, 1 for CT and CTA, and 1 for MRI and MRA services. These larger OPPS imaging families generally correspond to the larger APC groups of services paid under OPPS relative to the service-specific payment under the MPFS. We believe that these larger OPPS imaging families are appropriate because eliminating the contiguous body area concept that is central to the MPFS imaging families should not significantly limit potential efficiencies in an imaging session. For example, we would not expect second and subsequent imaging services of the same modality involving noncontiguous body areas to require duplicate facility

services such as greeting the patient, providing education and obtaining consent, retrieving prior exams, setting up an intravenous infusion, and preparing and cleaning the room, any more than second and subsequent imaging procedures of the same modality on contiguous body areas. The contiguous body area concept was a component of MedPAC's recommendation for reducing physician payment, but we believe it is less appropriate for a single, session-based OPPS composite imaging payment. In addition, using these collapsed OPPS families would add only 12 percent additional claims to those eligible for composite payment relative to using the 11 MPFS imaging families, suggesting that under the OPPS, multiple imaging claims are within the same imaging modality and involve contiguous body areas the vast majority of the time. Nevertheless, the three OPPS imaging families would allow us to capture additional claims for payment under an imaging composite payment methodology.

Another unique aspect of imaging services for OPPS ratesetting, in general, is their inclusion on our bypass list and contribution to creating ''pseudo'' single claims, particularly those services that are specifically performed without the administration of contrast. Our creation of ''pseudo'' single claims from multiple procedure claims is discussed in section II.A.1.b. of this proposed rule. In beginning to model these potential multiple imaging composite APCs, we noted that there would be overlap between the bypass list and noncontrast imaging HCPCS codes that are included in the three OPPS imaging families. The bypass process removes any line-item for a bypass HCPCS code, irrespective of units, from multiple procedure claims. The line-item information is used to make at least one ''pseudo'' single bill and the line-items remaining on the claim are split by date and reassessed for single bill status. To model the median costs for the potential multiple imaging composite APCs, we removed any HCPCS codes in the OPPS imaging families that overlap with codes on our bypass list to avoid splitting claims with multiple units or multiple occurrences of codes in an OPPS imaging family into new ''pseudo'' single claims. The imaging HCPCS codes that we removed from the bypass list for purposes of calculating proposed multiple imaging composite APC median costs appear in Table 7 below. (We refer readers to section II.A.1.b. of this proposed rule for further discussion of how we treat claims with HCPCS codes in the OPPS imaging families that are also on the bypass list.) We integrated the identification of imaging composite ''single session'' claims, that is, claims with multiple imaging procedures within the same family on the same date of service, into the creation of ''pseudo'' single claims to ensure that claims were split in the ''pseudo'' single process into accurate reflections of either a composite ''single session'' imaging service or a standard sole imaging service resource cost. Like all single bills, the new composite ''single session'' claims were for the same date of service and contained no other separately paid services in order to isolate the session imaging costs. Our last step after processing all claims through the ''pseudo'' single process was to make line-items for HCPCS codes in the OPPS imaging families remaining on multiple procedure claims with one unit of the imaging HCPCS code and no other imaging services in the families into ''pseudo'' single bills for use in calculating the median costs for sole imaging services.

TABLE 7.—PROPOSED OPPS IMAGING FAMILY SERVICES OVERLAPPING WITH HCPCS CODES ON THE PROPOSED CY 2009 BYPASS LIST

Family 1—Ultrasound	
76700	Us exam, abdom, complete.
76705	Echo exam of abdomen.
76770	Us exam abdo back wall, comp.
76775	Us exam abdo back wall, lim.
Family 1—Ultrasound	
76776	Us exam k transpl w/doppler.
76856	Us exam, pelvic, complete.
76870	Us exam, scrotum.
76857	Us exam, pelvic, limited.
Family 2—CT and CTA With and Without Contrast	
70450	Ct head/brain w/o dye.
70480	Ct orbit/ear/fossa w/o dye.
70486	Ct maxillofacial w/o dye.
70490	Ct soft tissue neck w/o dye.
71250	Ct thorax w/o dye.
72125	Ct neck spine w/o dye.
72128	Ct chest spine w/o dye.
72131	Ct lumbar spine w/o dye.
72192	Ct pelvis w/o dye.
73200	Ct upper extremity w/o dye.
73700	Ct lower extremity w/o dye.
74150	Ct abdomen w/o dye.
Family 3—MRI and MRA With and Without Contrast	
70336	Magnetic image, jaw joint.
70544	Mr angiography head w/o dye.
70551	Mri brain w/o dye.
72141	Mri neck spine w/o dye.
72146	Mri chest spine w/o dye.
72148	Mri lumbar spine w/o dye.
73218	Mri upper extremity w/o dye.
Family 3—MRI and MRA With and Without Contrast	
73221	Mri joint upr extrem w/o dye.
Family 3—MRI and MRA With and Without Contrast	
73718	Mri lower extremity w/o dye.
73721	Mri jnt of lwr extre w/o dye.

One final requirement of our assessment of multiple imaging composite APCs was our expansion of the OPPS families for the three modalities—ultrasound, CT and CTA, and MRI and MRA—into five composite APCs to accommodate the statutory requirement in section 1833(t)(2)(G) of the Act, that the OPPS provide payment for imaging services provided with contrast and without contrast through separate payment groups. Ultrasound studies do not utilize contrast and thus this family constituted a single composite APC. However, we had to split the families for CT and CTA, and MRI and MRA, into two separate composite APCs each to reflect whether the procedures were performed with or without contrast. We examined the HCPCS codes on our ''single session'' claims, and if the claim had at least one HCPCS code that was performed with contrast, we classified the ''single session'' bill as ''with contrast.'' We then recalculated the median costs for the standard (sole service) imaging APCs based on single and ''pseudo'' single bills and the imaging composite APC median costs based on appropriate ''single session'' bills with multiple imaging procedures.

We were able to identify 1.7 million ''single session'' claims out of an estimated 4 million potential composite cases from our ratesetting claims database, or almost half of all eligible claims, to calculate median costs for the 5 OPPS multiple imaging composite APCs. We used 8 million single and ''pseudo'' single claims to set the medians for the standard (sole service) APCs for the same imaging procedures. We specifically note that the proposed CY 2009 payment rates for multiple imaging services provided during the same session and within the same OPPS

imaging family are based entirely on median costs derived empirically from OPPS claims and Medicare cost report data.

In general, we found that the per service median cost for each of the multiple imaging procedures performed during a single session, and reflected in the composite APC median costs, was modestly less than the sole service median cost when only one imaging service was performed during a single session, as reflected in the median cost of the standard (sole service) imaging APCs (that is, those imaging services that would not have qualified for payment through a multiple imaging composite APC under the proposed composite methodology). However, we also noticed that the proposed CY 2009 median costs for the standard (sole service) imaging APCs increased slightly compared to the median costs that we would calculate using the current OPPS imaging service payment policy. These variations in median costs are consistent with our expectations. Because the OPPS cost-based payment weight methodology estimates a standard cost per imaging procedure for each hospital, these results suggest that the imaging composite ''single session'' claims disproportionately represent services furnished by more efficient providers that frequently perform more than one imaging procedure during a single session. The lower cost claims also may include more providers that appropriately report costs and charges for nonstandard cost centers for advanced imaging on their cost reports.

In light of these findings, we determined that a proposal to revise our methodology for paying for multiple imaging procedures is warranted because the current OPPS policy of providing a full APC payment for each imaging service on a claim, regardless of how many procedures are performed during a single session using the same imaging modality, neither reflects nor promotes the efficiencies hospitals can achieve when they perform multiple imaging procedures during a single session, as seen in the claims data.

Therefore, we are proposing to utilize the three OPPS imaging families discussed above, incorporating statutory requirements to differentiate OPPS payment for imaging services provided with contrast and without contrast as required by section 1833(t)(2)(G) of the Act, to create five multiple imaging composite APCs for payment in CY 2009. The proposed APCs are: APC 8004 (Ultrasound Composite); APC 8005 (CT and CTA without Contrast Composite); APC 8006 (CT and CTA with Contrast Composite); APC 8007 (MRI and MRA without Contrast Composite); and APC 8008 (MRI and MRA with Contrast Composite). We calculated the proposed median costs for these APCs using CY 2007 claims data by isolating ''single session'' claims with more than one imaging service within a family as discussed above. Unlike our CY 2006 proposal where we would have applied a 50-percent payment reduction for second and subsequent imaging procedures comparable to the proposed MPFS policy, the CY 2009 OPPS proposal would calculate the composite APC payment amounts empirically from estimated costs on claims for multiple imaging services provided in a single session. This proposed composite methodology for multiple imaging services parallels the payment methodologies that we are proposing for other composite APCs under the CY 2009 OPPS.

Table 8 below presents the HCPCS codes comprising the three OPPS imaging families and five composite APCs that would be created under this proposal for CY 2009, along with the proposed median costs upon which the payment rates for these composite APCs would be based. The HCPCS codes included in Table 8 are assigned status indicator ''Q3'' in Addendum B to this proposed rule to identify their status as potentially payable through a composite APC. Their composite APC assignments are identified in Addendum M to this proposed rule.

To implement this proposed policy, we would provide one composite APC payment each time a hospital bills more than one procedure described by the HCPCS codes in one OPPS imaging family displayed in Table 8 below on a single date of service. If the hospital performs a procedure without contrast during the same session as at least one other procedure with contrast using the same imaging modality, then the hospital would receive payment for the ''with contrast'' composite APC. A single imaging procedure, or imaging procedures reported with HCPCS codes assigned to different OPPS imaging families, would be paid according to the standard OPPS methodology through the standard (sole service) imaging APCs to which they are proposed for assignment in CY 2009. We are proposing that hospitals would continue to use the same HCPCS codes to report imaging services, and that the I/OCE would determine when combinations of imaging procedures would qualify for composite APC payment or would map to standard APCs for payment. We would make a single payment for those imaging services that qualify for composite APC payment, as well as the packaged services furnished on the same date of service. The proposed composite APCs would have status indicators of ''S,'' signifying that payment for the APC would not be reduced when appearing on the same claim with other significant procedures.

TABLE 8.—PROPOSED OPPS IMAGING FAMILIES AND MULTIPLE IMAGING PROCEDURE COMPOSITE APCS

Family 1—Ultrasound	
APC 8004 (Ultrasound Composite)	**Proposed CY 2009 Median Cost = $194.14**
76604	Us exam, chest.
76700	Us exam, abdom, complete.
76705	Echo exam of abdomen.
76770	Us exam abdo back wall, comp.
76775	Us exam abdo back wall, lim.
76776	Us exam k transpl w/Doppler.
76831	Echo exam, uterus.
76856	Us exam, pelvic, complete.
76870	Us exam, scrotum.
76857	Us exam, pelvic, limited.
Family 2—CT and CTA With and Without Contrast	
APC 8005 (CT and CTA without Contrast Composite)*	**Proposed CY 2009 Median Cost = $422.98**
0067T	Ct colonography;dx.
70450	Ct head/brain w/o dye.
70480	Ct orbit/ear/fossa w/o dye.
70486	Ct maxillofacial w/o dye.
70490	Ct soft tissue neck w/o dye.
71250	Ct thorax w/o dye.
72125	Ct neck spine w/o dye.
Family 2—CT and CTA With and Without Contrast	
APC 8005 (CT and CTA without Contrast Composite)*	**Proposed CY 2009 Median Cost = $422.98**
72128	Ct chest spine w/o dye.
72131	Ct lumbar spine w/o dye.
72192	Ct pelvis w/o dye.
73200	Ct upper extremity w/o dye.
73700	Ct lower extremity w/o dye.
74150	Ct abdomen w/o dye.
APC 8006 (CT and CTA with Contrast Composite)	**Proposed CY 2009 Median Cost = $639.09**
70487	Ct maxillofacial w/dye.
70460	Ct head/brain w/dye.

TABLE 8.—PROPOSED OPPS IMAGING FAMILIES AND MULTIPLE IMAGING PROCEDURE COMPOSITE APCS—Continued

70470	Ct head/brain w/o & w/dye.
70481	Ct orbit/ear/fossa w/dye.
70482	Ct orbit/ear/fossa w/o&w/dye.
70488	Ct maxillofacial w/o & w/dye.
70491	Ct soft tissue neck w/dye.
70492	Ct sft tsue nck w/o & w/dye.
70496	Ct angiography, head.
70498	Ct angiography, neck.
71260	Ct thorax w/dye.
71270	Ct thorax w/o & w/dye.
71275	Ct angiography, chest.
72126	Ct neck spine w/dye.
72127	Ct neck spine w/o & w/dye.
72129	Ct chest spine w/dye.
72130	Ct chest spine w/o & w/dye.
72132	Ct lumbar spine w/dye.
72133	Ct lumbar spine w/o & w/dye.
72191	Ct angiograph pelv w/o&w/dye.
72193	Ct pelvis w/dye.
72194	Ct pelvis w/o & w/dye.
73201	Ct upper extremity w/dye.
73202	Ct uppr extremity w/o&w/dye.
73206	Ct angio upr extrm w/o&w/dye.

Family 2—CT and CTA With and Without Contrast

APC 8006 (CT and CTA with Contrast Composite)	Proposed CY 2009 Median Cost = $639.09
73701	Ct lower extremity w/dye.
73702	Ct lwr extremity w/o&w/dye.
73706	Ct angio lwr extr w/o&w/dye.
74160	Ct abdomen w/dye.
74170	Ct abdomen w/o & w/dye.
74175	Ct angio abdom w/o & w/dye.
75635	Ct angio abdominal arteries.

* If a ''without contrast'' CT or CTA procedure is performed during the same session as a ''with contrast'' CT or CTA procedure, the I/OCE will assign APC 8006 rather than APC 8005.

Family 3—MRI and MRA With and Without Contrast

APC 8007 (MRI and MRA without Contrast Composite)*	Proposed CY 2009 Median Cost = $724.66
70336	Magnetic image, jaw joint.
70540	Mri orbit/face/neck w/o dye.
70544	Mr angiography head w/o dye.
70547	Mr angiography neck w/o dye.
70551	Mri brain w/o dye.
70554	Fmri brain by tech.
71550	Mri chest w/o dye.
72141	Mri neck spine w/o dye.
72146	Mri chest spine w/o dye.

TABLE 8.—PROPOSED OPPS IMAGING FAMILIES AND MULTIPLE IMAGING PROCEDURE COMPOSITE APCS—Continued

72148	Mri lumbar spine w/o dye.
72195	Mri pelvis w/o dye.
73218	Mri upper extremity w/o dye.
73221	Mri joint upr extrem w/o dye.
73718	Mri lower extremity w/o dye.
73721	Mri jnt of lwr extre w/o dye.
74181	Mri abdomen w/o dye.
75557	Cardiac mri for morph.
75559	Cardiac mri w/stress img.
C8901	MRA w/o cont, abd.

Family 3—MRI and MRA With and Without Contrast

APC 8007 (MRI and MRA without Contrast Composite)*	Proposed CY 2009 Median Cost = $724.66
C8904	MRI w/o cont, breast, uni.
C8907	MRI w/o cont, breast, bi.
C8910	MRA w/o cont, chest.
C8913	MRA w/o cont, lwr ext.
C8919	MRA w/o cont, pelvis.

APC 8008 (MRI and MRA with Contrast Composite)	Proposed CY 2009 Median Cost = $1,002.72
70549	Mr angiograph neck w/o&w/dye.
70542	Mri orbit/face/neck w/dye.
70543	Mri orbt/fac/nck w/o & w/dye.
70545	Mr angiography head w/dye.
70546	Mr angiograph head w/o&w/dye.

APC 8008 (MRI and MRA with Contrast Composite)	Proposed CY 2009 Median Cost = $1,002.72
70548	Mr angiography neck w/dye.
70552	Mri brain w/dye.
70553	Mri brain w/o & w/dye.
71551	Mri chest w/dye.
71552	Mri chest w/o & w/dye.
72142	Mri neck spine w/dye.
72147	Mri chest spine w/dye.
72149	Mri lumbar spine w/dye.
72156	Mri neck spine w/o & w/dye.
72157	Mri chest spine w/o & w/dye.
72158	Mri lumbar spine w/o & w/dye.
72196	Mri pelvis w/dye.
72197	Mri pelvis w/o & w/dye.
73219	Mri upper extremity w/dye.
73220	Mri uppr extremity w/o&w/dye.
73222	Mri joint upr extrem w/dye.
73223	Mri joint upr extr w/o&w/dye.
73719	Mri lower extremity w/dye.
73720	Mri lwr extremity w/o&w/dye.
73722	Mri joint of lwr extr w/dye.

TABLE 8.—PROPOSED OPPS IMAGING FAMILIES AND MULTIPLE IMAGING PROCEDURE COMPOSITE APCS—Continued

Family 3—MRI and MRA With and Without Contrast

APC 8008 (MRI and MRA with Contrast Composite)	Proposed CY 2009 Median Cost = $1,002.72
73723	Mri joint lwr extr w/o&w/dye.
74182	Mri abdomen w/dye.
74183	Mri abdomen w/o & w/dye.
75561	Cardiac mri for morph w/dye.
75563	Card mri w/stress img & dye.
C8900	MRA w/cont, abd.
C8902	MRA w/o fol w/cont, abd.
C8903	MRI w/cont, breast, uni.
C8905	MRI w/o fol w/cont, brst, un.
C8906	MRI w/cont, breast, bi.
C8908	MRI w/o fol w/cont, breast.
C8909	MRA w/cont, chest.
C8911	MRA w/o fol w/cont, chest.
C8912	MRA w/cont, lwr ext.
C8914	MRA w/o fol w/cont, lwr ext.

APC 8008 (MRI and MRA with Contrast Composite)	Proposed CY 2009 Median Cost = $1,002.72
C8918	MRA w/cont, pelvis.
C8920	MRA w/o fol w/cont, pelvis.

* If a ''without contrast'' MRI or MRA procedure is performed during the same session as a ''with contrast'' MRI or MRA procedure, the I/OCE will assign APC 8008 rather than 8007.

3. Proposed Calculation of OPPS Scaled Payment Weights

Using the APC median costs discussed in sections II.A.1. and 2. of this proposed rule, we calculated the proposed relative payment weights for each APC for CY 2009 shown in Addenda A and B to this proposed rule. In years prior to CY 2007, we standardized all the relative payment weights to APC 0601 (Mid Level Clinic Visit) because mid-level clinic visits were among the most frequently performed services in the hospital outpatient setting. We assigned APC 0601 a relative payment weight of 1.00 and divided the median cost for each APC by the median cost for APC 0601 to derive the relative payment weight for each APC.

Beginning with the CY 2007 OPPS (71 FR 67990), we standardized all of the relative payment weights to APC 0606 (Level 3 Clinic Visits) because we deleted APC 0601 as part of the reconfiguration of the visit APCs. We selected APC 0606 as the base because

APC 0606 was the middle level clinic visit APC (that is, Level 3 of five levels). We had historically used the median cost of the middle level clinic visit APC (that is APC 0601 through CY 2006) to calculate unscaled weights because mid-level clinic visits were among the most frequently performed services in the hospital outpatient setting. Therefore, for CY 2009, to maintain consistency in using a median for calculating unscaled weights representing the median cost of some of the most frequently provided services, we are proposing to continue to use the median cost of the mid-level clinic visit APC, proposed APC 0606, to calculate unscaled weights. Following our standard methodology, but using the proposed CY 2009 median cost for APC 0606, for CY 2009 we assigned APC 0606 a relative payment weight of 1.00 and divided the median cost of each APC by the proposed median cost for APC 0606 to derive the unscaled relative payment weight for each APC. The choice of the APC on which to base the relative weights for all other APCs does not affect the payments made under the OPPS because we scale the weights for budget neutrality.

Section 1833(t)(9)(B) of the Act requires that APC reclassification and recalibration changes, wage index changes, and other adjustments be made in a manner that assures that aggregate payments under the OPPS for CY 2009 are neither greater than nor less than the aggregate payments that would have been made without the changes. To comply with this requirement concerning the APC changes, we compared aggregate payments using the CY 2008 relative weights to aggregate payments using the CY 2009 proposed relative weights. Again this year, we included payments to CMHCs in our comparison. Based on this comparison, we adjusted the relative weights for purposes of budget neutrality. The unscaled relative payment weights were adjusted by a weight scaler of 1.3354 for budget neutrality. In addition to adjusting for increases and decreases in weight due to the recalibration of APC medians, the scaler also accounts for any change in the base, other than changes in volume which are not a factor in the weight scaler. The proposed relative payment weights listed in Addenda A and B to this proposed rule incorporate the recalibration adjustments discussed in sections II.A.1. and 2. of this proposed rule.

Section 1833(t)(14)(H) of the Act, as added by section 621(a)(1) of Pub. L. 108–173, states that, ''Additional expenditures resulting from this paragraph shall not be taken into account in establishing the conversion factor, weighting and other adjustment factors for 2004 and 2005 under paragraph (9) but shall be taken into account for subsequent years.'' Section 1833(t)(14) of the Act provides the payment rates for certain ''specified covered outpatient drugs.'' Therefore, the cost of those specified covered outpatient drugs (as discussed in section V. of this proposed rule) is included in the budget neutrality calculations for the CY 2009 OPPS.

4. Proposed Changes to Packaged Services

a. Background

The OPPS, like other prospective payment systems, relies on the concept of averaging, where the payment may be more or less than the estimated costs of providing a service or package of services for a particular patient, but with the exception of outlier cases, is adequate to ensure access to appropriate care. Packaging and bundling payment for multiple interrelated services into a single payment create incentives for providers to furnish services in the most efficient way by enabling hospitals to manage their resources with maximum flexibility, thereby encouraging long-term cost containment. For example, where there are a variety of supplies that could be used to furnish a service, some of which are more expensive than others, packaging encourages hospitals to use the least expensive item that meets the patient's needs, rather than to routinely use a more expensive item. Packaging also encourages hospitals to negotiate carefully with manufacturers and suppliers to reduce the purchase price of items and services or to explore alternative group purchasing arrangements, thereby encouraging the most economical health care. Similarly, packaging encourages hospitals to establish protocols that ensure that necessary services are furnished, while carefully scrutinizing the services ordered by practitioners to maximize the efficient use of hospital resources. Finally, packaging payments into larger payment bundles promotes the stability of payment for services over time. Packaging and bundling also may reduce the importance of refining service-specific payment because there is more opportunity for hospitals to average payment across higher cost cases requiring many ancillary services and lower cost cases requiring fewer ancillary services.

Decisions about packaging and bundling payment involve a balance between ensuring some separate payment for individual services and establishing incentives for efficiency through larger units of payment. Over the past several years of the OPPS, greater unpackaging of payment has occurred simultaneously with continued growth in OPPS expenditures as a result of increasing volumes of individual services. In an attempt to address this increase in volume of services, in the CY 2008 OPPS/ASC final rule with comment period, we finalized additional packaging for the CY 2008 OPPS, which included the establishment of four new composite APCs for CY 2008, specifically APC 8000 (Cardiac Electrophysiologic Evaluation and Ablation Composite), APC 8001 (LDR Prostate Brachytherapy Composite), APC 8002 (Level I Extended Assessment & Management Composite), and APC 8003 (Level II Extended Assessment & Management Composite) (72 FR 66650 through 66659). HCPCS codes that may be paid through a composite APC if certain composite-specific criteria are met or otherwise may be paid separately are assigned status indicator ''Q'' for CY 2008, and we consider them to be conditionally packaged. We discuss composite APCs in more detail in section II.A.2.e. of this proposed rule.

In addition, in the CY 2008 OPPS/ASC final rule with comment period, (72 FR 66610 through 66659), we adopted the packaging of payment for items and services in the seven categories listed below into the payment for the primary diagnostic or therapeutic modality to which we believe these items and services are typically ancillary and supportive. The seven categories are: Guidance services, image processing services, intraoperative services, imaging supervision and interpretation services, diagnostic radiopharmaceuticals, contrast media, and observation services. We specifically chose these categories of HCPCS codes for packaging because we believe that the items and services described by the codes in these categories are the HCPCS codes that are typically ancillary and supportive to a primary diagnostic or therapeutic modality and, in those cases, are an integral part of the primary service they support. We finalized our assignment of status indicator ''N'' to those HCPCS codes that we believe are always integral to the performance of the primary modality, so we always package their costs into the costs of the separately paid primary services with which they are billed. Services assigned status indicator ''N'' in CY 2008 are unconditionally packaged.

We also finalized our assignment of status indicator ''Q'' to those HCPCS

codes that we believe are typically integral to the performance of the primary modality and, in such cases, we package payment for their costs into the costs of the separately paid primary services with which they are usually billed. An ''STVX-packaged code'' describes a HCPCS code whose payment is packaged when one or more separately paid primary services are furnished in the hospital outpatient encounter. A ''T-packaged code'' describes a code whose payment is packaged when one or more separately paid surgical procedures are provided during the hospital encounter. ''STVX-packaged codes'' and ''T-packaged codes'' are paid separately in those uncommon cases when they do not meet their respective criteria for packaged payment. ''STVX-packaged codes'' and ''T-packaged HCPCS codes'' assigned status indicator ''Q'' in CY 2008 are conditionally packaged.

We use the term ''dependent service'' to refer to the HCPCS codes that represent services that are typically ancillary and supportive to a primary diagnostic or therapeutic modality. We use the term ''independent service'' to refer to the HCPCS codes that represent the primary therapeutic or diagnostic modality into which we package payment for the dependent service. We note that, in future years as we consider the development of larger payment groups that more broadly reflect services provided in an encounter or episode of care, it is possible that we might propose to bundle payment for a service that we now refer to as ''independent.''

An example of a CY 2008 change in the OPPS packaging status for a dependent HCPCS code that is ancillary and supportive is CPT code 61795 (Stereotactic computer-assisted volumetric (navigational) procedure, intracranial, extracranial, or spinal (List separately in addition to code for primary procedure)). CPT code 61795 was assigned separate payment in CY 2007 but its payment is packaged during CY 2008. This service is only performed during the course of a surgical procedure. Several of the surgical procedures that we would expect to be reported in association with CPT code 61795 are assigned to APC 0075 (Level V Endoscopy Upper Airway) for CY 2008. We consider the stereotactic guidance service to be an ancillary and supportive service that may be performed only in the same operative session as a procedure that could otherwise be performed independently of the stereotactic guidance service.

During its March 2008 meeting, the APC Panel recommended that CMS report to the APC Panel at its first CY 2009 meeting the impact of packaging on the net payments for patient care. We will take this recommendation into consideration and determine which data we can provide at the first CY 2009 APC Panel meeting that would best respond to this recommendation. The APC Panel also recommended that CMS present data at the first CY 2009 APC Panel meeting on usage and frequency, geographic distribution, and size and type of hospitals performing nuclear medicine examinations and using radioisotopes to ensure that access to these services is preserved for Medicare beneficiaries. This recommendation is discussed in more detail in section V.B.2.b. of this proposed rule.

Hospitals include charges for packaged services on their claims, and the costs associated with those packaged services are then added to the costs of separately payable procedures on the same claims in establishing payment rates for the separately payable services. We encourage hospitals to report all HCPCS codes that describe packaged services that were provided, unless CPT or CMS provide other guidance. If a HCPCS code is not reported when a packaged service is provided, it can be challenging to track utilization patterns and resource costs.

For CY 2009, we are proposing to further refine our identification of the different types of conditionally packaged HCPCS codes that were previously all assigned status indicator ''Q'' (Packaged Services Subject to Separate Payment under OPPS Payment Criteria) under the OPPS. We are proposing to create and assign status indicators ''Q1'' \ (''STVX-Packaged Codes''), ''Q2'' (''T-Packaged Codes''), or ''Q3'' (Codes that may be paid through a composite APC) to each conditionally packaged HCPCS code. We refer readers to section XIII.A.1. of this proposed rule for a complete discussion of status indicators and our proposed status indicator changes for CY 2009.

While most conditionally packaged HCPCS codes are assigned to only one of the conditionally packaged categories described above, for CY 2009, we are proposing to assign one particular HCPCS code to two conditionally packaged categories. Specifically, we are proposing to treat CPT code 75635 (Computed tomographic angiography, abdominal aorta and bilateral iliofemoral lower extremity runoff, with contrast material(s), including noncontrast images, if performed, and image postprocessing) as both a ''T-packaged code'' and a component of composite APC 8006 (CT and CTA with Contrast Composite). We are proposing to assign this code status indicator ''Q2'' in Addendum B and ''Q3'' in Addendum M, to signify its dual treatment. For CY 2009, we are proposing to first assess whether CPT code 75635 would be packaged or separately payable, based on its status as a ''T-packaged code.'' If the service reported with CPT code 75635 would be separately payable due to the absence of another procedure on the claim with status indicator ''T'' for the same date of service, the code would then be assessed in the context of any other relevant imaging services reported on the claim for the same date of service to determine whether payment for CPT code 75635 under composite APC 8006 would be appropriate. If the criteria for payment of the code under composite APC 8006 are not met, then CPT code 75635 would be separately paid based on the proposed APC 0662 (CT Angiography) and its corresponding proposed payment rate displayed in Addendum B to this proposed rule.

b. Service-Specific Packaging Issues

(1) Packaged Services Addressed by APC Panel Recommendations

The Packaging Subcommittee of the APC Panel was established to review all packaged HCPCS codes. In deciding whether to package a service or pay for a code separately, we have historically considered a variety of factors, including whether the service is normally provided separately or in conjunction with other services; how likely it is for the costs of the packaged code to be appropriately mapped to the separately payable codes with which it was performed; and whether the expected cost of the service is relatively low. As discussed in section II.A.4.a. of this proposed rule regarding our packaging approach for CY 2008, we established packaging criteria that apply to seven categories of codes whose payments are packaged. Four of the APC Panel's packaging recommendations from its March 2008 meeting reference codes that are included in the seven categories of services that we packaged for CY 2008. For these four recommendations, we specifically applied the packaging considerations that apply to those seven categories of codes in determining whether a code should be proposed as packaged or separately payable for CY 2009. Specifically, we determined whether a service is a dependent service falling into one of the seven specified categories that is always or almost always provided integral to an independent service. For those two APC Panel recommendations that do not fit into any of the seven categories of services that were part of the CY 2008

packaging approach, we applied the packaging criteria noted above that were historically used under the OPPS. Moreover, we took into consideration our interest in possibly expanding the size of payment groups for component services to provide encounter-based or episode-of-care-based payment in the future in order to encourage hospital efficiency and provide hospitals with maximal flexibility to manage their resources.

The Packaging Subcommittee reviewed the packaging status of numerous HCPCS codes and reported its findings to the APC Panel at its March 2008 meeting. The APC Panel accepted the report of the Packaging Subcommittee, heard several presentations on certain packaged services, discussed the deliberations of the Packaging Subcommittee, and recommended that—

1. CMS provide additional data to support packaging radiation oncology guidance services for review by the Data Subcommittee at the next APC Panel meeting.

2. CPT code 36592 (Collection of blood specimen using established central or peripheral catheter, venous, not otherwise specified) be treated as an ''STVX-packaged code'' for CY 2009 and assigned to the same APC as CPT code 36591 (Collection of blood specimen from a completely implantable venous access device) until adequate data are collected that would enable CMS to determine its own payment rate.

3. HCPCS code A4306 (Disposable drug delivery system, flow rate of less than 50 mL per hour) remain packaged for CY 2009.

4. CPT code 74305 (Cholangiography and/or pancreatography; through existing catheter, radiological supervision and interpretation) be treated as a ''T-packaged code'' for CY 2009 and that CMS consider assigning this code to APC 0263 (Level I Miscellaneous Radiology Procedures).

5. CMS reinstate separate payment for the following intravascular ultrasound and intracardiac echocardiography codes: CPT codes 37250 (Intravascular ultrasound (non-coronary vessel) during diagnostic evaluation and/or therapeutic intervention; initial vessel); 37251 (Intravascular ultrasound (non-coronary vessel) during diagnostic evaluation and/or therapeutic intervention; each additional vessel); 92978 (Intravascular ultrasound (coronary vessel or graft) during diagnostic evaluation and/or therapeutic intervention including imaging supervision, interpretation and report; initial vessel); 92979 (Intravascular ultrasound (coronary vessel or graft) during diagnostic evaluation and/or therapeutic intervention including imaging supervision, interpretation and report; each additional vessel); and 93662 (Intracardiac echocardiography during therapeutic/diagnostic intervention, including imaging supervision and interpretation).

6. CMS continue to package diagnostic radiopharmaceuticals for CY 2009.

7. The Packaging Subcommittee continue its work.

We address each of these recommendations in turn in the discussion that follows.

Recommendation 1

In response to the APC Panel's recommendation, we are adopting the recommendation and will provide data related to radiation oncology guidance services to the Data Subcommittee at the next APC Panel meeting. For CY 2009, we are proposing to maintain the packaged status of radiation oncology guidance services. These services are ancillary and dependent in relation to the radiation therapy services with which they are most commonly furnished. Consistent with the principles of a prospective payment system, in some cases payment in an individual case exceeds the average cost, and in other cases payment is less than the average cost, but on balance, payment should approximate the relative cost of the average case. While we are aware that some of the radiation oncology guidance codes describe relatively new technologies, we do not believe that beneficiary access to care would be harmed by packaging payment for radiation oncology guidance services. We believe that packaging will create incentives for hospitals and their physician partners to work together to establish appropriate protocols that will eliminate unnecessary services where they exist and institutionalize approaches to providing necessary services more efficiently. Therefore, we see no basis for treating radiation oncology services differently from other guidance services that are ancillary and dependent to the procedures they facilitate.

Recommendation 2

For CY 2009, we are adopting the APC Panel recommendation and proposing to treat CPT code 36592 (Collection of blood specimen using established central or peripheral catheter, venous, not otherwise specified) as an ''STVX-packaged code'' and assigning it to APC 0624 (Phlebotomy and Minor Vascular Access Device Procedures), the same APC to which we are proposing to assign CPT 36591 code (Collection of blood specimen from a completely implantable venous access device).

CPT code 36592 became effective January 1, 2008, and was assigned interim status indicator ''N'' in the CY 2008 OPPS/ASC final rule with comment period. Several members of the public requested that we change the status of this code from unconditionally packaged to conditionally packaged, thereby paying it identically to CPT code 36591. CPT code 36591 also became effective January 1, 2008, and was assigned interim status indicator ''Q'' with treatment as an ''STVX-packaged code'' and assignment to APC 0624. CPT code 36591 was a direct replacement for CPT code 36540, which was deleted effective January 1, 2008, but was an ''STVX-packaged code'' with assignment to APC 0624 for CY 2007. These members of the public stated that the resource costs associated with drawing blood from an established central or peripheral catheter were almost identical to the resources associated with drawing blood from an implanted venous access device.

We agree that the resource costs associated with CPT code 36592 are likely similar to the resource costs associated with CPT code 36591. When cost data for CPT code 36592 are available for the CY 2010 OPPS annual update, we will reevaluate whether assignment to APC 0624 continues to be appropriate.

In summary, for CY 2009, we are proposing to change the packaged status of CPT code 36592 from unconditionally packaged to conditionally packaged, as an ''STVX-packaged code,'' which is parallel to the proposed treatment of CPT code 36591. This service would be paid separately when it is provided in an encounter without a service assigned status indicator ''S,'' ''T,'' ''V,'' or ''X.'' In all other circumstances, its payment would be packaged.

As noted above, for CY 2009, we are proposing to further refine our identification of the different types of conditionally packaged HCPCS codes that were previously all assigned status indicator ''Q'' (Packaged Services Subject to Separate Payment under OPPS Payment Criteria) under the OPPS. Therefore, we are proposing to assign status indicator''Q1'' to CPT code 36592 for CY 2009, which indicates that it is an ''STVX-packaged code.'' We refer readers to section XIII.A.1. for a complete discussion of status indicators and our proposed status indicator changes for CY 2009.

We note that we expect hospitals to follow the CPT guidance related to CPT

codes 36591 and 36592 regarding when these services should be appropriately reported.

Recommendation 3

For CY 2009, we are adopting the APC Panel's recommendation and proposing to maintain the packaged status of HCPCS code A4306 (Disposable drug delivery system, flow rate of less than 50 mL per hour).

HCPCS code A4306 describes a disposable drug delivery system with a flow rate of less than 50 mL per hour. Beginning in CY 2007, HCPCS code A4306 is payable under the OPPS with status indicator ''N,'' indicating that its payment is unconditionally packaged. We packaged this code because it is considered a supply, and under the OPPS it is standard to package payment for all supplies, including implantable and non-implantable supplies, into payment for the procedures in which the supplies are used. In March 2007, we first discussed this code with the APC Panel. A manufacturer noted in a presentation during the March 2007 APC Panel meeting that there is a particular disposable drug delivery system that is reported with HCPCS code A4306 that is specifically used to treat postoperative pain. The manufacturer requested that this code be moved to its own APC for CY 2008 so that the service could receive separate payment. During its September 2007 meeting, the APC Panel recommended that this code remain packaged for CY 2008 and asked CMS to present additional data to the APC Panel when available.

During the APC Panel's March 2008 meeting, we provided to the Packaging Subcommittee additional cost data related to this code. Our CY 2007 proposed rule claims data indicate that HCPCS code A4306 was billed on OPPS claims approximately 2,400 times, yielding a line-item median cost of approximately $4. The individual costs for this supply range from $4 per unit to $2,056 per unit. The Packaging Subcommittee suggested that this code may not always be correctly reported by hospitals as the data also show that this code was frequently billed together with computed tomography (CT) scans of various regions of the body, without surgical procedures on the same date of service. The APC Panel speculated that this code may be currently reported when other types of drug delivery devices are utilized for nonsurgical procedures or for purposes other than the treatment of postoperative pain. It was also noted that hospitals may actually be appropriately reporting HCPCS code A4306, which may be used to describe supplies used for purposes other than postoperative pain relief.

In summary, because HCPCS code A4306 represents a supply and payment of supplies is packaged under the OPPS according to longstanding policy, we are proposing to maintain the unconditionally packaged status of HCPCS code A4306 for CY 2009.

Recommendation 4

For CY 2009, we are adopting the APC Panel's recommendation and proposing to treat CPT code 74305 (Cholangiography and/or pancreatography; through existing catheter, radiological supervision and interpretation) as a ''T-packaged code'' and assign it to APC 0263 (Level I Miscellaneous Radiology Procedures).

Effective January 1, 2008, CPT code 74305 is unconditionally packaged and falls into the imaging supervision and interpretation category of codes that we created as part of the CY 2008 packaging approach. Several members of the public recently noted that CPT code 74305 may sometimes be provided in a single hospital encounter with CPT code 47505 (Injection procedure for cholangiography through an existing catheter (eg, percutaneous transepatic or T-tube)), which is unconditionally packaged itself, when these are the only two services reported on a claim. In the case where only these two services were performed, the hospital would receive no separate payment. Our claims data indicate that CPT code 74305 is infrequently provided without any other separately payable services on the same date of service.

Therefore, for CY 2009, we are proposing to change the packaged status of CPT code 74305 from unconditionally packaged to conditionally packaged, as a ''T-packaged code,'' which is parallel to the treatment of many other conditionally packaged imaging supervision and interpretation codes. Hospitals would receive separate payment for this service when it appears on a claim without a surgical procedure. The payment for this service would be packaged into payment for a status indicator ''T'' surgical procedure when it appears on the same date as a surgical procedure. Hospitals that furnish this imaging supervision and interpretation service on the same date as an independent surgical procedure assigned status indicator ''T'' must bill both services on the same claim.

As noted above, for CY 2009, we are proposing to further refine our identification of the different types of conditionally packaged HCPCS codes that were previously all assigned status indicator ''Q'' (Packaged Services Subject to Separate Payment under OPPS Payment Criteria) under the OPPS. Therefore, we are proposing to assign status indicator ''Q2'' to CPT code 74305 for CY 2009, which indicates that it is a ''T-packaged code.'' We refer readers to section XIII.A.1. for a complete discussion of status indicators and our proposed status indicator changes for CY 2009.

In summary, for CY 2009, we are proposing to change the status indicator for CPT code 74305 from ''N'' to ''Q2,'' with assignment to APC 0263 (Level I Miscellaneous Radiology Procedures) when it would be separately paid.

Recommendation 5

For CY 2009, we are proposing to maintain the packaged status of CPT codes 37250 (Intravascular ultrasound (non-coronary vessel) during diagnostic evaluation and/or therapeutic intervention; initial vessel); 37251 (Intravascular ultrasound (non-coronary vessel) during diagnostic evaluation and/or therapeutic intervention; each additional vessel); 92978 (Intravascular ultrasound (coronary vessel or graft) during diagnostic evaluation and/or therapeutic intervention including imaging supervision, interpretation and report; initial vessel); 92979 (Intravascular ultrasound (coronary vessel or graft) during diagnostic evaluation and/or therapeutic intervention including imaging supervision, interpretation and report; each additional vessel); and 93662 (Intracardiac echocardiography during therapeutic/diagnostic intervention, including imaging supervision and interpretation). We are not adopting the APC Panel's recommendation to pay separately for these intraoperative intravascular ultrasound (IVUS) and intracardiac echocardiography (ICE) services for CY 2009.

These services were newly packaged for CY 2008 because they were members of the intraoperative category of services that were included in the CY 2008 packaging approach. The intraoperative category includes those codes that are reported for supportive dependent diagnostic testing or other minor procedures performed during surgical or other independent procedures. Because these intraoperative IVUS and ICE services support the performance of an independent procedure and they are provided in the same operative session as the independent procedure, we packaged their payment into the OPPS payment for the independent procedure performed. We believe these IVUS and ICE services are always integral to and dependent upon the independent

services that they support and, therefore, we believe their payment would be appropriately packaged into the independent procedure.

A presenter at the March 2008 APC Panel meeting requested separate payment for these services, noting that they are high cost and provided with relatively low frequency compared to the services they typically accompany. We continue to believe that these services are ancillary and dependent in relation to the independent cardiac and vascular procedures with which they are most commonly furnished. We note that resource cost was not a factor we considered when deciding to package intraoperative services. Packaging payment for items and services that are directly related to performing a procedure, even when those packaged items and services have variable resource costs or different frequencies of use in relationship to one another or to the independent services into which their payment is packaged, has been a principle of the OPPS since the inception of that payment system. For example, once an implantable device is no longer eligible for device pass-through payment, our standard policy is to package the payment for the device into the payment for the procedures with which the device was reported. These former pass-through devices may be high or low cost in relationship to the other costs of the associated surgical procedures, or the devices may be implanted in a large or small proportion of those surgical procedures, but the device payment is nevertheless packaged. We do not believe that the fact that a procedure may be performed with assorted technologies of varying resource costs is a sufficient reason to pay separately for a particular technology that is clearly ancillary and dependent in relationship to independent associated procedures. We acknowledge that the costs associated with packaged services may contribute more or less to the median cost of the independent service, depending on how often the dependent service is billed with the independent service. Consistent with the principles of a prospective payment system, in some cases payment in an individual case exceeds the average cost, and in other cases payment is less than the average cost, but on balance, payment should approximate the relative cost of the average case. While we understand that these services represent technologies that are not commonly used in most institutions, we do not believe that beneficiary access to care would be harmed by packaging payment for IVUS and ICE services. We note that IVUS and ICE services are existing, established technologies and that hospitals have provided some of these services in the HOPD since the implementation of the OPPS in CY 2000. We believe that packaging will create incentives for hospitals and their physician partners to work together to establish appropriate protocols that will eliminate unnecessary services where they exist and institutionalize approaches to providing necessary services more efficiently. Therefore, we see no basis for treating IVUS and ICE services differently from other intraoperative services that are ancillary and dependent to the procedure they facilitate.

In summary, we are proposing to maintain the unconditionally packaged status of CPT codes 37250, 37251, 92978, 92979, and 93662 for CY 2009.

Recommendation 6

For CY 2009, we are adopting the APC Panel recommendation and proposing to maintain the packaged status of diagnostic radiopharmaceuticals. This recommendation is discussed in detail in section V.B.2.b. of this proposed rule.

Recommendation 7

In response to the APC Panel's recommendation for the Packaging Subcommittee to remain active until the next APC Panel meeting, we note that the APC Panel Packaging Subcommittee remains active, and additional issues and new data concerning the packaging status of codes will be shared for its consideration as information becomes available. We continue to encourage submission of common clinical scenarios involving currently packaged HCPCS codes to the Packaging Subcommittee for its ongoing review, and we also encourage recommendations of specific services or procedures whose payment would be most appropriately packaged under the OPPS. Additional detailed suggestions for the Packaging Subcommittee should be submitted by e-mail to *APCPanel@cms.hhs.gov* with Packaging Subcommittee in the subject line.

(2) IVIG Preadministration-Related Services

We are proposing to package payment for HCPCS code G0332 (Services for intravenous infusion of immunoglobulin prior to administration (this service is to be billed in conjunction with administration of immunoglobulin)) for CY 2009. Immune globulin is a complicated biological product that is developed from human plasma obtained from human plasma donors. Its purification is a complex process that occurs along a very long timeline and, therefore, only a small number of manufacturers provide commercially available products. In past years, there have been issues reported with the supply of intravenous immune globulin (IVIG) due to numerous factors, including decreased manufacturing capacity, increased usage, more sophisticated processing steps, and low demand for byproducts from IVIG fractionation.

Under the OPPS, the current CY 2008 payment methodology for IVIG treatments consists of three components, which include payment for the drug itself (described by a HCPCS J-code), administration of the IVIG product (described by one or more CPT codes), and the preadministration-related services (HCPCS code G0332). The CY 2009 proposed OPPS payment rates for IVIG products are established based on the Part B ASP drug methodology, as discussed further in section V.B.3. of this proposed rule. Under the OPPS, payment is made separately for the administration of IVIG and those services are reported using the CPT code for the first hour and, as needed, additional hour CPT infusion codes. The CY 2009 proposed OPPS payments for drug administration services are discussed in section VIII.B. of this proposed rule. As explained in detail in the CY 2006 OPPS, CY 2007 OPPS/ASC, and CY 2008 OPPS/ASC final rules with comment period (70 FR 68648 to 68650, 71 FR 68092 to 68093, and 72 FR 66697 to 66698, respectively), we temporarily paid separately for the IVIG preadministration-related services in CY 2006 through CY 2008 because of reported instability in the IVIG marketplace due, in part, to the implementation of the new ASP payment methodology for IVIG drugs. Under the CY 2006 and CY 2007 OPPS, HCPCS code G0332 was assigned to New Technology APC 1502 (New Technology—Level II ($50–$100)), with a payment rate of $75. For CY 2008, HCPCS code G0332 was reassigned to APC 0430 (Drug Preadministration-Related Services), with a payment rate of approximately $38 set prospectively based on robust CY 2006 claims data for this code. In addition, a separate payment for HCPCS code G0332 has been made under the MPFS during the same time period, CY 2006 to CY 2008.

We specifically indicated in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66697 through 66698) that we would consider packaging payment for HCPCS code G0332 in future years and that we intended to reevaluate the

appropriateness of separate payment for IVIG preadministration-related services for the CY 2009 OPPS rulemaking cycle, especially as we explore the potential for greater packaging under the OPPS. We note that the Office of the Inspector General's (OIG's) study on the availability and pricing of IVIG published in a report in April 2007 entitled, ''Intravenous Immune Globulin: Medicare Payment and Availability (OEI–03–05–00404),'' found that for the third quarter of CY 2006, just over half of the IVIG sales to hospitals and physicians were at prices below Medicare payment amounts. Relative to the previous three quarters, this represented a substantial increase in the percentage of sales with prices below Medicare amounts. We have reviewed national claims data for IVIG drug utilization, as well as utilization of the preadministration-related services HCPCS code. These data show modest increases in the utilization of IVIG drugs and the preadministration-related services code, which suggest that IVIG pricing and access may be improving.

IVIG preadministration-related services are dependent services that are always provided in conjunction with other separately payable services, such as drug administration services, and thus are well suited for packaging into the payment for the separately payable services that they usually accompany. The recent findings of the OIG report suggest that stability in the IVIG market had improved in late CY 2006. No other comprehensive studies have been presented to indicate continued instability in market conditions or systematic problems with patient access. In addition, beginning July 1, 2007, six new HCPCS codes for specific IVIG products were adopted to implement separate payment for these products, contributing to generally increased payments for IVIG products and, we believe, improved market stability. Therefore, consistent with our OPPS payment policy for the facility resources expended to prepare for the administration of all other drugs and biologicals under the OPPS, we now believe that payment for the hospital resources required to locate and obtain the appropriate IVIG products and to schedule patients' infusions should be made through the OPPS payment for the associated drug administration services. Furthermore, the cost data that we have gathered for the services described by HCPCS code G0332 since CY 2006, including the line-item median cost for the code of approximately $38 from CY 2007 claims data, indicate that the cost of the services is relatively low. Therefore, because HCPCS code G0332 meets our historical criteria for packaged payment, because we paid separately for these services on a temporary basis only, and because we believe that the reported transient market conditions that led us to adopt the separate payment for IVIG preadministration-related services have improved, we now believe that packaged payment is more appropriate for the CY 2009 OPPS, consistent with our ongoing efforts to expand the size of the OPPS payment bundles. Therefore, we are proposing to assign status indicator ''N'' to HCPCS code G0332 for CY 2009. We will continue to work with stakeholders of the IVIG industry to understand their concerns regarding the pricing of IVIG and Medicare beneficiary access to this important therapy.

The treatment of these services under the MPFS will be addressed separately in the CY 2009 MPFS proposed rule.

B. Proposed Conversion Factor Update

Section 1833(t)(3)(C)(ii) of the Act requires us to update the conversion factor used to determine payment rates under the OPPS on an annual basis. Section 1833(t)(3)(C)(iv) of the Act provides that, for CY 2009, the update is equal to the hospital inpatient market basket percentage increase applicable to hospital discharges under section 1886(b)(3)(B)(iii) of the Act. The proposed hospital market basket increase for FY 2009 published in the IPPS proposed rule on April 30, 2008 is 3.0 percent (73 FR 23708). To set the proposed OPPS conversion factor for CY 2009, we increased the CY 2008 conversion factor of $63.694, as specified in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66677), by 3.0 percent. Hospitals that fail to meet the reporting requirements of the Hospital Outpatient Quality Data Reporting (HOP QDRP) program are subject to a reduction of 2.0 percentage points from the market basket update to the conversion factor. For a complete discussion of the HOP QDRP program, we refer readers to section XVI. of this proposed rule.

In accordance with section 1833(t)(9)(B) of the Act, we further adjust the conversion factor annually to ensure that any revisions we are proposing to our updates for a revised wage index and rural adjustment are made on a budget neutral basis. We calculated an overall budget neutrality factor of 1.0010 for wage index changes by comparing total payments from our simulation model using the FY 2009 IPPS proposed wage index values to those payments using the current (FY 2008) IPPS wage index values. For CY 2009, we are not proposing a change to our rural adjustment policy. Therefore, the budget neutrality factor for the rural adjustment is 1.000.

For CY 2009, in this proposed rule, we estimate that allowed pass-through spending for both drugs and biologicals and devices would equal approximately $19 million, which represents 0.07 percent of total projected OPPS spending for CY 2009. Therefore, the conversion factor was also adjusted by the difference between the 0.09 percent pass-through dollars set aside for CY 2008 and the 0.07 percent estimate for CY 2009 pass-through spending. Finally, proposed payments for outliers remain at 1.0 percent of total OPPS payments for CY 2009.

The proposed market basket increase update factor of 3.0 percent for CY 2009, the required wage index budget neutrality adjustment of approximately 1.0010, and the proposed adjustment of 0.02 percent of projected OPPS spending for the difference in the pass-through set aside result in a proposed full market basket conversion factor for CY 2009 of $65.684. To calculate the CY 2009 reduced market basket conversion factor for those hospitals that fail to meet the requirements of the HOP QDRP for the full CY 2009 payment update, we made all other adjustments discussed above, but used a reduced market basket increase update factor of 1.0 percent. This results in a proposed reduced market basket conversion factor for CY 2009 of $64.409.

C. Proposed Wage Index Changes

Section 1833(t)(2)(D) of the Act requires the Secretary to determine a wage adjustment factor to adjust, for geographic wage differences, the portion of the OPPS payment rate, which includes the copayment standardized amount, that is attributable to labor and labor-related cost. This adjustment must be made in a budget neutral manner and budget neutrality is discussed in section II.B. of this proposed rule.

The OPPS labor-related share is 60 percent of the national OPPS payment. This labor-related share is based on a regression analysis that determined that approximately 60 percent of the costs of services paid under the OPPS were attributable to wage costs. We confirmed that this labor-related share for outpatient services is still appropriate during our regression analysis for the payment adjustment for rural hospitals in the CY 2006 OPPS final rule with comment period (70 FR 68553). Therefore, we are not proposing to revise this policy for the CY 2009 OPPS. We refer readers to section II.G. of this

proposed rule for a description and example of how the wage index for a particular hospital is used to determine the payment for the hospital.

As discussed in section II.A.2.c. of this proposed rule, for estimating national median APC costs, we standardize 60 percent of estimated claims costs for geographic area wage variation using the same FY 2009 pre-reclassified wage indices that the IPPS uses to standardize costs. This standardization process removes the effects of differences in area wage levels from the determination of a national unadjusted OPPS payment rate and the copayment amount.

As published in the original OPPS April 7, 2000 final rule with comment period (65 FR 18545), the OPPS has consistently adopted the final IPPS wage indices as the wage indices for adjusting the OPPS standard payment amounts for labor market differences. Thus, the wage index that applies to a particular acute short-stay hospital under the IPPS will also apply to that hospital under the OPPS. As initially explained in the September 8, 1998 OPPS proposed rule, we believed and continue to believe that using the IPPS wage index as the source of an adjustment factor for the OPPS is reasonable and logical, given the inseparable, subordinate status of the HOPD within the hospital overall. In accordance with section 1886(d)(3)(E) of the Act, the IPPS wage index is updated annually. Therefore, in accordance with our established policy, we are proposing to use the final FY 2009 version of the IPPS wage indices used to pay IPPS hospitals to adjust the CY 2009 OPPS payment rates and copayment amounts for geographic differences in labor cost for all providers that participate in the OPPS, including providers that are not paid under the IPPS (referred to in this section as ''non-IPPS'' providers).

We note that the proposed FY 2009 IPPS wage indices continue to reflect a number of adjustments implemented over the past few years, including revised Office of Management and Budget (OMB) standards for defining geographic statistical areas (Core Based Statistical Areas or CBSAs), reclassification to different geographic areas, rural floor provisions and the accompanying budget neutrality adjustment, an adjustment for out-migration labor patterns, an adjustment for occupational mix, and a policy for allocating hourly wage data among campuses of multicampus hospital systems that cross CBSAs. In addition, our proposed changes to the FY 2009 IPPS wage index also included a revision of the reclassification average hourly wage comparison criteria and a state-level rural floor and imputed floor budget neutrality adjustment applied to the wage index. We refer readers to the FY 2009 IPPS proposed rule (73 FR 23617 through 23639) for a detailed discussion of these proposed changes to the wage index. In addition, we refer readers to the CY 2005 OPPS final rule with comment period (69 FR 65842 through 65844) and subsequent OPPS rules for a detailed discussion of the history of these wage index adjustments as applied under the OPPS.

The IPPS wage index that we are proposing to adopt includes all reclassifications that are approved by the Medicare Geographic Classification Review Board (MGCRB) for FY 2009. We note that reclassifications under section 508 of Pub. L. 108–173 were extended by section 106(a) of the MIEA–TRHCA and were set to terminate September 30, 2007. However, section 117(a)(1) of the Medicare, Medicaid, and SCHIP Extension Act (MMSEA) of 2007 (Pub. L. 110–173) further extended geographic reclassifications under section 508 until September 30, 2008. In addition, section 117(a)(2) of the MMSEA extended certain special exception reclassifications as well. On February 22, 2008, we published a notice in the **Federal Register** (73 FR 9807) that indicated how we are implementing section 117(a) of the MMSEA under the IPPS. We also issued a joint signature memorandum on January 28, 2008, that explained how section 117 of the MMSEA would apply to the OPPS. As we stated in that memorandum, while most of the reclassifications extended by the MMSEA would expire September 30, 2008, for both the IPPS and the OPPS (with OPPS hospitals reverting to a previous reclassification or home area wage index from October 1, 2008, to December 31, 2008), special exception wage indices for certain hospitals would be extended through December 31, 2008, under the OPPS in order to give these hospitals the special exception wage index under the OPPS for the same time period as under the IPPS. Because the MMSEA provisions expire in 2008, and are not applicable to FY 2009, we are not making any proposals related to those provisions for the OPPS wage index for CY 2009.

For purposes of the OPPS, we are proposing to continue our policy in CY 2009 to allow non-IPPS hospitals paid under the OPPS to qualify for the out-migration adjustment if they are located in a section 505 out-migration county. We note that because non-IPPS hospitals cannot reclassify, they are eligible for the out-migration wage adjustment. Table 4J published in the Addendum to the FY 2009 IPPS proposed rule identifies counties eligible for the out-migration adjustment and providers receiving the adjustment. As we have done in prior years, we are reprinting the Table 4J, as Addendum L to this proposed rule, with the addition of non-IPPS hospitals that would receive the section 505 out-migration adjustment under the CY 2009 OPPS.

As stated earlier in this section, we continue to believe that using the IPPS wage index as the source of an adjustment factor for the OPPS is reasonable and logical, given the inseparable, subordinate status of the HOPD within the hospital overall. Therefore, we are proposing to use the final FY 2009 IPPS wage indices for calculating the OPPS payments in CY 2009. With the exception of the out-migration wage adjustment table (Addendum L to this proposed rule), which includes non-IPPS hospitals paid under the OPPS, we are not reprinting the proposed FY 2009 IPPS wage indices referenced in this discussion of the wage index. We refer readers to the CMS Web site for the OPPS at: *http://www.cms.hhs.gov/providers/hopps.* At this link, the reader will find a link to the proposed FY 2009 IPPS wage indices tables.

D. Proposed Statewide Average Default CCRs

CMS uses CCRs to determine outlier payments, payments for pass-through devices, and monthly interim transitional corridor payments under the OPPS. Some hospitals do not have a CCR because there is no cost report available. For these hospitals, CMS uses the statewide average default CCRs to determine the payments mentioned above until a hospital's Medicare contractor is able to calculate the hospital's actual CCR from its most recently submitted Medicare cost report. These hospitals include, but are not limited to, hospitals that are new, have not accepted assignment of an existing hospital's provider agreement, and have not yet submitted a cost report. CMS also uses the statewide average default CCRs to determine payments for hospitals that appear to have a biased CCR, that is, the CCR falls outside predetermined floor and ceiling thresholds for a valid CCR, or for hospitals whose most recent cost report reflects an all-inclusive rate status (Section 10.11, Chapter 4, Medicare Claims Processing Manual Pub. 100–04). In this proposed rule, we are proposing to update the default ratios for CY 2009 using the most recent cost report data, and we are proposing to codify our

policies for using the default ratios for hospitals that do not have a CCR for outlier payments specifically. We refer readers to section II.F. of this proposed rule where we discuss this proposal for default CCRs as part of our broader proposal to implement an outlier reconciliation process similar to that implemented under the IPPS.

For CY 2009, we used our standard methodology of calculating the statewide default CCRs using the same hospital overall CCRs that we use to adjust charges to costs on claims data. Table 9 lists the proposed CY 2009 default urban and rural CCRs by State and compares them to last year's default CCRs. These CCRs are the ratio of total costs to total charges from each provider's most recently submitted cost report, for those cost centers relevant to outpatient services weighted by Medicare Part B charges. We also adjusted ratios from submitted cost reports to reflect final settled status by applying the differential between settled to submitted costs and charges from the most recent pair of final settled and submitted cost reports. We then weighted each hospital's CCR by claims volume corresponding to the year of the majority of cost reports used to calculate the overall CCR. We refer readers to section II.E. of the CY 2008 OPPS/ASC final rule with comment period (72 FR 66680 through 66682) and prior OPPS rules for a more detailed discussion of our established methodology for calculating the statewide average default CCRs, including the hospitals used in our calculations and trimming criteria.

For this proposed rule, approximately 38 percent of the submitted cost reports represented data for cost reporting periods ending in CY 2005 and 60 percent were for cost reporting periods ending in CY 2006. Table 9 lists the proposed CY 2009 default urban and rural CCRs by State and compares them to last year's default CCRs. For Maryland, we used an overall weighted average CCR for all hospitals in the nation as a substitute for Maryland CCRs. Few providers in Maryland are eligible to receive payment under the OPPS, which limits the data available to calculate an accurate and representative CCR. In general, observed changes between CY 2008 and CY 2009 are modest and the few significant changes are associated with a small number of hospitals. The national urban and rural CCRs observed for Maryland changed by less than 1 percent.

TABLE 9.—PROPOSED CY 2009 STATEWIDE AVERAGE CCRS

State	Urban/rural	Proposed CY 2009 default CCR	Previous default CCR (CY 2008 OPPS final rule)
ALASKA	RURAL	0.562	0.537
ALASKA	URBAN	0.351	0.351
ALABAMA	RURAL	0.223	0.228
ALABAMA	URBAN	0.210	0.213
ARKANSAS	RURAL	0.258	0.266
ARKANSAS	URBAN	0.276	0.270
ARIZONA	RURAL	0.269	0.264
ARIZONA	URBAN	0.232	0.232
CALIFORNIA	RURAL	0.223	0.232
CALIFORNIA	URBAN	0.221	0.218
COLORADO	RURAL	0.355	0.355
COLORADO	URBAN	0.251	0.254
CONNECTICUT	RURAL	0.394	0.391
CONNECTICUT	URBAN	0.337	0.339
DISTRICT OF COLUMBIA	URBAN	0.329	0.346
DELAWARE	RURAL	0.298	0.302
DELAWARE	URBAN	0.368	0.400
FLORIDA	RURAL	0.212	0.219
FLORIDA	URBAN	0.194	0.198
GEORGIA	RURAL	0.273	0.279
GEORGIA	URBAN	0.262	0.269
HAWAII	RURAL	0.371	0.373
HAWAII	URBAN	0.345	0.317
IOWA	RURAL	0.346	0.349
IOWA	URBAN	0.317	0.325
IDAHO	RURAL	0.434	0.445
IDAHO	URBAN	0.419	0.414
ILLINOIS	RURAL	0.286	0.286
ILLINOIS	URBAN	0.272	0.271
INDIANA	RURAL	0.306	0.313
INDIANA	URBAN	0.299	0.301
KANSAS	RURAL	0.317	0.318
KANSAS	URBAN	0.241	0.240
KENTUCKY	RURAL	0.240	0.244
KENTUCKY	URBAN	0.264	0.262
LOUISIANA	RURAL	0.280	0.271
LOUISIANA	URBAN	0.268	0.277
MARYLAND	RURAL	0.307	0.308
MARYLAND	URBAN	0.283	0.284
MASSACHUSETTS	URBAN	0.342	0.338
MAINE	RURAL	0.445	0.433
MAINE	URBAN	0.425	0.424
MICHIGAN	RURAL	0.326	0.331

TABLE 9.—PROPOSED CY 2009 STATEWIDE AVERAGE CCRS—Continued

State	Urban/rural	Proposed CY 2009 default CCR	Previous default CCR (CY 2008 OPPS final rule)
MICHIGAN	URBAN	0.328	0.318
MINNESOTA	RURAL	0.497	0.499
MINNESOTA	URBAN	0.340	0.342
MISSOURI	RURAL	0.277	0.289
MISSOURI	URBAN	0.282	0.292
MISSISSIPPI	RURAL	0.265	0.267
MISSISSIPPI	URBAN	0.216	0.217
MONTANA	RURAL	0.444	0.453
MONTANA	URBAN	0.452	0.450
NORTH CAROLINA	RURAL	0.284	0.286
NORTH CAROLINA	URBAN	0.305	0.321
NORTH DAKOTA	RURAL	0.363	0.379
NORTH DAKOTA	URBAN	0.357	0.378
NEBRASKA	RURAL	0.345	0.347
NEBRASKA	URBAN	0.292	0.290
NEW HAMPSHIRE	RURAL	0.374	0.375
NEW HAMPSHIRE	URBAN	0.311	0.337
NEW JERSEY	URBAN	0.272	0.276
NEW MEXICO	RURAL	0.270	0.275
NEW MEXICO	URBAN	0.344	0.353
NEVADA	RURAL	0.311	0.329
NEVADA	URBAN	0.200	0.200
NEW YORK	RURAL	0.414	0.417
NEW YORK	URBAN	0.396	0.402
OHIO	RURAL	0.359	0.354
OHIO	URBAN	0.263	0.268
OKLAHOMA	RURAL	0.279	0.288
OKLAHOMA	URBAN	0.241	0.245
OREGON	RURAL	0.320	0.321
OREGON	URBAN	0.374	0.366
PENNSYLVANIA	RURAL	0.285	0.298
PENNSYLVANIA	URBAN	0.232	0.241
PUERTO RICO	URBAN	0.514	0.474
RHODE ISLAND	URBAN	0.295	0.308
SOUTH CAROLINA	RURAL	0.260	0.258
SOUTH CAROLINA	URBAN	0.245	0.244
SOUTH DAKOTA	RURAL	0.333	0.334
SOUTH DAKOTA	URBAN	0.269	0.289
TENNESSEE	RURAL	0.253	0.256
TENNESSEE	URBAN	0.229	0.241
TEXAS	RURAL	0.268	0.271
TEXAS	URBAN	0.246	0.242
UTAH	RURAL	0.417	0.416
UTAH	URBAN	0.433	0.406
VIRGINIA	RURAL	0.268	0.268
VIRGINIA	URBAN	0.275	0.275
VERMONT	RURAL	0.409	0.416
VERMONT	URBAN	0.408	0.340
WASHINGTON	RURAL	0.357	0.358
WASHINGTON	URBAN	0.360	0.368
WISCONSIN	RURAL	0.399	0.384
WISCONSIN	URBAN	0.357	0.362
WEST VIRGINIA	RURAL	0.295	0.298
WEST VIRGINIA	URBAN	0.361	0.360
WYOMING	RURAL	0.421	0.449
WYOMING	URBAN	0.333	0.351

E. Proposed OPPS Payment to Certain Rural Hospitals

1. Hold Harmless Transitional Payment Changes Made by Pub. L. 109–171 (DRA)

When the OPPS was implemented, every provider was eligible to receive an additional payment adjustment (called either transitional corridor payment or transitional outpatient payment) if the payments it received for covered outpatient department (OPD) services under the OPPS were less than the payments it would have received for the same services under the prior reasonable cost-based system. Section 1833(t)(7) of the Act provides that the transitional corridor payments are temporary payments for most providers to ease their transition from the prior reasonable cost-based payment system to the OPPS system. There are two exceptions, cancer hospitals and

children's hospitals, to this provision and those hospitals receive the transitional corridor payments on a permanent basis. Section 1833(t)(7)(D)(i) of the Act originally provided for transitional corridor payments to rural hospitals with 100 or fewer beds for covered OPD services furnished before January 1, 2004. However, section 411 of Pub. L. 108–173 amended section 1833(t)(7)(D)(i) of the Act to extend these payments through December 31, 2005, for rural hospitals with 100 or fewer beds. Section 411 also extended the transitional corridor payments to sole community hospitals (SCHs) located in rural areas for services furnished during the period that begins with the provider's first cost reporting period beginning on or after January 1, 2004, and ended on December 31, 2005. Accordingly, the authority for making transitional corridor payments under section 1833(t)(7)(D)(i) of the Act, as amended by section 411 of Pub. L. 108–173, for rural hospitals having 100 or fewer beds and SCHs located in rural areas expired on December 31, 2005.

Section 5105 of Pub. L. 109–171 reinstituted the hold harmless transitional outpatient payments (TOPs) for covered OPD services furnished on or after January 1, 2006, and before January 1, 2009, for rural hospitals having 100 or fewer beds that are not SCHs. When the OPPS payment is less than the payment the provider would have received under the previous reasonable cost-based system, the amount of payment is increased by 95 percent of the amount of the difference between the two payment systems for CY 2006, by 90 percent of the amount of that difference for CY 2007, and by 85 percent of the amount of that difference for CY 2008.

For CY 2006, we implemented section 5105 of Pub. L. 109–171 through Transmittal 877, issued on February 24, 2006. We did not specifically address whether TOPs apply to essential access community hospitals (EACHs), which are considered to be SCHs under section 1886(d)(5)(D)(iii)(III) of the Act. Accordingly, under the statute, EACHs are treated as SCHs. Therefore, we believed and continue to believe that EACHs are not currently eligible for TOPs under Pub. L. 109–171. However, they are eligible for the adjustment for rural SCHs. In the CY 2007 OPPS/ASC final rule with comment period (71 FR 68010 and 68228), we updated § 419.70(d) to reflect the requirements of Pub. L. 109–171.

Effective for services provided on or after January 1, 2009, rural hospitals having 100 or fewer beds that are not SCHs will no longer be eligible for hold harmless TOPs, in accordance with section 5105 of Pub. L. 109–171.

2. Proposed Adjustment for Rural SCHs Implemented in CY 2006 Related to Pub. L. 108–173 (MMA)

In the CY 2006 OPPS final rule with comment period (70 FR 68556), we finalized a payment increase for rural SCHs of 7.1 percent for all services and procedures paid under the OPPS, excluding drugs, biologicals, brachytherapy seeds, and services paid under pass-through payment policy in accordance with section 1833(t)(13)(B) of the Act, as added by section 411 of Pub. L. 108–173. Section 411 gave the Secretary the authority to make an adjustment to OPPS payments for rural hospitals, effective January 1, 2006, if justified by a study of the difference in costs by APC between hospitals in rural and urban areas. Our analysis showed a difference in costs for rural SCHs. Therefore, we implemented a payment adjustment for only those hospitals beginning January 1, 2006.

In CY 2007, we became aware that we did not specifically address whether the adjustment applies to EACHs, which are considered to be SCHs under section 1886(d)(5)(D)(iii)(III) of the Act. Thus, under the statute, EACHs are treated as SCHs. Therefore, in the CY 2007 OPPS/ASC final rule with comment period (71 FR 68010 and 68227), for purposes of receiving this rural adjustment, we revised § 419.43(g) to clarify that EACHs are also eligible to receive the rural SCH adjustment, assuming these entities otherwise meet the rural adjustment criteria. Currently, fewer than 10 hospitals are classified as EACHs and as of CY 1998, under section 4201(c) of Pub. L. 105–33, a hospital can no longer become newly classified as an EACH.

This adjustment for rural SCHs is budget neutral and applied before calculating outliers and copayment. As stated in the CY 2006 OPPS final rule with comment period (70 FR 68560), we would not reestablish the adjustment amount on an annual basis, but we note that we may review the adjustment in the future and, if appropriate, would revise the adjustment.

For CY 2009, we are proposing to continue our current policy of a budget neutral 7.1 percent payment increase for rural SCHs, including EACHs, for all services and procedures paid under the OPPS, excluding drugs, biologicals, and services paid under the pass-through payment policy in accordance with section 1833(t)(13)(B) of the Act. This adjustment is in accordance with section 411 of the MMA, which gave the Secretary the authority to make an adjustment to OPPS payments for rural hospitals, if justified by a study of the difference in costs by APC between hospitals in rural and urban areas. Our past analysis showed a difference in costs only for rural SCHs, and we implemented a payment adjustment for those hospitals beginning January 1, 2006. For CY 2009, we also are proposing to continue to include brachytherapy sources in the group of services eligible for the 7.1 percent payment increase because we are proposing to pay them at prospective rates based on their median costs as calculated from historical claims data. We intend to reassess the 7.1 percent adjustment in the near future by examining differences between urban and rural hospitals' costs using updated claims, cost, and provider information. In that process, we will include brachytherapy sources in each hospital's mix of services.

F. Proposed Hospital Outpatient Outlier Payments

1. Background

Currently, the OPPS pays outlier payments on a service-by-service basis. For CY 2008, the outlier threshold is met when the cost of furnishing a service or procedure by a hospital exceeds 1.75 times the APC payment amount and exceeds the APC payment rate plus a $1,575 fixed-dollar threshold. We introduced a fixed-dollar threshold in CY 2005 in addition to the traditional multiple threshold in order to better target outliers to those high cost and complex procedures where a very costly service could present a hospital with significant financial loss. If a hospital meets both of these conditions, the multiple threshold and the fixed-dollar threshold, the outlier payment is calculated as 50 percent of the amount by which the cost of furnishing the service exceeds 1.75 times the APC payment rate. This outlier payment has historically been considered a final payment by longstanding OPPS policy.

It has been our policy for the past several years to report the actual amount of outlier payments as a percent of total spending in the claims being used to model the proposed OPPS. An accounting error for CY 2005, CY 2006, and CY 2007 inflated CMS' estimates of OPPS expenditures, which led us to underestimate outlier payment as a percentage of total OPPS spending in prior rules. Total OPPS expenditures have been revised downward, and we have accordingly revised our outlier payment estimates. We further note that the CY 2005 outlier payment estimate included in the CY 2007 OPPS/ASC

final rule with comment period (71 FR 68010) has not changed based on revised spending estimates. However, we previously stated that CY 2006 outlier payment was equal to 1.1 percent of OPPS expenditures for CY 2006 (72 FR 66685), but based on our revised numbers, actual outlier payments are equal to approximately 1.3 percent of CY 2006 OPPS expenditures. Our current estimate of total outlier payments as a percent of total CY 2007 OPPS payment, using available CY 2007 claims and the revised OPPS expenditure estimate, is approximately 0.9 percent. For CY 2007, the estimated outlier payment was set at 1.0 percent of the total aggregated OPPS payments. Therefore, for CY 2007 we estimate that we paid approximately 0.1 percent less than the CY 2007 outlier target of 1.0 percent of total aggregated OPPS payments. We will update our estimate of CY 2007 outlier spending in the CY 2009 OPPS/ASC final rule with comment period.

As explained in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66685), we set our projected target for aggregate outlier payments at 1.0 percent of aggregate total payments under the OPPS for CY 2008. The outlier thresholds were set so that estimated CY 2008 aggregate outlier payments would equal 1.0 percent of aggregate total payments under the OPPS. Using the same set of CY 2007 claims and CY 2008 payment rates, we currently estimate that outlier payments for CY 2008 would be approximately 0.8 percent of total CY 2008 OPPS payments. The difference between 1.0 percent and 0.8 percent is reflected in the regulatory impact analysis in section XXI.B. of this proposed rule. We note that we provide estimated CY 2009 outlier payments for hospitals and CMHCs with claims included in the claims data that we used to model impacts on the CMS Web site in the Hospital-Specific Impacts—Provider-Specific Data file on the CMS Web site at: *http://www.cms.hhs.gov/HospitalOutpatientPPS/*.

2. Proposed Outlier Calculation

For CY 2009, we are proposing to continue our policy of setting aside 1.0 percent of aggregate total payments under the OPPS for outlier payments. We are proposing that a portion of that 1.0 percent, specifically 0.07 percent, would be allocated to CMHCs for partial hospitalization program outlier payments. This is the amount of estimated outlier payments that would result from the proposed CMHC outlier threshold of 3.40 times the CY 2009 PHP APC payment rates, as a proportion of all payments dedicated to outlier payments. For further discussion of CMHC outlier payments, we refer readers to section X.B.4. of this proposed rule.

To ensure that estimated CY 2009 aggregate outlier payments would equal 1.0 percent of estimated aggregate total payments under the OPPS, we are proposing that the hospital outlier threshold be set so that outlier payments would be triggered when the cost of furnishing a service or procedure by a hospital exceeds 1.75 times the APC payment amount and exceeds the APC payment rate plus an $1,800 fixed-dollar threshold. This proposed threshold reflects the methodology discussed below, as well as proposed APC recalibration for CY 2009.

We calculated the fixed-dollar threshold for this proposed rule using largely the same methodology as we did in CY 2008. For purposes of estimating outlier payments for this proposed rule, we used the CCRs available in the April 2008 update to the OPSF.

The claims that we use to model each OPPS update lag by 2 years. For this proposed rule, we used CY 2007 claims to model the CY 2009 OPPS. In order to estimate CY 2009 hospital outlier payments for this proposed rule, we inflated the charges on the CY 2007 claims using the same inflation factor of 1.1204 that we used to estimate the IPPS fixed-dollar outlier threshold for the FY 2009 IPPS proposed rule. For 1 year, the inflation factor is 1.0585. The methodology for determining this charge inflation factor was discussed in the FY 2009 IPPS proposed rule (73 FR 23710 through 23711). As we stated in the CY 2005 OPPS final rule with comment period (69 FR 65845), we believe that the use of this charge inflation factor is appropriate for the OPPS because, with the exception of the routine service cost centers, hospitals use the same cost centers to capture costs and charges across inpatient and outpatient services.

As noted in the CY 2007 OPPS/ASC final rule with comment period (71 FR 68011), we are concerned that we may systematically overestimate the OPPS hospital outlier threshold if we did not apply a CCR inflation adjustment factor. Therefore, we are proposing to apply the same CCR inflation adjustment factor that we proposed to apply for the FY 2009 IPPS outlier calculation to the CCRs used to simulate the CY 2009 OPPS outlier payments that determined the fixed-dollar threshold. Specifically, for CY 2009, we are proposing to apply an adjustment of 0.9920 to the CCRs that are currently in the April 2008 OPSF to trend them forward from CY 2008 to CY 2009. The methodology for calculating this adjustment is discussed in the FY 2009 IPPS proposed rule (73 FR 23710 through 23711).

Therefore, to model hospital outliers for this proposed rule, we applied the overall CCRs from the April 2008 OPSF file after adjustment (using the proposed CCR inflation adjustment factor of 0.9920 to approximate CY 2009 CCRs) to charges on CY 2007 claims that were adjusted (using the proposed charge inflation factor of 1.1204 to approximate CY 2009 charges). We simulated aggregated CY 2009 hospital outlier payments using these costs for several different fixed-dollar thresholds, holding the 1.75 multiple constant and assuming that outlier payment would continue to be made at 50 percent of the amount by which the cost of furnishing the service would exceed 1.75 times the APC payment amount, until the total outlier payments equaled 1.0 percent of aggregated estimated total CY 2009 OPPS payments. We estimate that a proposed fixed-dollar threshold of $1,800, combined with the proposed multiple threshold of 1.75 times the APC payment rate, would allocate 1.0 percent of aggregated total OPPS payments to outlier payments. We are proposing to continue to make an outlier payment that equals 50 percent of the amount by which the cost of furnishing the service exceeds 1.75 times the APC payment amount when both the 1.75 multiple threshold and the fixed-dollar $1,800 threshold are met. For CMHCs, if a CMHC's cost for partial hospitalization exceeds 3.40 times the payment rate for APC 0172 (Level I Partial Hospitalization (3 services)) or APC 0173 (Level II Partial Hospitalization (4 or more services)), the outlier payment is calculated as 50 percent of the amount by which the cost exceeds 3.40 times the APC payment rate.

New section 1833(t)(17)(A) of the Act, which applies to hospitals as defined under section 1886(d)(1)(B) of the Act, requires that hospitals that fail to report data required for the quality measures selected by the Secretary, in the form and manner required by the Secretary under 1833(t)(17)(B) of the Act, incur a 2.0 percentage point reduction to their OPD fee schedule increase factor, that is, the annual payment update factor. The application of a reduced OPD fee schedule increase factor results in reduced national unadjusted payment rates that will apply to certain outpatient items and services performed by hospitals that are required to report outpatient quality data and that fail to meet the HOP QDRP requirements. For hospitals that fail to meet the HOP

QDRP quality data reporting requirements, we are proposing that the hospitals' costs would be compared to the reduced payments for purposes of outlier eligibility and payment calculation. We believe no changes in the regulation text would be necessary to implement this policy because using the reduced payment for these outlier eligibility and payment calculations is contemplated in the current regulations at § 419.43(d). This proposal conforms to current practice under the IPPS in this regard. Specifically, under the IPPS, for purposes of determining the hospital's eligibility for outlier payments, the hospital's estimated operating costs for a discharge are compared to the outlier cost threshold based on the hospital's actual DRG payment for the case. For more information on the HOP QDRP, we refer readers to section XVI. of this proposed rule.

3. Outlier Reconciliation

As provided in section 1833(t)(5) of the Act, and described in the CY 2001 final rule with comment period (65 FR 18498), we initiated the use of a provider-specific overall CCR to estimate a hospital's or CMHC's costs from billed charges on a claim to determine whether a service's cost was significantly higher than the APC payment to qualify for outlier payment. Currently, these facility-specific overall CCRs are determined using the most recent settled or tentatively settled cost report for each facility. At the end of the cost reporting period, the hospital or CMHC submits a cost report to its Medicare contractor, who then calculates the overall CCR that is used to determine outlier payments for the facility. We believe the intent of the statute is that outlier payments would be made only in situations where the cost of a service provided is extraordinarily high. For example, under our existing outlier methodology, a hospital's billed current charges may be significantly higher than the charges included in the hospital's overall CCR that is used to calculate outlier payments, while the hospital's costs are more similar to the costs included in the overall CCR. In this case, the hospital's overall CCR used to calculate outlier payments is not representative of the hospital's current charge structure. The overall CCR applied to the hospital's billed charges would estimate an inappropriately high cost for the service, resulting in inappropriately high outlier payments. This is contrary to the goal of outlier payments, which are intended to reduce the hospital's financial risk associated with services that have especially high costs. The reverse could be true as well, if a hospital significantly lowered its current billed charges in relationship to its costs, which would result in inappropriately low outlier payments.

For CY 2009, we are proposing to address vulnerabilities in the OPPS outlier payment system that lead to differences between billed charges and charges included in the overall CCR used to estimate cost. Our proposal would apply to all hospitals and CMHCs paid under the OPPS. The main vulnerability in the OPPS outlier payment system is the time lag between the CCRs from the latest settled cost report and current charges that create the potential for hospitals and CMHCs to set their own charges to exploit the delay in calculating new CCRs. A facility can increase its outlier payments during this time lag by increasing its charges significantly in relation to its cost increases. The time lag may lead to inappropriately high CCRs relative to billed charges that overestimate cost, and as a result, greater outlier payments. Therefore, we are taking steps to ensure that outlier payments appropriately account for financial risk when providing an extraordinarily costly and complex service, while only being made for services that legitimately qualify for the additional payment.

We believe that some CMHCs may have historically increased and decreased their charges in response to Medicare outlier payment policies. The HHS Office of the Inspector General (OIG) has published several reports that found that CMHCs took advantage of vulnerabilities in the outpatient outlier payment methodology by increasing their billed charges after their CCRs were established to garner greater outlier payments (DHHS OIG June 2007, A–07–06–0459, page 2). We discuss the OIG's most recent report and accompanying recommendations in section XIV.C. of this proposed rule. We similarly noted in the CY 2004 OPPS final rule with comment period (68 FR 63470) that some CMHCs manipulated their charges in order to inappropriately receive outlier payments.

To address these vulnerabilities in the area of the OPPS outlier payment methodology, we are proposing to update our regulations to codify two existing longstanding OPPS policies, as discussed in further detail below. For the CY 2009 OPPS, we are also proposing to incorporate outlier policies comparable to those that have been included in several Medicare prospective payment systems, in particular the IPPS (68 FR 34494). Specifically, we are proposing to allow Medicare contractors to use a different CCR in certain circumstances to estimate costs, and we are proposing to require reconciliation of outlier payments in certain circumstances. We believe that all these proposed changes would address most of the current vulnerabilities present in the OPPS outlier payment system.

First, we are proposing to update the regulations to codify two existing outlier policies. These policies are currently stated in Pub 100–04, Chapter 4, section 10.11.1 of the Internet-Only Manual, as updated via Transmittal 1445, Change Request 5946, dated February 8, 2008. To be consistent with our manual instructions, for CY 2009, we are proposing to revise 42 CFR 419.43 to add two new paragraphs (d)(5)(ii) and (d)(5)(iii). Specifically, we are proposing to add new paragraph (d)(5)(ii) to incorporate rules governing the overall ancillary CCR applied to processed claims and new paragraph (d)(5)(iii) to incorporate existing policy governing when a statewide average CCR may be used instead of an overall ancillary CCR. We note that use of a statewide average CCR in the specified cases is to ensure that the most appropriate CCR possible is used for outlier payment calculations. For purposes of this discussion and OPPS payment policy in general, we treat ''overall CCR'' and ''overall ancillary CCR'' as synonymous terms that refer to the overall CCR that is calculated based on cost report data, which for hospitals, pertains to a specific set of ancillary cost centers.

We are proposing new § 419.43(d)(5)(ii) to specify use of the hospital's or CMHC's most recently updated overall CCR for purposes of calculating outlier payments. Our ability to identify true outlier cases depends on the accuracy of the CCRs. To the extent some facilities may be motivated to maximize outlier payments by taking advantage of the time lag in updating the CCRs, the payment system remains vulnerable to overpayments to individual hospitals or CMHCs. This proposed provision specifies that the overall CCR applied at the time a claim is processed is based on either the most recently settled or tentatively settled cost report, whichever is from the latest cost reporting period. We are also proposing new § 419.43(d)(5)(iii) to describe several circumstances in which a Medicare contractor may substitute a statewide average CCR for a hospital's or CMHC's CCR. In the CY 2007 OPPS/ASC final rule with comment period (71 FR 68006), we finalized this policy but inadvertently did not update our regulations. We refer readers to section II.D. of this proposed rule for a more

detailed discussion of statewide average CCRs. In summary, Medicare contractors can use a statewide CCR for new hospitals or CMHCs that have not accepted assignment of the existing provider agreement and who have not yet submitted a cost report; for hospitals or CMHCs whose Medicare contractor is unable to obtain accurate data with which to calculate the overall ancillary CCR; and for facilities whose actual CCR is more than 3 standard deviations above the geometric mean of other overall CCRs. For CY 2009, we estimate this upper threshold to be 1.3. While this existing policy minimizes the use of CCRs that are significantly above the mean for cost estimation, facilities with CCRs that fall significantly below the mean would continue to have their actual CCRs utilized, instead of the statewide default CCR. We also are proposing to reevaluate the upper threshold and propose a new upper threshold, if appropriate, through rulemaking each year.

These improvements somewhat mitigate, but do not fully eliminate, a hospital's or CMHC's ability to significantly increase its charges in relation to its cost increases each year, thereby receiving significant outlier payments because of the inflated CCR. Therefore, we also are proposing two new policies to more fully address the vulnerabilities described above. Specifically, we are proposing new § 419.43(d)(5)(i) that states that for hospital outpatient services performed on or after January 1, 2009, CMS may specify an alternative CCR or the facility may request an alternative CCR under certain circumstances. The alternative CCR in either case may be either higher or lower than the otherwise applicable CCR. In addition, we are proposing to allow a facility to request that its CCR be prospectively adjusted if the facility presents substantial evidence that the overall CCR that is currently used to calculate outlier payments is inaccurate. Such an alternative CCR may be appropriate if a facility's charges have increased at an excessive rate, relative to the rate of increase among other hospitals or CMHCs. CMS would have the authority to direct the Medicare contractor to calculate a CCR from the cost report that accounts for the increased charges. As explained in greater detail below, we are also proposing new § 419.43(d)(5)(iv) to allow Medicare contractors the administrative discretion to reconcile hospital or CMHC cost reports under certain circumstances.

We are proposing to implement a reconciliation process similar to that implemented by the IPPS in FY 2003 (68 FR 34494). This proposed policy would subject certain outlier payments to reconciliation when a hospital or CMHC cost report is settled. While the existing policies described above partially address the vulnerabilities in the OPPS outlier payment system, the proposed reconciliation process would more fully ensure accurate outlier payments for those facilities whose CCRs fluctuate significantly, relative to the CCRs of other facilities. We are proposing that this reconciliation process would only apply to those services provided on or after January 1, 2009. We considered proposing that this reconciliation process would become effective beginning with services provided during the hospital's first cost reporting period beginning in CY 2009 but believe effectuating this policy based upon date of service would be less burdensome for hospitals. We are specifically soliciting public comment related to the effective date for the reconciliation process that would be most administratively feasible for hospitals and CMHCs. We note this reconciliation process would be done on a limited basis in order to ease the administrative burden on Medicare contractors, as well as to focus on those facilities that appear to have improperly manipulated their charges to receive excessive outlier payments. We are proposing to set reconciliation thresholds in the manual, reevaluate them annually, and modify them as necessary. Following current IPPS outlier policy, these thresholds would include a measure of acceptable percent change in a hospital's or CMHC's CCR and an amount of outlier payment involved. We are further proposing that when the cost report is settled, reconciliation of outlier payments would be based on the overall CCR calculated based on the ratio of costs and charges computed from the cost report at the time the cost report coinciding with the service dates is settled. Reconciling these outlier payments would ensure that the outlier payments made are appropriate and that final outlier payments reflect the most accurate cost data. Because reconciliation entails evaluating claims for outlier payments using a revised CCR, this process would not apply to services and items not otherwise subject to outlier payments, including items and services paid at charges reduced to cost.

This reconciliation process would require recalculating outlier payments for individual claims. We understand that the aggregate change in a facility's outlier payments cannot be determined because changes in the CCR would affect the eligibility and amount of outlier payment. For example, if a CCR declined, some services may no longer qualify for any outlier payments while other services may qualify for lower outlier payments. Therefore, the only way to accurately determine the net effect of a decrease in an overall CCR on a facility's total outlier payments is to assess the impact on a claim-by-claim basis. At this time, CMS is developing a method for reexamining claims to calculate outlier payments using a revised CCR.

Similar to the IPPS, we also are proposing to adjust the amount of final outlier payments determined during reconciliation for the time value of money. A second vulnerability remaining after reconciliation is related to the same issue of the ability of hospitals and CMHCs to manipulate the system by significantly increasing charges in the year the service is performed, and obtaining excessive outlier payments as a result. Even though under the proposal the excess money would be refunded at the time of reconciliation, the facility would have access to excess payments from the Medicare Trust Fund on a short-term basis. In cases of underpayment, the facility would not have had access to appropriate outlier payment for that time period.

Accordingly, we believe it is necessary to adjust the amount of the final outlier payment to reflect the time value of the funds for that time period. Therefore, we are proposing to add section § 419.43(d)(6) to provide that when the cost report is settled, outlier payments would be subject to an adjustment to account for the value of the money for the time period in which the money was inappropriately held by the hospital or CMHC. This would also apply where outlier payments were underpaid. In those cases, the adjustment would result in additional payments to hospitals or CMHCs. Any adjustment would be made based on a widely available index to be established in advance by the Secretary, and would be applied from the midpoint of the cost reporting period to the date of reconciliation (or when additional payments are issued, in the case of underpayments). This adjustment to reflect the time value of a facility's outlier payments would ensure that the outlier payment finalized at the time its cost report is settled appropriately reflects the hospital's or CMHC's approximate marginal costs in excess of the APC payments for services, taking into consideration the applicable outlier thresholds.

Despite the fact that each individual facility's outlier payments may be subject to adjustment when the cost report is settled, we continue to believe that the hospital multiple and fixed-dollar outlier thresholds should be based on projected payments using the latest available historical data, without retroactive adjustments, to ensure that actual outlier payments are equal to the target spending percentage of total anticipated hospital outpatient spending. The proposed reconciliation process and ability to change overall CCRs are intended only to adjust actual outlier payments so that they most closely reflect true costs rather than artificially inflated costs. These adjustments would be made irrespective of whether total outlier spending targets are met or not.

We are not proposing to make any changes to the method that we use to calculate outlier thresholds for CY 2009. The multiple and fixed-dollar outlier thresholds are an important aspect of the prospective nature of the OPPS and key to their importance is their predictability and stability for the prospective payment year. The outlier payment policy is designed to alleviate any financial disincentive hospitals may have in providing any medically necessary care their patients may require, even to those patients who are very sick and would be likely more costly to treat. Preset and publicized OPPS outlier thresholds allow hospitals and CMHCs to approximate their Medicare payment for an individual patient while that patient is still in the hospital. Even though we are proposing to make outlier payments susceptible to a reconciliation based on the facility's actual CCRs during the contemporaneous cost reporting period, the facility should still be in a position to make this approximation. Hospitals and CMHCs have immediate access to the information needed to determine what their CCR will be for a specific time period when their cost report is settled. Even if the final CCR is likely to be different from the ratio used initially to process and pay the claim, hospitals and CMHCs not only have the information available to estimate their CCRs, but they also have the ability to control those CCRs, through the structure and levels of their charges. If we were to make retroactive adjustments to hospital outlier payments to ensure that we met total OPPS outlier spending targets, we would undermine the critical predictability aspect of the prospective nature of the OPPS. Making such an across-the-board adjustment would lead to either more or less outlier payments for all hospitals that would, therefore, be unable to immediately approximate the payment they would receive for especially costly services at the time those services were provided. We believe that it is neither necessary nor appropriate to make such an aggregate retroactive adjustment.

For the corresponding proposed regulation text changes, we refer readers to § 419.43(d)(5) and § 419.43(d)(6) of this proposed rule.

G. Proposed Calculation of an Adjusted Medicare Payment From the Proposed National Unadjusted Medicare Payment

The basic methodology for determining prospective payment rates for HOPD services under the OPPS is set forth in existing regulations at § 419.31, § 419.32, § 419.43 and § 419.44. The payment rate for most services and procedures for which payment is made under the OPPS is the product of the conversion factor calculated in accordance with section II.B. of this proposed rule and the relative weight determined under section II.A. of this proposed rule. Therefore, the national unadjusted payment rate for most APCs contained in Addendum A to this proposed rule and for most HCPCS codes, to which separate payment under the OPPS has been assigned in Addendum B to this proposed rule, was calculated by multiplying the proposed CY 2009 scaled weight for the APC by the proposed CY 2009 conversion factor. We note that section 1833(t)(17)(A) of the Act, which applies to hospitals as defined under section 1886(d)(1)(B) of the Act, requires that hospitals that fail to report data required for the quality measures selected by the Secretary, in the form and manner required by the Secretary under 1833(t)(17)(B) of the Act, incur a 2.0 percentage point reduction to their OPD fee schedule increase factor, that is, the annual payment update factor. The application of a reduced OPD fee schedule increase factor results in reduced national unadjusted payment rates that will apply to certain outpatient items and services provided by hospitals that are required to report outpatient quality data and that fail to meet the HOP QDRP requirements. For further discussion of the proposed payment reduction for hospitals that fail to meet the HOP QDRP data reporting requirements, we refer readers to section XVI.D. of this proposed rule.

We demonstrate in the steps below how to determine the APC payment that would be made in a calendar year under the OPPS to a hospital that fulfills the HOP QDRP data reporting requirements and to a hospital that fails to meet the HOP QDRP data reporting requirements for a service that has any of the status indicator assignments: ''P,'' ''Q1,'' ''Q2,'' ''Q3,'' ''R,'' ''S,'' ''T,'' ''U,'' ''V,'' or ''X'' (as defined in Addendum D1 to this proposed rule), in a circumstance in which the multiple procedure discount does not apply and the procedure is not bilateral.

Individual providers interested in calculating the proposed payment amount that they specifically would receive for a specific service from the proposed national unadjusted payment rates presented in Addenda A and B to this proposed rule, should follow the formulas presented in the following steps. For purposes of the payment calculations below, we refer to the national unadjusted payment rate for hospitals that meet their HOP QDRP reporting requirements as the ''full'' national unadjusted payment rate. We refer to the national unadjusted payment rate for hospitals that fail to meet their HOP QDRP reporting requirements as the ''reduced'' national unadjusted payment rate. The ''reduced'' national unadjusted payment rate is calculated by multiplying the proposed reporting ratio of 0.981 times the ''full'' national unadjusted payment rate. The national unadjusted payment rate used in the calculations below is either the ''full'' national unadjusted payment rate or the ''reduced'' national unadjusted payment rate, depending on whether the hospital met its HOP QDRP reporting requirements in order to receive the full CY 2009 OPPS increase factor.

Step 1. Calculate 60 percent (the labor-related portion) of the national unadjusted payment rate. Since the initial implementation of the OPPS, we have used 60 percent to represent our estimate of that portion of costs attributable, on average, to labor. We refer readers to the April 7, 2000 final rule with comment period (65 FR 18496 through 18497) for a detailed discussion of how we derived this percentage. We confirmed that this labor-related share for hospital outpatient services is still appropriate during our regression analysis for the payment adjustment for rural hospitals in the CY 2006 OPPS final rule with comment period (70 FR 68553).

The formula below is a mathematical representation of Step 1 discussed above and identifies the labor-related portion of a specific payment rate for the specific service.

x − Labor-related portion of the national unadjusted payment rate

x = .60 * (national unadjusted payment rate)

Step 2. Determine the wage index area in which the hospital is located and identify the wage index level that applies to the specific hospital. The wage index values assigned to each area reflect the new geographic statistical areas as a result of revised OMB standards (urban and rural) to which hospitals are assigned for FY 2009 under the IPPS, reclassifications through the Medicare Geographic Reclassification Review Board (MCGRB), section 1886(d)(8)(B) ''Lugar'' hospitals, and section 401 of Pub. L. 108–173. We note that the reclassifications of hospitals under the section 508 of Pub. L. 108–173 are scheduled to expire on September 30, 2008 and will not be applicable to FY 2009. The wage index values include the occupational mix adjustment described in section II.C. of this proposed rule that was developed for the proposed FY 2009 IPPS payment rates published in the **Federal Register** on April 30, 2008 (73 FR 23624 through 23632).

Step 3. Adjust the wage index of hospitals located in certain qualifying counties that have a relatively high percentage of hospital employees who reside in the county, but who work in a different county with a higher wage index, in accordance with section 505 of Pub. L. 108–173. Addendum L to this proposed rule contains the qualifying counties and the proposed wage index increase developed for the FY 2009 IPPS and published in the FY 2009 IPPS proposed rule as Table 4J (73 FR 23810 through 23819). This step is to be followed only if the hospital has chosen not to accept reclassification under Step 2 above.

Step 4. Multiply the applicable wage index determined under Steps 2 and 3 by the amount determined under Step 1 that represents the labor-related portion of the national unadjusted payment rate.

The formula below is a mathematical representation of Step 4 discussed above and adjusts the labor-related portion of the national payment rate for the specific service by the wage index.

x_a *− Labor-related portion of the national unadjusted payment rate (wage adjusted)*

x_a = .60 * (national unadjusted payment rate) * applicable wage index.

Step 5. Calculate 40 percent (the nonlabor-related portion) of the national unadjusted payment rate and add that amount to the resulting product of Step 4. The result is the wage index adjusted payment rate for the relevant wage index area.

The formula below is a mathematical representation of Step 5 discussed above and calculates the remaining portion of the national payment rate, the amount not attributable to labor, and the adjusted payment for the specific service.

y − Nonlabor-related portion of the national unadjusted payment rate

y = .40 * (national unadjusted payment rate)

Adjusted Medicare Payment = $y + x_a$

Step 6. If a provider is a SCH, as defined in the regulations at § 412.92, or an EACH, which is considered to be a SCH under section 1886(d)(5)(D)(iii)(III) of the Act, and located in a rural area, as defined in § 412.64(b), or is treated as being located in a rural area under § 412.103, multiply the wage index adjusted payment rate by 1.071 to calculate the total payment.

The formula below is a mathematical representation of Step 6 discussed above and applies the rural adjustment for rural SCHs.

Adjusted Medicare Payment (SCH or EACH) = Adjusted Medicare Payment × 1.071

We have provided examples below of the calculation of both the full and reduced national unadjusted payment rates that will apply to certain outpatient items and services performed by hospitals that meet and that fail to meet the HOP QDRP requirements, using the steps outlined above. For purposes of this example, we will use a provider that is located in Brooklyn, New York that is assigned to CBSA 35644. This provider bills one service that is assigned to APC 0019 (Level I Excision/Biopsy). The proposed CY 2009 full national unadjusted payment rate for APC 0019 is $288.20. The reduced national unadjusted payment rate for a hospital that fails to meet the HOP QDRP requirements would be $282.72. This reduced rate is calculated by multiplying the reporting ratio of 0.981 by the full unadjusted payment rate for APC 0019.

The FY 2009 wage index for a provider located in CBSA 35644 in New York is 1.3043. The labor portion of the proposed full national unadjusted payment is $225.54 (.60 × 288.20 × 1.3043). The labor portion of the reduced national unadjusted payment is $221.25 (.60 × 282.72 × 1.3043). The nonlabor portion of the proposed full national unadjusted payment is $115.28 (.40 × $288.20). The nonlabor portion of the reduced national unadjusted payment is $113.08 (.40 × $282.72). The sum of the labor and nonlabor portions of the proposed full national adjusted payment is $340.82 ($225.54 + $115.28). The sum of the reduced national adjusted payment is $334.33 ($221.25 + $113.08).

H. Proposed Beneficiary Copayments

1. Background

Section 1833(t)(3)(B) of the Act requires the Secretary to set rules for determining copayment amounts to be paid by beneficiaries for covered OPD services. Section 1833(t)(8)(C)(ii) of the Act specifies that the Secretary must reduce the national unadjusted copayment amount for a covered OPD service (or group of such services) furnished in a year in a manner so that the effective copayment rate (determined on a national unadjusted basis) for that service in the year does not exceed a specified percentage. As specified in section 1833(t)(8)(C)(ii)(V) of the Act, for all services paid under the OPPS in CY 2009, and in calendar years thereafter, the percentage is 40 percent of the APC payment rate. Section 1833(t)(3)(B)(ii) of the Act provides that, for a covered OPD service (or group of such services) furnished in a year, the national unadjusted copayment amount cannot be less than 20 percent of the OPD fee schedule amount. Sections 1834(d)(2)(C)(ii) and (d)(3)(C)(ii) of the Act further require that the copayment for screening flexible sigmoidoscopies and screening colonoscopies be equal to 25 percent of the payment amount. Since the beginning of the OPPS, we have applied the 25-percent copayment to screening flexible sigmoidoscopies and screening colonoscopies.

2. Proposed Copayment

For CY 2009, we are proposing to determine copayment amounts for new and revised APCs using the same methodology that we implemented for CY 2004. We refer readers to the November 7, 2003 OPPS final rule with comment period (68 FR 63458). In addition, we are proposing to use the same rounding methodology implemented in CY 2008 in instances where the application of our standard copayment methodology would result in a copayment amount that is less than 20 percent and cannot be rounded, under standard rounding principles, to 20 percent. (We refer readers to the CY 2008 OPPS/ASC final rule with comment period (72 FR 66687).) The proposed national unadjusted copayment amounts for services payable under the OPPS that would be effective January 1, 2009 are shown in Addendum A and Addendum B to this proposed rule. As discussed in section XVI.D. of this proposed rule, we are proposing that the Medicare beneficiary's minimum unadjusted copayment and national unadjusted copayment for a service to which a reduced national unadjusted payment rate applies would equal the product of the reporting ratio and the national unadjusted copayment, or the product of the reporting ratio and the minimum unadjusted copayment, respectively, for the service.

3. Calculation of a Proposed Adjusted Copayment Amount for an APC Group

Individuals interested in calculating their proposed national copayment liability for a given service provided by a hospital that met or failed to meet its HOP QDRP reporting requirements should follow the formulas presented in the following steps.

Step 1. Calculate the beneficiary payment percentage for the APC by dividing the APC's national unadjusted copayment by its payment rate. For example, using APC 0019, $71.87 is 24.938 percent of the proposed full national unadjusted payment rate of $288.20.

The formula below is a mathematical representation of Step 1 discussed above and calculates national copayment as a percentage of national payment for a given service.

b = Beneficiary payment percentage
b = national unadjusted copayment for APC/national unadjusted payment rate for APC

Step 2. Calculate the appropriate wage-adjusted payment rate for the APC for the provider in question, as indicated in section II.G. of this proposed rule. Calculate the rural adjustment for eligible providers as indicated in section II.G. of this proposed rule.

Step 3. Multiply the percentage calculated in Step 1 by the payment rate calculated in Step 2. The result is the wage-adjusted copayment amount for the APC.

The formula below is a mathematical representation of Step 3 discussed above and applies the beneficiary percentage to the adjusted payment rate for a service calculated under II.G. above, with and without the rural adjustment, to calculate the proposed adjusted beneficiary copayment for a given service.

Wage-adjusted copayment amount for the APC = Adjusted Medicare Payment * *b*

Wage-adjusted copayment amount for the APC (SCH or EACH) = (Adjusted Medicare Payment * 1.071)* *b*

Step 4. For a hospital that failed to meet its HOP QDRP reporting requirements, multiply the copayment calculated in Step 3 by the reporting ratio of 0.981.

The proposed unadjusted copayments for services payable under the OPPS that would be effective January 1, 2009 are shown in Addenda A and B to this proposed rule. Please note that the proposed national unadjusted payment rates and copayment rates shown in Addenda A and B to this proposed rule reflect the full market basket conversion factor increase as discussed in section XVI.D. of this proposed rule.

III. Proposed OPPS Ambulatory Payment Classification (APC) Group Policies

A. Proposed OPPS Treatment of New HCPCS and CPT Codes

1. Proposed Treatment of New HCPCS Codes Included in the April and July Quarterly OPPS Updates for CY 2008

During the April and July quarters of CY 2008, we created a total of 11 new Level II HCPCS codes that were not addressed in the CY 2008 OPPS/ASC final rule with comment period that updated the CY 2008 OPPS. For the April quarter of CY 2008, we recognized for separate payment a total of four new Level II HCPCS codes, specifically C9241 (Injection, doripenem, 10 mg); Q4096 (Injection, von willebrand factor complex, human, ristocetin cofactor (not otherwise specified), per i.u. VWF:RCO); Q4097 (Injection, immune globulin (Privigen), intravenous, non-lyophilized (e.g., liquid), 500 mg); and Q4098 (Injection, iron dextran, 50 mg). For the July quarter of CY 2008, we recognized a total of seven new Level II HCPCS codes, specifically C9242 (Injection, fosaprepitant, 1 mg); C9356 (Tendon, porous matrix of cross-linked collagen and glycosaminoglycan matrix (TenoGlide Tendon Protector Sheet), per square centimeter); C9357 (Dermal substitute, granulated cross-linked collagen and glycosaminoglycan matrix (Flowable Wound Matrix), 1 cc); C9358 (Dermal substitute, native, non-denatured collagen (SurgiMend Collagen Matrix), per 0.5 square centimeters); G0398 (Home sleep study test (HST) w/type II portable monitor, unattended; minimum of 7 channels: EEG, EOG, EMG, ECG/heart rate, airflow, respiratory effort and oxygen saturation); G0399 (Home sleep test (HST) with type III portable monitor, unattended; minimum of 4 channels: 2 respiratory movement/airflow, 1 ECG/heart rate and 1 oxygen saturation); and G0400 (Home sleep test (HST) with type IV portable monitor, unattended; minimum of 3 channels). We designated the payment status of these codes and added them either through the April update (Transmittal 1487, Change Request 5999, dated April 8, 2008) or the July update of the CY 2008 OPPS.

In this proposed rule, we are soliciting public comment on the status indicators, APC assignments, and payment rates of these codes, which are listed in Table 10 and Table 11 of this proposed rule. Because of the timing of this proposed rule, the codes implemented through the July 2008 OPPS update are not included in Addendum B to this proposed rule. We

are proposing to assign these new HCPCS codes for CY 2009 to APCs with the proposed payment rates as displayed in Table 11 and incorporate them into Addendum B to our final rule with comment period for CY 2009, which is consistent with our annual APC updating policy. The HCPCS codes implemented through the April 2008 OPPS update and displayed in Table 10 are included in Addendum B to this proposed rule, where their proposed payment rates can also be found.

TABLE 10.—NEW HCPCS CODES IMPLEMENTED IN APRIL 2008

HCPCS code	Long descriptor	Proposed CY 2009 status indicator	Proposed CY 2009 APC
C9241	Injection, doripenem, 10 mg	G	9241
Q4096	Injection, von willebrand factor complex, human, ristocetin cofactor (not otherwise specified), per i.u. VWF:RCO.	K	1213
Q4097	Injection, immune globulin (Privigen), intravenous, non-lyophilized (e.g., liquid), 500 mg	K	1214
Q4098	Injection, iron dextran, 50 mg	K	1215

TABLE 11.—NEW HCPCS CODES IMPLEMENTED IN JULY 2008

HCPCS code	Long descriptor	Proposed CY 2009 status indicator	Proposed CY 2009 APC	Proposed CY 2009 payment rate
C9242*	Injection, fosaprepitant, 1 mg	G	9242	$1.61
C9356*	Tendon, porous matrix of cross-linked collagen and glycosaminoglycan matrix (TenoGlide Tendon Protector Sheet), per square centimeter.	G	9356	16.92
C9357*	Dermal substitute, granulated cross-linked collagen and glycosaminoglycan matrix (Flowable Wound Matrix), 1 cc.	G	9357	883.33
C9358*	Dermal substitute, native, non-denatured collagen (SurgiMend Collagen Matrix), per 0.5 square centimeters.	G	9358	10.38
G0398	Home sleep study test (HST) with type II portable monitor, unattended; minimum of 7 channels: EEG, EOG, EMG, ECG/heart rate, airflow, respiratory effort and oxygen saturation.	S	0213	152.52
G0399	Home sleep test (HST) with type III portable monitor, unattended; minimum of 4 channels: 2 respiratory movement/airflow, 1 ECG/heart rate and 1 oxygen saturation.	S	0213	152.52
G0400	Home sleep test (HST) with type IV portable monitor, unattended; minimum of 3 channels.	S	0213	152.52

*The drug payment rates displayed in Table 11 reflect the July 2008 ASP data.

2. Proposed Treatment of New Category I and III CPT Codes and Level II HCPCS Codes

As has been our practice in the past, we implement new Category I and III CPT codes and new Level II HCPCS codes through program transmittals, which are released in the summer through the fall of each year for annual updating, effective January 1, in the final rule updating the OPPS for the following calendar year. These codes are flagged with comment indicator ''NI'' in Addendum B to the OPPS/ASC final rule with comment period to indicate that we are assigning them an interim payment status which is subject to public comment. Specifically, the status indicator, the APC assignment, or both, for all such codes flagged with comment indicator ''NI'' will be open to public comment in the CY 2009 OPPS/ASC final rule with comment period. We are proposing to continue this recognition and process for CY 2009. New Category I and III CPT codes, as well as new Level II HCPCS codes, effective January 1, 2009, will be listed in Addendum B to the CY 2009 OPPS/ASC final rule with comment period and designated using comment indicator ''NI.'' We will respond to all comments received concerning these codes in a subsequent final rule for the next calendar year's OPPS/ASC update.

In addition, we are proposing to continue our policy of the last 3 years of recognizing new mid-year CPT codes, generally Category III CPT codes, that the American Medical Association (AMA) releases in January for implementation the following July through the OPPS quarterly update process. Therefore, for CY 2009, we are proposing to include in Addendum B to the CY 2009 OPPS/ASC final rule with comment period the new Category III CPT codes released in January 2008 for implementation on July 1, 2008 (through the OPPS quarterly update process), and the new Category III codes released in July 2008 for implementation on January 1, 2009. However, only those new Category III CPT codes implemented effective January 1, 2009, will be flagged with comment indicator ''NI'' in Addendum B to the CY 2009 OPPS/ASC final rule with comment period, to indicate that we have assigned them an interim payment status which is subject to public comment. Category III CPT codes implemented in July 2008, which appear in Table 12 below, are subject to comment through this proposed rule, and we are proposing to finalize their status in the CY 2009 OPPS/ASC final rule with comment period.

TABLE 12.—CATEGORY III CPT CODES IMPLEMENTED IN JULY 2008

CPT code	Long descriptor	Proposed CY 2009 status indicator	Proposed CY 2009 APC
0188T	Remote real-time interactive videoconferenced critical care, evaluation and management of the critically ill or critically injured patient; first 30–74 minutes.	M	Not applicable.
0189T	Remote real-time interactive videoconferenced critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes.	M	Not applicable.
0190T	Placement of intraocular radiation source applicator	T	0237.
0191T	Insertion of anterior segment aqueous drainage device, without extraocular reservoir; internal approach.	T	0234.
0192T	Insertion of anterior segment aqueous drainage device, without extraocular reservoir; external approach.	T	0234.

B. Proposed OPPS Changes—Variations Within APCs

1. Background

Section 1833(t)(2)(A) of the Act requires the Secretary to develop a classification system for covered hospital outpatient services. Section 1833(t)(2)(B) of the Act provides that this classification system may be composed of groups of services, so that services within each group are comparable clinically and with respect to the use of resources. In accordance with these provisions, we developed a grouping classification system, referred to as APCs, as set forth in § 419.31 of the regulations. We use Level I and Level II HCPCS codes and descriptors to identify and group the services within each APC. The APCs are organized such that each group is homogeneous both clinically and in terms of resource use. Using this classification system, we have established distinct groups of similar services, as well as medical visits. We also have developed separate APC groups for certain medical devices, drugs, biologicals, therapeutic radiopharmaceuticals, and brachytherapy devices.

We have packaged into payment for each procedure or service within an APC group the costs associated with those items or services that are directly related to and supportive of performing the main independent procedures or furnishing the services. Therefore, we do not make separate payment for these packaged items or services. For example, packaged items and services include: (1) Use of an operating, treatment, or procedure room; (2) use of a recovery room; (3) observation services; (4) anesthesia; (5) medical/surgical supplies; (6) pharmaceuticals (other than those for which separate payment may be allowed under the provisions discussed in section V. of this proposed rule); (7) incidental services such as venipuncture; and (8) guidance services, image processing services, intraoperative services, imaging supervision and interpretation services, diagnostic radiopharmaceuticals, and contrast media. Further discussion of packaged services is included in section II.A.4. of this proposed rule.

In CY 2008, we implemented composite APCs to provide a single payment for groups of services that are typically performed together during a single clinical encounter and that result in the provision of a complete service. Under current CY 2008 OPPS policy, we provide composite APC payment for certain extended assessment and management services, low dose rate prostate brachytherapy, cardiac electrophysiologic evaluation and ablation, and mental health services. We also are proposing for CY 2009 a composite APC payment methodology for multiple imaging services. Further discussion of composite APCs is included in section II.A.2.e. of this proposed rule.

Under the OPPS, we generally pay for hospital outpatient services on a rate-per-service basis, where the service may be reported with one or more HCPCS codes. Payment varies according to the APC group to which the independent service or combination of services is assigned. Each APC weight represents the hospital median cost of the services included in that APC relative to the hospital median cost of the services included in APC 0606 (Level 3 Hospital Clinic Visits). The APC weights are scaled to APC 0606 because it is the middle level clinic visit APC (that is, where the level 3 clinic visit CPT code of five levels of clinic visits is assigned), and because middle level clinic visits are among the most frequently furnished services in the hospital outpatient setting.

Section 1833(t)(9)(A) of the Act requires the Secretary to review the components of the OPPS not less than annually and to revise the groups and relative payment weights and make other adjustments to take into account changes in medical practice, changes in technology, and the addition of new services, new cost data, and other relevant information and factors. Section 1833(t)(9)(A) of the Act, as amended by section 201(h) of the BBRA, also requires the Secretary, beginning in CY 2001, to consult with an outside panel of experts to review the APC groups and the relative payment weights (the APC Panel recommendations for specific services for the CY 2009 OPPS and our responses to them are discussed in the relevant specific sections throughout this proposed rule).

Finally, section 1833(t)(2) of the Act provides that, subject to certain exceptions, the items and services within an APC group cannot be considered comparable with respect to the use of resources if the highest median cost, or mean cost as elected by the Secretary, for an item or service in the group is more than 2 times greater than the lowest median cost for an item or service within the same group (referred to as the ''2 times rule''). We use the median cost of the item or service in implementing this provision. The statute authorizes the Secretary to make exceptions to the 2 times rule in unusual cases, such as low-volume items and services.

2. Application of the 2 Times Rule

In accordance with section 1833(t)(2) of the Act and § 419.31 of the regulations, we annually review the items and services within an APC group to determine, with respect to comparability of the use of resources, if the median cost of the highest cost item or service within an APC group is more than 2 times greater than the median of the lowest cost item or service within that same group (''2 times rule''). We are proposing to make exceptions to this limit on the variation of costs within each APC group in unusual cases such as low-volume items and services.

During the APC Panel's March 2008 meeting, we presented median cost and utilization data for services furnished during the period of January 1, 2007 through September 30, 2007, about which we had concerns or about which the public had raised concerns regarding their APC assignments, status indicator assignments, or payment rates. The discussions of most service-specific issues, the APC Panel recommendations, if any, and our proposals for CY 2009 are contained principally in sections III.C. and III.D. of this proposed rule.

In addition to the assignment of specific services to APCs that we discussed with the APC Panel, we also identified APCs with 2 times violations that were not specifically discussed with the APC Panel but for which we are proposing changes to their HCPCS codes' APC assignments in Addendum B to this proposed rule. In these cases, to eliminate a 2 times violation or to improve clinical and resource homogeneity, we are proposing to reassign the codes to APCs that contain services that are similar with regard to both their clinical and resource characteristics. We also are proposing to rename existing APCs, discontinue existing APCs, or create new clinical APCs to complement proposed HCPCS code reassignments. In many cases, the proposed HCPCS code reassignments and associated APC reconfigurations for CY 2009 included in this proposed rule are related to changes in median costs of services that are observed in the CY 2007 claims data newly available for CY 2009 ratesetting. We also are proposing changes to the status indicators for some codes that are not specifically and separately discussed in this proposed rule. In these cases, we are proposing to change the status indicators for some codes because we believe that another status indicator would more accurately describe their payment status from an OPPS perspective based on the policies that we are proposing for CY 2009 or because we are proposing new status indicators to differentiate a related group of services from other services that previously shared the same status indicator.

Addendum B to this proposed rule identifies with comment indicator ''CH'' those HCPCS codes for which we are proposing a change to the APC assignment or status indicator as assigned in the April 2008 Addendum B update (via Transmittal 1487, Change Request 5999, dated April 8, 2008). HCPCS codes with proposed CY 2009 changes in status indicator assignments from ''Q'' to ''Q1,'' from ''Q'' to ''Q2,'' or from ''Q'' to ''Q3'' are an exception to this identification practice because they are not flagged with comment indicator ''CH'' in Addendum B to this proposed rule. These proposed changes in status indicators are to facilitate policy transparency and operational logic rather than reflect changes in OPPS payment policy for these services, hence we believe that identifying these HCPCS codes with ''CH'' could be confusing to the public.

3. Proposed Exceptions to the 2 Times Rule

As discussed earlier, we may make exceptions to the 2 times limit on the variation of costs within each APC group in unusual cases such as low-volume items and services. Taking into account the APC changes that we are proposing for CY 2009 based on the APC Panel recommendations discussed mainly in sections III.C. and III.D. of this proposed rule, the other proposed changes to status indicators and APC assignments as identified in Addendum B to this proposed rule, and the use of CY 2007 claims data to calculate the median costs of procedures classified in the APCs, we reviewed all the APCs to determine which APCs would not satisfy the 2 times rule. We used the following criteria to decide whether to propose exceptions to the 2 times rule for affected APCs:

- Resource homogeneity
- Clinical homogeneity
- Hospital outpatient setting
- Frequency of service (volume)
- Opportunity for upcoding and code fragments.

For a detailed discussion of these criteria, we refer readers to the April 7, 2000 OPPS final rule with comment period (65 FR 18457).

Table 13 below lists the APCs that we are proposing to exempt from the 2 times rule for CY 2009 based on the criteria cited above. For cases in which a recommendation by the APC Panel appeared to result in or allow a violation of the 2 times rule, we generally accepted the APC Panel's recommendation because those recommendations were based on explicit consideration of resource use, clinical homogeneity, hospital specialization, and the quality of the CY 2007 claims data used to determine the APC payment rates that we are proposing for CY 2009. The median costs for hospital outpatient services for these and all other APCs that were used in the development of this proposed rule can be found on the CMS Web site at: *http://www.cms.hhs.gov/HospitalOutpatientPPS/01_overview.asp*.

TABLE 13.—PROPOSED APC EXCEPTIONS TO THE 2 TIMES RULE FOR CY 2009

APC	APC title
0060	Manipulation Therapy.
0080	Diagnostic Cardiac Catheterization.
0093	Vascular Reconstruction/Fistula Repair without Device.
0105	Repair/Revision/Removal of Pacemakers, AICDs, or Vascular Devices.
0141	Level I Upper GI Procedures.
0245	Level I Cataract Procedures without IOL Insert.
0303	Treatment Device Construction.
0330	Dental Procedures.
0409	Red Blood Cell Tests.
0426	Level II Strapping and Cast Application.
0432	Health and Behavior Services.
0604	Level 1 Hospital Clinic Visits.

C. New Technology APCs

1. Background

In the November 30, 2001 final rule (66 FR 59903), we finalized changes to the time period a service was eligible for payment under a New Technology APC. Beginning in CY 2002, we retain services within New Technology APC groups until we gather sufficient claims data to enable us to assign the service to a clinically appropriate APC. This policy allows us to move a service from a New Technology APC in less than 2 years if sufficient data are available. It also allows us to retain a service in a New Technology APC for more than 2 years if sufficient data upon which to base a decision for reassignment have not been collected.

We note that the cost bands for New Technology APCs range from $0 to $50 in increments of $10, from $50 to $100 in increments of $50, from $100 through $2,000 in increments of $100, and from $2,000 through $10,000 in increments of $500. These increments, which are in two parallel sets of New Technology APCs, one with status indicator ''S'' and the other with status indicator ''T,'' allow us to price new technology services more appropriately and consistently.

2. Proposed Movement of Procedures from New Technology APCs to Clinical APCs

As we explained in the November 30, 2001 final rule (66 FR 59897), we generally keep a procedure in the New Technology APC to which it is initially assigned until we have collected data sufficient to enable us to move the procedure to a clinically appropriate

APC. However, in cases where we find that our original New Technology APC assignment was based on inaccurate or inadequate information, or where the New Technology APCs are restructured, we may, based on more recent resource utilization information (including claims data) or the availability of refined New Technology APC cost bands, reassign the procedure or service to a different New Technology APC that most appropriately reflects its cost.

Consistent with our current policy, for CY 2009 we are proposing to retain services within New Technology APC groups until we gather sufficient claims data to enable us to assign the service to a clinically appropriate APC. The flexibility associated with this policy allows us to move a service from a New Technology APC in less than 2 years if sufficient data are available. It also allows us to retain a service in a New Technology APC for more than 2 years if sufficient hospital claims data upon which to base a decision for reassignment have not been collected. HCPCS codes C9725 (Placement of endorectal intracavitary applicator for high intensity brachytherapy), C9726 (Placement and removal (if performed) of applicator into breast for radiation therapy), and C9727 (Insertion of implants into the soft palate; minimum of three implants), which are presented below in Table 14 of this proposed rule, represent services assigned to New Technology APCs for CY 2008 for which we believe we have sufficient claims data to propose their reassignment to clinically appropriate APCs for CY 2009. These 3 procedures have been assigned to their New Technology APCs for at least 3 years, thereby providing us with sufficient data from at least 2 years of hospital claims upon which to base our proposed reassignments. In addition, these three procedures are clinically similar to other services currently paid through clinical APCs under the OPPS and for which we have substantial claims data regarding hospital costs. Therefore, for CY 2009, we are proposing to reassign these procedures to clinically appropriate APCs, applying their CY 2007 claims data to develop their clinical APC median costs upon which payments would be based. These procedures and their proposed APC assignments are displayed in Table 14 below.

HCPCS code C9723 (Dynamic infrared blood perfusion imaging (diri)) was assigned to New Technology APC 1502 (New Technology—Level II ($50–$100)) when it was implemented in April 2005. However, based on our claims data for the past 3 years, which have shown no utilization for this code, we are proposing to delete HCPCS code C9723 on December 31, 2008.

TABLE 14.—PROPOSED CY 2009 APC REASSIGNMENTS OF NEW TECHNOLOGY PROCEDURES TO CLINICAL APCS

HCPCS code	Short descriptor	CY 2008 SI	CY 2008 APC	Proposed CY 2009 APC	Proposed CY 2009 SI
C9725	Placement of endorectal intracavitary applicator for high intensity brachytherapy.	S	1507	0164	T
C9726	Placement and removal (if performed) of applicator into breast for radiation therapy.	S	1508	0028	T
C9727	Insertion of implants into the soft palate; minimum of three implants.	S	1510	0252	T

D. Proposed OPPS APC-Specific Policies

1. Trauma Response Associated With Hospital Critical Care Services (APC 0618)

In the CY 2007 OPPS/ASC final rule with comment period (71 FR 68133 through 68134), we discussed the creation of HCPCS code G0390 (Trauma response team activation associated with hospital critical care service), which became effective January 1, 2007. HCPCS code G0390 is reported by hospitals when providing critical care services in association with trauma response team activation. HCPCS code G0390 has been assigned to APC 0618 (Trauma Response with Critical Care) since CY 2007, with payment rates of approximately $495 and $330, for CYs 2007 and 2008, respectively. The creation of HCPCS code G0390 enables us to pay differentially for critical care when trauma response team activation is associated with critical care services and when there is no trauma response team activation. We instructed hospitals to continue to report CPT codes 99291 (Critical care, evaluation and management of the critically ill or critically injured patient; first 30–74 minutes) and 99292 (Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes (List separately in addition to code for primary service)) for critical care services when they also report HCPCS code G0390.

For CY 2007 and CY 2008, we calculated the median cost for APC 0617 (Critical Care) to which CPT code 99291 is assigned using the subset of single claims for CPT code 99291 that did not include charges under revenue code 068x, the trauma revenue code, reported on the same day. We established the median cost for APC 0618 (Trauma Response with Critical Care) by calculating the difference in median costs between the two subsets of single claims for CPT code 99291 representing the reporting of critical care services with and without revenue code 068x charges reported on the same day. For a complete description of the history of the policy and development of the payment methodology for these services, we refer readers to the CY 2007 OPPS/ASC final rule with comment period (71 FR 68133 through 68134). We provided billing guidance in CY 2006 in Transmittal 1139, Change Request 5438, issued on December 22, 2006, specifically clarifying when it would be appropriate to report HCPCS code G0390. The I/OCE logic only accepts HCPCS code G0390 when it is reported with revenue code 068x and CPT code 99291 on the same claim and on the same date of service.

For CY 2009, we are proposing a median cost for APC 0617 of approximately $488 and a median cost for APC 0618 of approximately $989. For CY 2009 OPPS ratesetting, we are using claims data from CY 2007 that also include claims for HCPCS code G0390, as CY 2007 is the initial year that we established OPPS payment for HCPCS code G0390. We are proposing to use the line-item median cost for HCPCS code G0390 in the CY 2007 claims to set the median cost for APC 0618, as HCPCS code G0390 is the only code assigned to that APC. As discussed in section II.A.1.b. of this proposed rule, we are proposing to add HCPCS code G0390 to the CY 2009 bypass list to isolate the line-item cost for HCPCS code G0390 and ensure that the critical

care claims for CPT code 99291 that are reported with HCPCS code G0390 are available to set the medians for APC 0617 and composite APC 8003. The costs of packaged revenue code charges and HCPCS codes for services with status indicator ''N'' on a claim with HCPCS code G0390 would be associated with CPT code 99291 for ratesetting, if the claim for CPT code 99291 is a single or ''pseudo'' single bill.

For APC 0617, we are proposing to calculate the median cost using our standard methodology that excludes those single claims for critical care services that are eligible for payment through the Level II extended assessment and management composite APC, that is APC 8003, as described in section II.A.2.e.(1) of this proposed rule. We believe that these proposed refinements in median cost calculations would result in more accurate cost estimates and payments for APCs 0617 and 0618 for CY 2009.

2. Suprachoroidal Delivery of Pharmacologic Agent (APC 0236)

CPT code 0186T (Suprachoroidal delivery of pharmacologic agent (does not include supply of medication)) is a new code for CY 2008. It was released on the AMA CPT Web site on July 1, 2007, and implemented on January 1, 2008. In the CY 2008 OPPS/ASC final rule with comment period (72 FR 66997), we assigned this code to APC 0236 (Level II Posterior Segment Eye Procedures) with a CY 2008 payment rate of approximately $1,161. We also assigned this code comment indicator ''NI'' in Addendum B to the CY 2008 OPPS/ASC final rule with comment period to indicate that it is a new code for CY 2008 with an interim payment status subject to public comment following publication of that rule.

As has been our practice in the past, we implement new HCPCS codes in the OPPS/ASC final rule with comment period, at which time we invite public comment on our interim treatment of the new codes. We subsequently respond to those comments in the final rule with comment period for the following year's OPPS update.

In its March 2008 presentation to the APC Panel, a presenter requested the reassignment of CPT code 0186T from APC 0236 to APC 0237 (Level III Posterior Segment Eye Procedures), which has a CY 2008 payment rate of approximately $1,774. The presenter indicated that CPT code 0186T is analogous to CPT code 67027 (Implantation of intravitreal drug delivery system (e.g., ganciclovir implant), includes concomitant removal of vitreous), which is assigned to APC 0672 (Level IV Posterior Segment Eye Procedures) with a CY 2008 payment rate of about $2,370. Although the presenter stated that both procedures share similar clinical characteristics and resource costs, the presenter believed that CPT code 0186T would be most appropriately assigned to APC 0237 based on the procedure's estimated hospital cost. The APC Panel noted that because the CPT code is new and there are no claims data for this procedure, the APC Panel would not make a specific CY 2009 APC assignment recommendation to CMS at this time. However, the APC Panel recommended that CMS share with the APC Panel the claims data for CPT code 0186T at the first CY 2009 APC Panel meeting, and that CMS reevaluate the assignment of CPT code 0186T to APC 0236 on the basis of those data. We are accepting the recommendation of the APC Panel and will provide the initial OPPS claims data available for this CPT code, based on CY 2008 claims data, for the first CY 2009 APC Panel meeting. These data will not be available until the CY 2010 OPPS update rulemaking cycle.

Under the OPPS, we generally assign a new Category III CPT code to an APC if we believe that the procedure, if covered, would be appropriate for separate payment under the OPPS. A specific assignment to a clinical APC where HCPCS codes with comparable clinical and resource characteristics also reside is based on a variety of types of information including, but not limited to: Advice from our medical advisors, information from specialty societies, review of resource costs for related services from historical hospital claims data, consideration of the clinical similarity of the service to existing procedures, and review of any other information available to us.

Based upon our further review and analysis of the clinical characteristics and resource costs associated with CPT code 0186T, we agree with the presenter that the most appropriate CY 2009 APC assignment for this procedure is APC 0237. We believe that the other procedures also assigned to APC 0237 are similar to the procedure described by CPT code 0186T. Therefore, for CY 2009, we are proposing to reassign CPT code 0186T from APC 0236 to APC 0237, which has a proposed median cost of approximately $1,447. We also note that because CPT code 0186T describes a specific drug administration service, the drug itself would be separately reported under the appropriate Level II HCPCS drug code.

3. Closed Treatment of Fracture of Finger/Toe/Trunk (APC 0043)

We received a comment to the CY 2008 OPPS/ASC proposed rule on the variety of procedures assigned to APC 0043 (Closed Treatment Fracture Finger/Toe/Trunk). The commenter did not agree with the placement of various procedures in APC 0043 as many of the procedures vary in resource costs. In particular, the commenter asserted that the costs associated with finger treatments, hip dislocations, and spinal fractures vary significantly, and further stated that the costs of treating spinal fractures are significantly greater than the costs associated with finger or toe fractures. The commenter also expressed concern that grouping all of the approximately 150 procedures in one clinical APC violated the 2 times rule, and that continuing to exempt APC 0043 from the 2 times rule was not appropriate. The commenter recommended that CMS pay appropriately for these procedures, and stated that this could be achieved by dividing the procedures currently assigned to APC 0043 into several APCs. However, the commenter did not make any specific recommendations regarding alternative APC configurations. Because APC 0043 contains so many different fracture treatment procedures with low volume, we were concerned that any restructuring for CY 2008 without the benefit of public comment could result in the reconfiguration of APCs that did not reflect improved clinical and resource homogeneity over the proposed configuration. Therefore, we did not reconfigure APC 0043 for CY 2008, and we finalized a payment rate for APC 0043 of about $113.

In the CY 2008 OPPS/ASC final rule with comment period (72 FR 66723), we stated that we agreed with the commenter that grouping all of the closed fracture treatment procedures in one APC may not accurately distinguish the more expensive from the less resource-intensive fracture treatment procedures. However, we also explained that we found that there were only 13 procedures that were significant procedures with the frequency necessary to assess the APC's alignment with the 2 times rule. The other procedures were all very low volume and, therefore, not significant procedures for purposes of evaluating the APC with respect to the 2 times rule. We noted that APC 0043 has been exempted from the 2 times rule for the past 7 years under the OPPS, and we had not previously received public comments regarding the structure of this APC. In that same rule (72 FR 66723) we

specifically invited public recommendations on potential alternative APC configurations for the services currently assigned to APC 0043 for the CY 2009 APC review process. We received no public comments on this APC issue.

In the CY 2008 OPPS/ASC final rule with comment period (72 FR 66723), we also stated that we would bring this APC issue to the attention of the APC Panel at its March 2008 meeting and requested input as to how to most appropriately categorize the procedures in APC 0043. Based on the updated CY 2007 hospital outpatient claims data available for the March 2008 APC Panel meeting, we presented a possible reconfiguration of APC 0043 for the APC Panel's consideration. In particular, the potential reconfiguration reviewed and discussed by the APC Panel would delete APC 0043 and replace it with three new APCs, configured based on the hospital resource data from the CY 2007 claims data, as well as the clinical characteristics of the procedures currently assigned to APC 0043. The APC Panel recommended that CMS adopt the approach that CMS described to the APC Panel to reconfigure APC 0043 into three new APCs, and we are accepting the APC Panel's recommendation for CY 2009. Therefore, for CY 2009, we are proposing three new APCs to replace APC 0043, with proposed configurations as displayed in Table 15 below.

Based on these configurations, proposed new APC 0129 (Level I Closed Treatment Fracture Finger/Toe/Trunk) has a proposed APC median cost of approximately $104, with the HCPCS code-specific median costs of the significant procedures ranging from approximately $74 to $124. Proposed new APC 0138 (Level II Closed Treatment Fracture Finger/Toe/Trunk) has a proposed APC median cost of approximately $397, with only one significant procedure with a HCPCS code-specific median cost of approximately $399. Proposed new APC 0139 (Level III Closed Treatment Fracture Finger/Toe/Trunk) has a proposed APC median cost of approximately $1,340, with only one significant volume HCPCS code whose median cost is approximately $1,574.

While all three proposed APCs contain many procedures that are very low in volume, this reconfiguration reflects an attempt to realign the procedures previously assigned to APC 0043 based on their clinical characteristics and resource costs into APC groups that are more homogeneous. Therefore, for CY 2009, we are proposing to reconfigure APC 0043 by deleting APC 0043 and reassigning the HCPCS codes previously assigned to APC 0043 to proposed new APCs 0129, 0138, and 0139.

TABLE 15.—PROPOSED NEW APCS FOR CLOSED TREATMENT FRACTURE OF FINGER/TOE/TRUNK

Proposed CY 2009 new APC	HCPCS code	SI	Short descriptor	Proposed CY 2009 APC median cost
0129	21800	T	Treatment of rib fracture	$103.52
	21820	T	Treat sternum fracture.	
	22305	T	Treat spine process fracture.	
	23500	T	Treat clavicle fracture.	
	23540	T	Treat clavicle dislocation.	
	23570	T	Treat shoulder blade fx.	
	23600	T	Treat humerus fracture.	
	23620	T	Treat humerus fracture.	
	23650	T	Treat shoulder dislocation.	
	23675	T	Treat dislocation/fracture.	
	23929	T	Shoulder surgery procedure.	
	24500	T	Treat humerus fracture.	
	24505	T	Treat humerus fracture.	
	24530	T	Treat humerus fracture.	
	24560	T	Treat humerus fracture.	
	24565	T	Treat humerus fracture.	
	24576	T	Treat humerus fracture.	
	24600	T	Treat elbow dislocation.	
	24640	T	Treat elbow dislocation.	
	24650	T	Treat radius fracture.	
	24670	T	Treat ulnar fracture.	
	24675	T	Treat ulnar fracture.	
	24999	T	Upper arm/elbow surgery.	
	25500	T	Treat fracture of radius.	
	25530	T	Treat fracture of ulna.	
	25535	T	Treat fracture of ulna.	
	25560	T	Treat fracture radius & ulna.	
	25600	T	Treat fracture radius/ulna.	
	25622	T	Treat wrist bone fracture.	
	25630	T	Treat wrist bone fracture.	
	25650	T	Treat wrist bone fracture.	
	25660	T	Treat wrist dislocation.	
	25675	T	Treat wrist dislocation.	
	25680	T	Treat wrist fracture.	
	25999	T	Forearm or wrist surgery.	
	26600	T	Treat metacarpal fracture.	
	26605	T	Treat metacarpal fracture.	
	26641	T	Treat thumb dislocation.	
	26670	T	Treat hand dislocation.	
	26700	T	Treat knuckle dislocation.	
	26705	T	Treat knuckle dislocation.	

TABLE 15.—PROPOSED NEW APCS FOR CLOSED TREATMENT FRACTURE OF FINGER/TOE/TRUNK—Continued

Proposed CY 2009 new APC	HCPCS code	SI	Short descriptor	Proposed CY 2009 APC median cost
	26720	T	Treat finger fracture, each.	
	26725	T	Treat finger fracture, each.	
	26740	T	Treat finger fracture, each.	
	26742	T	Treat finger fracture, each.	
	26750	T	Treat finger fracture, each.	
	26755	T	Treat finger fracture, each.	
	26770	T	Treat finger dislocation.	
	26989	T	Hand/finger surgery.	
	27193	T	Treat pelvic ring fracture.	
	27200	T	Treat tail bone fracture.	
	27220	T	Treat hip socket fracture.	
	27230	T	Treat thigh fracture.	
	27250	T	Treat hip dislocation.	
	27256	T	Treat hip dislocation.	
	27265	T	Treat hip dislocation.	
	27267	T	Cltx thigh fx.	
	27299	T	Pelvis/hip joint surgery.	
	27501	T	Treatment of thigh fracture.	
	27503	T	Treatment of thigh fracture.	
	27508	T	Treatment of thigh fracture.	
	27516	T	Treat thigh fx growth plate.	
	27517	T	Treat thigh fx growth plate.	
	27520	T	Treat kneecap fracture.	
	27530	T	Treat knee fracture.	
	27538	T	Treat knee fracture(s).	
	27550	T	Treat knee dislocation.	
	27560	T	Treat kneecap dislocation.	
	27599	T	Leg surgery procedure.	
	27750	T	Treatment of tibia fracture.	
	27760	T	Cltx medial ankle fx.	
	27767	T	Cltx post ankle fx.	
	27768	T	Cltx post ankle fx w/mnpj.	
	27780	T	Treatment of fibula fracture.	
	27786	T	Treatment of ankle fracture.	
	27788	T	Treatment of ankle fracture.	
	27808	T	Treatment of ankle fracture.	
	27816	T	Treatment of ankle fracture.	
	27824	T	Treat lower leg fracture.	
	27830	T	Treat lower leg dislocation.	
	27899	T	Leg/ankle surgery procedure.	
	28400	T	Treatment of heel fracture.	
	28430	T	Treatment of ankle fracture.	
	28435	T	Treatment of ankle fracture.	
	28450	T	Treat midfoot fracture, each.	
	28455	T	Treat midfoot fracture, each.	
	28470	T	Treat metatarsal fracture.	
	28475	T	Treat metatarsal fracture.	
	28490	T	Treat big toe fracture.	
	28495	T	Treat big toe fracture.	
	28510	T	Treatment of toe fracture.	
	28515	T	Treatment of toe fracture.	
	28530	T	Treat sesamoid bone fracture.	
	28540	T	Treat foot dislocation.	
	28600	T	Treat foot dislocation.	
	28605	T	Treat foot dislocation.	
	28630	T	Treat toe dislocation.	
	28660	T	Treat toe dislocation.	
	28899	T	Foot/toes surgery procedure.	
0138	20660	T	Apply, rem fixation device	397.39
	22310	T	Treat spine fracture.	
	23520	T	Treat clavicle dislocation.	
	23525	T	Treat clavicle dislocation.	
	23545	T	Treat clavicle dislocation.	
	23575	T	Treat shoulder blade fx.	
	23665	T	Treat dislocation/fracture.	
	24535	T	Treat humerus fracture.	
	24577	T	Treat humerus fracture.	
	24655	T	Treat radius fracture.	
	25505	T	Treat fracture of radius.	

TABLE 15.—PROPOSED NEW APCS FOR CLOSED TREATMENT FRACTURE OF FINGER/TOE/TRUNK—Continued

Proposed CY 2009 new APC	HCPCS code	SI	Short descriptor	Proposed CY 2009 APC median cost
	25520	T	Treat fracture of radius.	
	25565	T	Treat fracture radius & ulna.	
	25605	T	Treat fracture radius/ulna.	
	25624	T	Treat wrist bone fracture.	
	25635	T	Treat wrist bone fracture.	
	26340	T	Manipulate finger w/anesth.	
	26645	T	Treat thumb fracture.	
	26675	T	Treat hand dislocation.	
	27238	T	Treat thigh fracture.	
	27246	T	Treat thigh fracture.	
	27500	T	Treatment of thigh fracture.	
	27510	T	Treatment of thigh fracture.	
	27810	T	Treatment of ankle fracture.	
	27818	T	Treatment of ankle fracture.	
	27840	T	Treat ankle dislocation.	
	28570	T	Treat foot dislocation.	
0139	22315	T	Treat spine fracture	1,339.53
	23505	T	Treat clavicle fracture.	
	23605	T	Treat humerus fracture.	
	23625	T	Treat humerus fracture.	
	24620	T	Treat elbow fracture.	
	25259	T	Manipulate wrist w/anesthes.	
	25690	T	Treat wrist dislocation.	
	26607	T	Treat metacarpal fracture.	
	26706	T	Pin knuckle dislocation.	
	27502	T	Treatment of thigh fracture.	
	27532	T	Treat knee fracture.	
	27752	T	Treatment of tibia fracture.	
	27762	T	Cltx med ankle fx w/mnpj.	
	27781	T	Treatment of fibula fracture.	
	27825	T	Treat lower leg fracture.	
	27831	T	Treat lower leg dislocation.	
	28405	T	Treatment of heel fracture.	
	28575	T	Treat foot dislocation.	

4. Individual Psychotherapy (APCs 0322 and 0323)

APC 0323 (Extended Individual Psychotherapy) had a 2 times rule violation for CYs 2007 and 2008, and was exempted from the 2 times rule during those years. APC 0323 would continue to have a 2 times rule violation in CY 2009 if its configuration is not adjusted. In the CY 2008 OPPS/ASC final rule with comment period (72 FR 66739), we agreed to review APC 0323 at the next APC Panel meeting and seek the APC Panel's guidance in reconfiguring this APC for CY 2009.

It was brought to our attention that a handful of CPT codes describe psychotherapy services that could be appropriately provided and reported as part of a partial hospitalization program, but would not otherwise be appropriately reported by a HOPD for those psychotherapy services. Specifically, the category heading in the 2008 CPT book specifies that the CPT codes listed in Table 16 below are to be reported for services provided in an ''inpatient hospital, partial hospital, or residential care facility.'' These CPT codes have been assigned to APCs 0322 (Brief Individual Psychotherapy) and 0323 since the implementation of the OPPS.

TABLE 16.—INPATIENT HOSPITAL, PARTIAL HOSPITAL, OR RESIDENTIAL CARE FACILITY PSYCHOTHERAPY CODES

CPT code	Long descriptor
90816	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 20 to 30 minutes face-to-face with the patient;
90817	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 20 to 30 minutes face-to-face with the patient; with medical evaluation and management services.
90818	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 45 to 50 minutes face-to-face with the patient;
90819	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 45 to 50 minutes face-to-face with the patient; with medical evaluation and management.
90821	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 75 to 80 minutes face-to-face with the patient;

TABLE 16.—INPATIENT HOSPITAL, PARTIAL HOSPITAL, OR RESIDENTIAL CARE FACILITY PSYCHOTHERAPY CODES—Continued

CPT code	Long descriptor
90822	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 75 to 80 minutes face-to-face with the patient; with medical evaluation and management services.
90823	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 20 to 30 minutes face-to-face with the patient;
90824	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 20 to 30 minutes face-to-face with the patient; with medical evaluation and management services.
90826	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 45 to 50 minutes face-to-face with the patient;
90827	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 45 to 50 minutes face-to-face with the patient; with medical evaluation and management services.
90828	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 75 to 80 minutes face-to-face with the patient;
90829	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 75 to 80 minutes face-to-face with the patient; with medical evaluation and management services.

The 2008 CPT book also includes a parallel set of CPT codes whose category heading in the CPT book specifies that these codes are to be reported for services provided in the office or other outpatient facilities. These CPT codes are listed in Table 17. These CPT codes have also been assigned to APCs 0322 and 0323 since the implementation of the OPPS.

TABLE 17.—OFFICE OR OTHER OUTPATIENT FACILITY PSYCHOTHERAPY CODES

CPT code	Long descriptor
90804	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient;
90805	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient; with medical evaluation and management services.
90806	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient;
90807	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient; with medical evaluation and management.
90808	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 75 to 80 minutes face-to-face with the patient;
90809	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 75 to 80 minutes face-to-face with the patient; with medical evaluation and management services.
90810	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient;
90811	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient; with medical evaluation and management services.
90812	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient;
90813	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient; with medical evaluation and management services.
90814	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 75 to 80 minutes face-to-face with the patient;
90815	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 75 to 80 minutes face-to-face with the patient; with medical evaluation and management services.

Our CY 2007 claims data for this proposed rule (excluding all claims for partial hospitalization services) include approximately 10,000 OPPS claims for CPT codes 90816 through 90829, compared with approximately 500,000 claims for CPT codes 90804 through 90815. We are unclear as to what HOPD services these claims for CPT codes 90816 through 90829 represent and believe that these may be miscoded claims. We do not believe that CPT codes 90816 through 90829 could be appropriately reported for hospital outpatient services that are not part of a partial hospitalization program. Therefore, for CY 2009, we are proposing to assign status indicator ''P'' to CPT codes 90816 through 90829, indicating that these services may be billed appropriately and paid under the

OPPS only when they are part of a partial hospitalization program. Partial hospitalization services are not included in our ratesetting process for nonpartial hospitalization OPPS services. Under this proposal, hospitals would continue to report CPT codes 90804 through 90815 for individual psychotherapy services provided in the HOPD that are not part of partial hospitalization services, consistent with CPT instructions.

We recalculated the median costs for APCs 0322 and 0323, after assigning status indicator ''P'' to CPT codes 90816 through 90829. As partial hospitalization services only, the claims data for these codes would only be considered for ratesetting with respect to partial hospitalization services paid through the two proposed CY 2009 partial hospitalization APCs, specifically APC 0172 (Level I Partial Hospitalization (3 services)) and APC 0173 (Level II Partial Hospitalization (4 or more services)), and no historical hospital claims data would continue to map to APCs 0322 and 0323. We refer readers to section X.B. of this proposed rule for a complete discussion of the proposed CY 2009 partial hospitalization payment policy. The CY 2009 proposed median costs for APCs 0322 and 0323 are approximately $88 and $108, respectively. This new configuration for APC 0323 eliminates the longstanding 2 times violation for this APC, although the median cost remains approximately the same as it was for CYs 2007 and 2008.

During its March 2008 APC Panel meeting, the APC Panel recommended that CMS restructure APC 0323 as described above, and that a similar restructuring be considered for APC 0322. For CY 2009, we are adopting the APC Panel's recommendation and, therefore, we are proposing to assign status indicator ''P'' to CPT codes 90816 through 90829.

5. Implant Injection for Vesicoureteral Reflex (APC 0162)

Following publication of the CY 2008 OPPS/ASC final rule with comment period, several members of the public contacted us to express their concerns regarding decreased access to and inadequate payment for CPT code 52327 (Cystourethroscopy, including ureteral catheterization, with subureteric injection of implant material). The CY 2008 OPPS payment for this procedure, which is assigned to APC 0162 (Level III Cystourethroscopy and other Genitourinary Procedures), is approximately $1,578. This procedure is primarily performed on pediatric patients to correct an anatomical defect that causes urine to reflux back to the kidneys (vesicoureteral reflux disease or VUR). From the perspective of these stakeholders, the assignment of this procedure to APC 0162 provides inadequate payment to cover the hospital's cost for the procedure, which they asserted requires expensive implant material. Specifically, they stated that the currently available CPT and Level II HCPCS coding lacks the specificity needed to properly account for the cost of the ureteral implant, resulting in inadequate payment for this procedure. In addition to receiving several letters on this subject, we also met with several stakeholders about the concerns of pediatric urologists regarding decreased access to and inadequate payment for performance of this procedure.

At the March 2008 APC Panel meeting, a presenter requested that the APC Panel recommend reassignment of CPT code 52327 from APC 0162 to APC 0385 (Level I Prosthetic Urological Procedures), which has a CY 2008 payment rate of approximately $5,327. The presenter indicated that while CPT code 52327 is clinically similar to other procedures assigned to APC 0162, it is not similar in terms of resource utilization. The presenter stated that CPT code 52327 is the only procedure assigned to APC 0162 that uses a high cost implant, yet it is paid the same as procedures that do not. The APC Panel recommended that CMS consider reassigning CPT code 52327 to a more appropriate APC.

Based upon our further review and analysis of the clinical characteristics and resource costs associated with the procedure, we are accepting the APC Panel's recommendation and proposing to reassign CPT code 52327 to APC 0163 (Level IV Cystourethroscopy and other Genitourinary Procedures) for CY 2009. The median cost of CPT code 52327 is approximately $2,030 based on 246 single claims available for this proposed rule. The proposed median cost of APC 0163 is approximately $2,388, and the median costs of significant procedures in this APC range from approximately $1,951 to $2,526. A number of the procedures assigned to APC 0163 are clinically similar to CPT code 52327, involving the use of a cystoscope and the implantation of devices. Based on our review of its clinical and resource characteristics, we believe the most appropriate CY 2009 APC assignment for CPT code 52327 is APC 0163. Therefore, for CY 2009, we are proposing to reassign CPT code 52327 from APC 0162 to APC 0163, with a proposed median cost of approximately $2,388.

IV. Proposed OPPS Payment for Devices

A. Pass-Through Payments for Devices

1. Expiration of Transitional Pass-Through Payments for Certain Devices

a. Background

Section 1833(t)(6)(B)(iii) of the Act requires that, under the OPPS, a category of devices be eligible for transitional pass-through payments for at least 2, but not more than 3, years. This period begins with the first date on which a transitional pass-through payment is made for any medical device that is described by the category. We may establish a new device category for pass-through payment in any quarter. Under our established policy, we base the expiration dates for the category codes on the date on which a category was first eligible for pass-through payment. We propose and finalize the dates for expiration of pass-through payments for device categories as part of the OPPS annual update.

Two currently eligible categories, C1821 (Interspinous process distraction device (implantable)) and L8690 (Auditory osseointegrated device, includes all internal and external components), were established for pass-through payment as of January 1, 2007. These two device categories will be eligible for pass-through payment for 2 years through December 31, 2008. In the CY 2008 OPPS/ASC final rule with comment period (72 FR 66751), we finalized our policy to expire these two categories from pass-through device payment after December 31, 2008.

We also have an established policy to package the costs of the devices no longer eligible for pass-through payments into the costs of the procedures with which the devices are reported in the claims data used to set the payment rates (67 FR 66763). Brachytherapy sources, which are now separately paid in accordance with section 1833(t)(2)(H) of the Act, are an exception to this established policy.

b. Proposed Policy

For CY 2009, we are implementing the final decisions that we discussed in the CY 2008 OPPS/ASC final rule with comment period that finalizes the expiration date of pass-through status for device categories C1821 and L8690. Therefore, as of January 1, 2009, we will discontinue pass-through payment for device category codes C1821 and L8690. In accordance with our established policy, we will package the costs of the devices assigned to these device categories into the costs of the procedures with which the devices were

billed in CY 2007, the year of hospital claims data used for this OPPS update.

We currently have no established device categories eligible for pass-through payment that are continuing into CY 2009. We continue to evaluate applications for devices pass-through payment on an ongoing basis. We may establish a new device category in any quarter, and we will advise the public of our decision to establish a new device category in a subsequent quarter in CY 2008 through the transmittal that implements the OPPS update for the applicable quarter. We would then propose an expiration date for such new categories in future OPPS annual updates.

2. Proposed Provisions for Reducing Transitional Pass-Through Payments To Offset Costs Packaged Into APC Groups

a. Background

We have an established policy to estimate the portion of each APC payment rate that could reasonably be attributed to the cost of the associated devices that are eligible for pass-through payments (66 FR 59904). We deduct from the pass-through payments for identified device categories eligible for pass-through payments an amount that reflects the portion of the APC payment amount that we determine is associated with the cost of the device, defined as the APC offset amount, as required by section 1833(t)(6)(D)(ii) of the Act. We have consistently employed an established methodology to estimate the portion of each APC payment rate that could reasonably be attributed to the cost of an associated device eligible for pass-through payment, using claims data from the period used for the most recent recalibration of the APC rates (72 FR 66751 through 66752). We establish and update the applicable APC offset amounts for eligible pass-through device categories through the transmittals that implement the quarterly OPPS updates.

b. Proposed Policy

We are proposing to continue our established policies for calculating and setting the APC offset amounts for each device category eligible for pass-through payment. We are also proposing to continue to review each new device category on a case-by-case basis, to determine whether device costs associated with the new category are packaged into the existing APC structure. If device costs packaged into the existing APC structure are associated with the new category, we would deduct the APC offset amount from the pass-through payment for the device category.

B. Proposed Adjustment to OPPS Payment for Partial or Full Credit Devices

1. Background

In recent years there have been several field actions and recalls as a result of implantable device failures. In many of these cases, the manufacturers have offered devices without cost to the hospital or with credit for the device being replaced if the patient required a more expensive device. In order to ensure that payment rates for procedures involving devices reflect only the full costs of those devices, our standard rate-setting methodology for device-dependent APCs uses only claims that contain the correct device code for the procedure, do not contain token charges, and do contain the ''FB'' modifier signifying that the device was furnished without cost or with a full credit.

To ensure equitable payment when the hospital receives a device without cost or with full credit, in CY 2007 we implemented a policy to reduce the payment for specified device-dependent APCs by the estimated portion of the APC payment attributable to device costs (that is, the device offset) when the hospital receives a specified device at no cost or with full credit. Hospitals are instructed to report such full credit/no cost cases using the ''FB'' modifier on the line with the procedure code in which the free device is used. In cases in which the device is furnished without cost, the hospital is to report a token device charge of less than $1.01. In cases in which the device being inserted is an upgrade (either of the same type of device or to a different type of device) with a full credit for the device being replaced, the hospital is to report as the device charge the difference between its usual charge for the replacement device being implanted and its usual charge for the replaced device for which it received full credit. In CY 2008, we expanded this payment adjustment policy to include cases in which hospitals receive partial credits of 50 percent or more of the cost of a specified device. Hospitals are instructed to append the ''FC'' modifier to the procedure code that reports the service provided to furnish the device when they receive a partial credit of 50 percent or more of the cost of the new device. In CY 2008, OPPS payment for the implantation procedure is reduced by 100 percent of the device offset for full credit/no cost cases when both a specified device code is present on the claim and the procedure code maps to a specified APC. Payment for the implantation procedure is reduced by 50 percent of the device offset for partial credit cases when both a specified device code is present on the claim and the procedure code maps to a specified APC. Beneficiary copayment is based on the reduced payment amount when either the ''FB'' or ''FC'' modifier is billed and the procedure and device codes appear on the lists of procedures and devices to which this policy applies. We refer readers to the CY 2008 OPPS/ASC final rule with comment period for more background information on the ''FB'' and ''FC'' payment adjustment policy (72 FR 66743 through 66749).

2. Proposed APCs and Devices Subject to the Adjustment Policy

For CY 2009, we are proposing to continue the policy of reducing OPPS payment by 100 percent of the device offset amount when a hospital furnishes a specified device without cost or with a full credit and by 50 percent of the device offset amount when the hospital receives partial credit in the amount of 50 percent or more of the cost for the device. Because the APC payments for the related services are specifically constructed to ensure that the full cost of the device is included in the payment, we continue to believe that it is appropriate to reduce the APC payment in cases in which the hospital receives a device without cost, with full credit, or with partial credit, in order to provide equitable payment in these cases (we refer readers to section II.A.2.d.(1) of this proposed rule for a description of our standard ratesetting methodology for device-dependent APCs). Moreover, the payment for these devices comprises a large part of the APC payment on which the beneficiary copayment is based, and we continue to believe it is equitable that the beneficiary cost sharing reflect the reduced costs in these cases.

We also are proposing to continue using the three criteria established in the CY 2007 OPPS/ASC final rule with comment period for determining the APCs to which this policy applies (71 FR 68072 through 68077). Specifically, (1) all procedures assigned to the selected APCs must require implantable devices that would be reported if device insertion procedures were performed, (2) the required devices must be surgically inserted or implanted devices that remain in the patient's body after the conclusion of the procedures (at least temporarily), and (3) the device offset amount must be significant, which for purposes of this policy is defined as exceeding 40 percent of the APC cost. We also are proposing to continue to restrict the devices to which

the APC payment adjustment would apply to a specific set of costly devices to ensure that the adjustment would not be triggered by the implantation of an inexpensive device whose cost would not constitute a significant proportion of the total payment rate for an APC. We continue to believe that these criteria are appropriate because free devices and credits are likely to be associated with particular cases only when the device must be reported on the claim and is of a type that is implanted and remains in the body when the beneficiary leaves the hospital. We believe that the reduction in payment is appropriate only when the cost of the device is a significant part of the total cost of the APC into which the device cost is packaged, and that the 40 percent threshold is a reasonable definition of a significant cost.

We examined the offset amounts calculated from the CY 2009 proposed rule data and the clinical characteristics of APCs to determine whether the APCs to which the full credit/no cost and partial credit device adjustment policy applies in CY 2008 continue to meet the criteria for CY 2009, and to determine whether other APCs to which the policy does not apply in CY 2008 would meet the criteria for CY 2009. Table 18 below lists the proposed APCs to which the payment reduction policy for full credit/no cost and partial credit devices would apply in CY 2009 and displays the proposed payment reduction percentages for both full credit/no cost and partial credit circumstances. Table 19 lists the proposed devices to which this policy would apply in CY 2009. As reflected in the tables, we are proposing to add APC 0425 (Level II Arthroplasty or Implantation with Prosthesis) and APC 0648 (Level IV Breast Surgery) and their associated devices that would not otherwise be on the device list for CY 2009 because the device offset percentages for these two APCs are above the 40 percent threshold based on the CY 2007 claims data available for the proposed rule. We also are proposing to remove APC 0106 (Insertion/Replacement of Pacemaker Leads and/or Electrodes) and device HCPCS codes associated only with procedures assigned to this APC because the proposed device offset percentage for that APC is less than 40 percent. We will update the lists of APCs and devices to which the full credit/no cost and partial credit device adjustment policy would apply in CY 2009 based on the final CY 2007 claims data available for the CY 2009 OPPS/ASC final rule with comment period.

TABLE 18.—PROPOSED APC ADJUSTMENTS IN CASES OF DEVICES FURNISHED AT NO COST OR WITH FULL OR PARTIAL CREDIT

APC	SI	APC title	Proposed CY 2009 reduction for full credit case (percent)	Proposed CY 2009 reduction for partial credit case (percent)
0039	S	Level I Implantation of Neurostimulator	83	42
0040	S	Percutaneous Implantation of Neurostimulator Electrodes, Excluding Cranial Nerve.	56	28
0061	S	Laminectomy, Laparoscopy, or Incision for Implantation of Neurostimulator Electrodes, Excluding Cranial Nerve.	61	30
0089	T	Insertion/Replacement of Permanent Pacemaker and Electrodes	72	36
0090	T	Insertion/Replacement of Pacemaker Pulse Generator	73	36
0107	T	Insertion of Cardioverter-Defibrillator	89	44
0108	T	Insertion/Replacement/Repair of Cardioverter-Defibrillator Leads	88	44
0222	S	Level II Implantation of Neurostimulator	84	42
0225	S	Implantation of Neurostimulator Electrodes, Cranial Nerve	61	30
0227	T	Implantation of Drug Infusion Device	81	40
0259	T	Level VII ENT Procedures	83	42
0315	S	Level III Implantation of Neurostimulator	88	44
0385	S	Level I Prosthetic Urological Procedures	57	29
0386	S	Level II Prosthetic Urological Procedures	64	32
0418	T	Insertion of Left Ventricular Pacing Elect	70	35
0425	T	Level II Arthroplasty or Implantation with Prosthesis	46	23
0648	T	Level IV Breast Surgery	41	21
0654	T	Insertion/Replacement of a permanent dual chamber pacemaker	77	38
0655	T	Insertion/Replacement/Conversion of a permanent dual chamber pacemaker	75	37
0680	S	Insertion of Patient Activated Event Recorders	71	35
0681	T	Knee Arthroplasty	74	37

TABLE 19.—PROPOSED DEVICES FOR WHICH THE "FB" OR "FC" MODIFIER MUST BE REPORTED WITH THE PROCEDURE CODE WHEN FURNISHED AT NO COST OR WITH FULL OR PARTIAL CREDIT

Device HCPCS code	Short descriptor
C1721	AICD, dual chamber.
C1722	AICD, single chamber.
C1728	Cath, brachytx seed adm.

TABLE 19.—PROPOSED DEVICES FOR WHICH THE "FB" OR "FC" MODIFIER MUST BE REPORTED WITH THE PROCEDURE CODE WHEN FURNISHED AT NO COST OR WITH FULL OR PARTIAL CREDIT—Continued

Device HCPCS code	Short descriptor
C1764	Event recorder, cardiac.
C1767	Generator, neurostim, imp.
C1771	Rep dev, urinary, w/sling.

TABLE 19.—PROPOSED DEVICES FOR WHICH THE "FB" OR "FC" MODIFIER MUST BE REPORTED WITH THE PROCEDURE CODE WHEN FURNISHED AT NO COST OR WITH FULL OR PARTIAL CREDIT—Continued

Device HCPCS code	Short descriptor
C1772	Infusion pump, programmable.
C1776	Joint device (implantable).
C1778	Lead, neurostimulator.

TABLE 19.—PROPOSED DEVICES FOR WHICH THE ''FB'' OR ''FC'' MODIFIER MUST BE REPORTED WITH THE PROCEDURE CODE WHEN FURNISHED AT NO COST OR WITH FULL OR PARTIAL CREDIT—Continued

Device HCPCS code	Short descriptor
C1779	Lead, pmkr, transvenous VDD.
C1785	Pmkr, dual, rate-resp.
C1786	Pmkr, single, rate-resp.
C1789	Prosthesis, breast, imp.
C1813	Prosthesis, penile, inflatab.
C1815	Pros, urinary sph, imp.
C1820	Generator, neuro rechg bat sys.
C1881	Dialysis access system.
C1882	AICD, other than sing/dual.
C1891	Infusion pump, non-prog, perm.
C1897	Lead, neurostim, test kit.
C1898	Lead, pmkr, other than trans.
C1900	Lead coronary venous.
C2619	Pmkr, dual, non rate-resp.
C2620	Pmkr, single, non rate-resp.
C2621	Pmkr, other than sing/dual.
C2622	Prosthesis, penile, non-inf.
C2626	Infusion pump, non-prog, temp.
C2631	Rep dev, urinary, w/o sling.
L8600	Implant breast silicone/eq.
L8614	Cochlear device/system.
L8690	Aud osseo dev, int/ext comp.

V. Proposed OPPS Payment Changes for Drugs, Biologicals, and Radiopharmaceuticals

A. Proposed OPPS Transitional Pass-Through Payment for Additional Costs of Drugs, Biologicals, and Radiopharmaceuticals

1. Background

Section 1833(t)(6) of the Act provides for temporary additional payments or ''transitional pass-through payments'' for certain drugs and biological agents. As originally enacted by the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act (BBRA) of 1999 (Pub. L. 106–113), this provision requires the Secretary to make additional payments to hospitals for current orphan drugs, as designated under section 526 of the Federal Food, Drug, and Cosmetic Act (Pub. L. 107–186); current drugs and biological agents and brachytherapy sources used for the treatment of cancer; and current radiopharmaceutical drugs and biological products. For those drugs and biological agents referred to as ''current,'' the transitional pass-through payment began on the first date the hospital OPPS was implemented (before enactment of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000 (Pub. L. 106–554), on December 21, 2000).

Transitional pass-through payments are also provided for certain ''new'' drugs and biological agents that were not being paid for as an HOPD service as of December 31, 1996, and whose cost is ''not insignificant'' in relation to the OPPS payments for the procedures or services associated with the new drug or biological. For pass-through payment purposes, radiopharmaceuticals are included as ''drugs.'' Under the statute, transitional pass-through payments can be made for at least 2 years but not more than 3 years. Proposed CY 2009 pass-through drugs and biologicals and their APCs are assigned status indicator ''G'' as indicated in Addenda A and B to this proposed rule.

Section 1833(t)(6)(D)(i) of the Act specifies that the pass-through payment amount, in the case of a drug or biological, is the amount by which the amount determined under section 1842(o) of the Act (or, if the drug or biological is covered under a competitive acquisition contract under section 1847B of the Act, an amount determined by the Secretary equal to the average price for the drug or biological for all competitive acquisition areas and year established under such section as calculated and adjusted by the Secretary) for the drug or biological exceeds the portion of the otherwise applicable Medicare OPD fee schedule that the Secretary determines is associated with the drug or biological. This methodology for determining the pass-through payment amount is set forth in § 419.64 of the regulations, which specifies that the pass-through payment equals the amount determined under section 1842(o) of the Act minus the portion of the APC payment that CMS determines is associated with the drug or biological. Section 1847A of the Act, as added by section 303(c) of Pub. L. 108–173, establishes the use of the average sales price (ASP) methodology as the basis for payment for drugs and biologicals described in section 1842(o)(1)(C) of the Act that are furnished on or after January 1, 2005. The ASP methodology, as applied under the OPPS, uses several sources of data as a basis for payment, including the ASP, wholesale acquisition cost (WAC), and average wholesale price (AWP). In this proposed rule, the term ''ASP methodology'' and ''ASP-based'' are inclusive of all data sources and methodologies described therein. Additional information on the ASP methodology can be found on the CMS Web site at: *http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/01_overview.asp#TopOfPage.*

As noted above, section 1833(t)(6)(D)(i) of the Act also states that if a drug or biological is covered under a competitive acquisition contract under section 1847B of the Act, the payment rate is equal to the average price for the drug or biological for all competitive acquisition areas and the year established as calculated and adjusted by the Secretary. Section 1847B of the Act, as added by section 303(d) of Pub. L. 108–173, establishes the payment methodology for Medicare Part B drugs and biologicals under the competitive acquisition program (CAP). The Part B drug CAP was implemented July 1, 2006, and includes approximately 190 of the most common Part B drugs provided in the physician's office setting. The list of drugs and biologicals covered under the Part B drug CAP, their associated payment rates, and the Part B drug CAP pricing methodology can be found on the CMS Web site at: *http://www.cms.hhs.gov/CompetitiveAcquisforBios.*

For CYs 2005, 2006, and 2007, we estimated the OPPS pass-through payment amount for drugs and biologicals to be zero based on our interpretation that the ''otherwise applicable Medicare OPD fee schedule'' amount was equivalent to the amount to be paid for pass-through drugs and biologicals under section 1842(o) of the Act (or section 1847B of the Act, if the drug or biological is covered under a competitive acquisition contract). We concluded for those years that the resulting difference between these two rates would be zero. For CY 2008, we estimated the OPPS pass-through payment amount for drugs and biologicals to be $6.6 million. Our proposed OPPS pass-through payment estimate for drugs and biologicals in CY 2009 is $8.9 million, which is discussed in section VI.B. of this proposed rule.

The pass-through application and review process for drugs and biologicals is explained on the CMS Web site at: *http://www.cms.hhs.gov/HospitalOutpatientPPS/04_passthrough_payment.asp.*

2. Proposed Drugs and Biologicals With Expiring Pass-Through Status in CY 2008

Section 1833(t)(6)(C)(i) of the Act specifies that the duration of transitional pass-through payments for drugs and biologicals must be no less than 2 years and no longer than 3 years. We are proposing that the pass-through status of 15 drugs and biologicals expire on December 31, 2008, as listed in Table 20 below. Our standard methodology for providing payment for drugs and biologicals with expiring pass-through status in an upcoming calendar year is to determine the product's estimated per day cost and compare it with the OPPS drug packaging threshold for that

calendar year (proposed at $60 for CY 2009). If the estimated per day cost is less than or equal to the applicable OPPS drug packaging threshold, we would package payment for the drug or biological into the payment for the associated procedure in the upcoming calendar year. If the estimated per day cost is greater than the OPPS drug packaging threshold, we would provide separate payment at the applicable relative ASP-based payment amount (proposed at ASP + 4 percent for CY 2009). For drugs and biologicals that are currently covered under the CAP, we are proposing to use the payment rates calculated under that program that are in effect as of April 1, 2008, for purposes of packaging decisions and for Addenda A and B to this proposed rule. We are proposing to update these payment rates for purposes of the CY 2009 OPPS/ASC final rule with comment period.

Three of the products with expiring pass-through status for CY 2009 are biologicals that are solely surgically implanted according to their Food and Drug Administration-approved indications. These products are described by HCPCS codes C9352 (Microporous collagen implantable tube (Neuragen Nerve Guide), per centimeter length); C9353 (Microporous collagen implantable slit tube (NeuraWrap Nerve Protector), per centimeter length); and J7348 (Dermal (substitute) tissue of nonhuman origin, with or without other bioengineered or processed elements, without metabolically active elements (Tissuemend), per square centimeter).

The methodology of calculating a product's estimated per day cost and comparing it to the annual OPPS drug packaging threshold has been used to determine the packaging status of all drugs and biologicals under the OPPS (except for our exemption for 5HT3 anti-emetics), including injectable products paid for under the OPPS as biologicals (such as intraarticular sodium hyaluronate products). However, we believe that the three products described above with expiring pass-through status for CY 2009 differ from other biologicals paid under the OPPS in that they specifically function as surgically implanted devices. Both implantable devices under the OPPS and these three biologicals with expiring pass-through status are always surgically inserted or implanted (including through a surgical incision or a natural orifice). Furthermore, in some cases these implantable biologicals can substitute for implantable nonbiologic devices (such as for synthetic nerve conduits or synthetic mesh used in tendon repair). To date, for other nonpass-through biologicals paid under the OPPS which may sometimes be used as implantable devices, we have instructed hospitals, via Transmittal 1336, Change Request 5718, dated September 14, 2007, to not separately bill for the HCPCS codes for the products when using these items as implantable devices (including as a scaffold or an alternative to human or nonhuman connective tissue or mesh used in a graft) during surgical procedures. In such cases, we consider payment for the biological used as an implantable device in a specific clinical case to be included in payment for the surgical procedure.

As we established in the CY 2003 OPPS final rule with comment period (67 FR 66763), when the pass-through payment period for an implantable device ends, it is standard OPPS policy to package payment for the implantable device into payment for its associated surgical procedure. We consider nonpass-through implantable devices to be integral and supportive items and services for which packaged payment is most appropriate. According to our regulations at § 419.2(b), as a prospective payment system, the OPPS establishes a national payment rate that includes operating and capital-related costs that are directly related and integral to performing a procedure or furnishing a service on an outpatient basis including, but not limited to, implantable prosthetics, implantable durable medical equipment, and medical and surgical supplies. Therefore, when the period of device pass-through payment ends, we package the costs of the devices no longer eligible for pass-through payment into the costs of the procedures with which the devices were reported in the claims data used to set the payment rates for the upcoming calendar year. We believe this policy to package payment for implantable devices that are integral to the performance of separately paid procedures should also apply to payment for implantable biologicals without pass-through status, when those biologicals function as implantable devices. As stated above, implantable biologicals may be used in place of other implantable nonbiologic devices whose costs are already accounted for in the associated procedural APC payments for surgical procedures. If we were to provide separate payment for these implantable biologicals without pass-through status, we would potentially be providing duplicate device payment, both through the packaged nonbiologic device cost included in the surgical procedure's payment and separate biological payment. We see no basis for treating implantable biological and nonbiologic devices without pass-through status differently for OPPS payment purposes, because both are integral to and supportive of the separately paid surgical procedures in which either may be used. Therefore, for CY 2009, we are proposing to package payment for any biological without pass-through status that is surgically inserted or implanted (through a surgical incision or a natural orifice) into the payment for the associated surgical procedure. As a result of this proposed methodology, HCPCS codes C9352, C9353 and J7348 would be packaged and assigned status indicator ''N'' for CY 2009. In addition, any new biologicals without pass-through status that are surgically inserted or implanted (through a surgical incision or a natural orifice) would be packaged beginning in CY 2009. Moreover, for nonpass-through biologicals which may sometimes be used as implantable devices, we would continue to instruct hospitals to not bill separately for the HCPCS codes for the products when used as implantable devices. This reporting would ensure that the costs of these products that may be, but are not always, used as implanted biologicals are appropriately packaged into payment for the associated implantation procedures.

TABLE 20.—PROPOSED DRUGS AND BIOLOGICALS FOR WHICH PASS-THROUGH STATUS WOULD EXPIRE DECEMBER 31, 2008

CY 2009 HCPCS code	CY 2008 HCPCS code	CY 2008 descriptor	Proposed CY 2009 SI	Proposed CY 2009 APC
C9352	C9352	Neuragen nerve guide, per cm	N	
C9353	C9353	Neurawrap nerve protector, cm	N	
J0129	J0129*	Abatacept injection	K	9230

TABLE 20.—PROPOSED DRUGS AND BIOLOGICALS FOR WHICH PASS-THROUGH STATUS WOULD EXPIRE DECEMBER 31, 2008—Continued

CY 2009 HCPCS code	CY 2008 HCPCS code	CY 2008 descriptor	Proposed CY 2009 SI	Proposed CY 2009 APC
J0348	J0348	Anadulafungin injection	K	0760
J0894	J0894*	Decitabine injection	K	9231
J1740	J1740*	Ibandronate sodium injection	K	9229
J1743	J1743	Idursulfase injection	K	9232
J2248	J2248	Micafungin sodium injection	K	9227
J2323	J2323*	Natalizumab injection	K	9126
J2778	J2778*	Ranibizumab injection	K	9233
J3243	J3243	Tigecycline injection	K	9228
J3473	J3473	Hyaluronidase recombinant	N	
J7348	J7348	Tissuemend tissue	N	
J7349	J7349	Primatrix tissue	K	1141
J9303	J9303	Panitumumab injection	K	9235

* Indicates that the drug was paid at a rate determined by the Part B drug CAP methodology while identified as pass-through under the OPPS.

3. Proposed Drugs, Biologicals, and Radiopharmaceuticals With New or Continuing Pass-Through Status in CY 2009

We are proposing to continue pass-through status in CY 2009 for 16 drugs and biologicals. These items, which were approved for pass-through status between April 1, 2007 and July 1, 2008, are listed in Table 21. The APCs and HCPCS codes for these proposed drugs and biologicals listed in Table 21 are assigned status indicator ''G'' in Addenda A and B to this proposed rule.

Section 1833(t)(6)(D)(i) of the Act sets the amount of pass-through payment for pass-through drugs and biologicals (the pass-through payment amount) as the difference between the amount authorized under section 1842(o) of the Act (or, if the drug or biological is covered under a CAP under section 1847B of the Act, an amount determined by the Secretary equal to the average price for the drug or biological for all competitive acquisition areas and year established under such section as calculated and adjusted by the Secretary) and the portion of the otherwise applicable fee schedule amount that the Secretary determines is associated with the drug or biological. Given our CY 2009, proposal to provide payment for nonpass-through separately payable drugs and biologicals at ASP+4 percent as described further in section V.B.3. of this proposed rule, we believe it would be consistent with the statute to provide payment for drugs and biologicals with pass-through status that are not part of the Part B drug CAP at a rate of ASP+6 percent, the amount authorized under section 1842(o) of the Act, rather than ASP+4 percent that would be the otherwise applicable fee schedule portion associated with the drug or biological. The difference between ASP+4 percent and ASP+6 percent, therefore, would be the CY 2009 pass-through payment amount for these drugs and biologicals. Thus, for CY 2009, we are proposing to pay for pass-through drugs and biologicals that are not part of the Part B drug CAP at ASP+6 percent, equivalent to the rate these drugs and biologicals would receive in the physician's office setting in CY 2009.

Section 1842(o) of the Act also states that if a drug or biological is covered under the CAP under section 1847B of the Act, the payment rate is equal to the average price for the drug or biological for all competitive acquisition areas and year established as calculated and adjusted by the Secretary. For CY 2009, we are proposing to provide payment for drugs and biologicals with pass-through status that are offered under the Part B drug CAP at a rate equal to the Part B drug CAP rate. Therefore, considering ASP+4 percent to be the otherwise applicable fee schedule portion associated with these drugs or biologicals, the difference between the Part B drug CAP rate and ASP+4 percent would be the pass-through payment amount for these drugs and biologicals. HCPCS codes that are offered under the CAP program as of April 1, 2008 are identified in Table 21 below with an asterisk.

In section V.B.5. of this proposed rule, we discuss our proposal to make separate payment in CY 2009 for new drugs and biologicals with a HCPCS code but without hospital claims data, consistent with the provisions of section 1842(o) of the Act, at a rate that is equivalent to the payment they would receive in a physician's office setting (or under section 1847B of the Act, if the drug or biological is covered under a competitive acquisition contract) only if we have received a pass-through application for the item and pass-through status has been subsequently granted. Otherwise, we are proposing to pay ASP+4 percent for these products in CY 2009.

In addition, we are proposing to update pass-through payment rates on a quarterly basis on our Web site during CY 2009 if later quarter ASP submissions (or more recent WAC or AWP information, as applicable) indicate that adjustments to the payment rates for these pass-through drugs and biologicals are necessary. If a drug or biological that has been granted pass-through status for CY 2009 becomes covered under the Part B drug CAP, we are proposing to make the appropriate adjustments to the payment rates for these drugs and biologicals on a quarterly basis.

In CY 2009, we are proposing to provide payment for diagnostic and therapeutic radiopharmaceuticals that are granted pass-through status based on the ASP methodology. As stated above, for purposes of pass-through payment, we consider radiopharmaceuticals to be drugs under the OPPS and, therefore, if a diagnostic or therapeutic radiopharmaceutical receives pass-through status during CY 2009, we are proposing to follow the standard ASP methodology to determine its pass-through payment rate under the OPPS. If ASP information is available, the payment rate would be equivalent to the payment rate that drugs receive under section 1842(o) of the Act, that is, ASP+6 percent. If ASP data are not available for a radiopharmaceutical, we are proposing to base the pass-through payment on the product's WAC. If WAC information is also not available, we are proposing to provide payment for the pass-through radiopharmaceutical at 95 percent of its most recent AWP.

TABLE 21.—PROPOSED DRUGS AND BIOLOGICALS WITH CONTINUING PASS-THROUGH STATUS IN CY 2009

CY 2008 HCPCS code	CY 2009 HCPCS code	Short descriptor	Proposed CY 2009 SI	Proposed CY 2009 APC
C9238	C9238	Inj, levetiracetam	G	9238
C9239	C9239	Inj, temsirolimus	G	1168
C9240*	C9240	Injection, ixabepilone	G	9240
C9241	C9241	Injection, doripenem	G	9241
C9242	C9242	Injection, fosaprepitant	G	9242
C9354	C9354	Veritas collagen matrix, cm2	G	9354
C9355	C9355	Neuromatrix nerve cuff, cm	G	9355
C9356	C9356	TenoGlide Tendon Prot, cm2	G	9356
C9357	C9357	Flowable Wound Matrix, 1 cc	G	9357
C9358	C9358	SurgiMend, 0.5 cm2	G	9358
J1300	J1300	Eculizumab injection	G	9236
J1571	J1571	HepaGam B IM Injection	G	0946
J1573	J1573	Hepagam B intravenous, inj	G	9356
J3488*	J3488	Reclast injection	G	0951
J9226	J9226	Supprelin LA implant	G	1142
J9261	J9261	Nelarabine injection	G	0825

* Indicates that the drug was paid at a rate determined by the Part B drug CAP methodology while identified as pass-through under the OPPS.

4. Proposed Reduction of Transitional Pass-Through Payments for Diagnostic Radiopharmaceuticals To Offset Costs Packaged Into APC Groups

Prior to CY 2008, certain diagnostic radiopharmaceuticals were paid separately under the OPPS if their mean per day costs were greater than the applicable year's drug packaging threshold. In CY 2008 (72 FR 66768), we packaged payment for all nonpass-through diagnostic radiopharmaceuticals as ancillary and supportive items and services. Specifically, we packaged payment for all nonpass-through diagnostic radiopharmaceuticals, including those products that would not otherwise have been packaged based solely on the CY 2008 drug packaging threshold, into payment for their associated nuclear medicine procedures. We are proposing to continue to package payment in CY 2009 for all nonpass-through diagnostic radiopharmaceuticals as discussed in section V.B.2.b. of this proposed rule.

As previously noted, for OPPS pass-through payment purposes, radiopharmaceuticals are considered to be ''drugs.'' As described above, section 1833(t)(6)(D)(i) of the Act specifies that the transitional pass-through payment amount for pass-through drugs and biologicals is the difference between the amount paid under section 1842(o) or the Part B drug CAP rate and the otherwise applicable OPPS payment amount. Furthermore, transitional pass-through payments for drugs, biologicals, and radiopharmaceuticals under the OPPS are made for a period of at least 2 but not more than 3 years. There are currently no radiopharmaceuticals with pass-through status under the OPPS. For new pass-through radiopharmaceuticals with no ASP information or CAP rate, our proposed CY 2009 payment methodology is discussed in section V.A.3. of this proposed rule. According to this proposal and consistent with our CY 2008 final policy (72 FR 66755), new pass-through diagnostic radiopharmaceuticals without ASP information would be paid based on WAC or, if WAC is not available, based on 95 percent of the product's most recently published AWP.

As described in section IV.A.2.a. of this proposed rule regarding pass-through device payment, we have consistently employed an established methodology to estimate the portion of each APC payment rate that could reasonably be attributed to the cost of an associated device eligible for pass-through payment (the APC device offset amount) to avoid duplicate payment for the device portion of a procedure. This calculation uses calendar year claims data from the period used for the most recent recalibration of the APC payment rates (72 FR 66751 through 66752). We evaluate new pass-through device categories individually to determine if there are device costs packaged into the associated procedural APC payment rate from predecessor devices that resemble the new pass-through device category, suggesting that a device offset amount would be appropriate. On an ongoing basis, through the quarterly transmittals that implement the quarterly OPPS updates, we establish the applicable APC device offset amount, if any, in the same quarter as the eligible pass-through device category is first established. We update device offset amounts annually for eligible pass-through device categories when we recalibrate APC payment rates. We note that we initially implemented the device offset policy in CY 2001 only for pacemakers and neurostimulators but subsequently expanded the offset to other pass-through devices with costs from predecessor devices packaged into the existing APC structure beginning in CY 2002. Since April 2002, we have applied a uniform reduction, the APC device offset amount for the associated procedure, to payment for each of the devices receiving transitional pass-through payments furnished on or after April 1, 2002, and for which we have determined that the pass-through device resembles packaged predecessor devices.

Because of our proposed CY 2009 packaging policy for diagnostic radiopharmaceuticals, we believe that a payment offset policy, as discussed previously for implantable devices, is now appropriate for diagnostic radiopharmaceuticals approved for pass-through payment status. An APC radiopharmaceutical offset amount would allow us to avoid duplicate payment for the diagnostic radiopharmaceutical portion of a nuclear medicine procedure by providing a diagnostic radiopharmaceutical pass-through payment that represents the difference between the payment rate for the diagnostic radiopharmaceutical and the packaged radiopharmaceutical cost included in the procedural APC payment for the nuclear medicine procedure. The otherwise applicable OPPS payment amount for the diagnostic radiopharmaceutical would roughly be the median cost of the predecessor diagnostic radiopharmaceuticals that is packaged into the payment for the nuclear

medicine procedure. This APC radiopharmaceutical offset amount, similar to the longstanding device offset policy for payment of implantable devices with pass-through status, would be calculated based on a percentage of the APC payment for a nuclear medicine procedure attributable to the costs of packaged diagnostic radiopharmaceuticals, as reflected in the most recent complete year of hospital outpatient claims data.

Beginning in CY 2009, we are proposing to review each new pass-through diagnostic radiopharmaceutical on a case-by-case basis, to determine whether radiopharmaceutical costs associated with predecessors of the new product are packaged into the existing APC structure for those nuclear medicine procedures with which the new radiopharmaceutical would be used. This proposed methodology is consistent with our current policy for new device categories. Because of the nature of diagnostic radiopharmaceuticals and the small number of nuclear medicine procedures to which they are typically closely linked, we believe that we would usually find costs for predecessor diagnostic radiopharmaceuticals packaged into the existing APC payment for the nuclear medicine procedures associated with the new product. In these cases, we would deduct the uniform, applicable APC radiopharmaceutical offset amount for the associated nuclear medicine procedure, calculated as described below, from the pass-through payment for the diagnostic radiopharmaceutical. We are proposing to establish the pertinent APC radiopharmaceutical offset amounts for newly eligible pass-through diagnostic radiopharmaceuticals quarterly through the transmittals that implement the quarterly OPPS updates and update these offset amounts annually, as needed.

Not all CY 2007 OPPS claims for nuclear medicine procedures include radiolabeled products because radiopharmaceutical claims processing edits were implemented beginning in CY 2008. These claims processing edits require that a radiolabeled product be included on all claims for nuclear medicine procedures to ensure that we capture the full costs of the packaged diagnostic radiopharmaceuticals used for the procedures in future ratesetting. Because our most recent claims data do not yet reflect the results of these edits, we are proposing to use only those claims that pass the radiopharmaceutical edits to set rates for nuclear medicine procedures in CY 2009 as discussed in section II.A.2.d.(5) of this proposed rule. We are proposing to use the same claims to calculate the APC radiopharmaceutical offset amounts. Specifically, we would calculate the APC radiopharmaceutical offset fraction as: 1 minus (the cost from single procedure claims in the APC that pass the radiopharmaceutical edits after removing the costs for packaged diagnostic radiopharmaceuticals divided by the cost from single procedure claims in the APC that pass the radiopharmaceutical edits). To determine the actual APC offset amount, we would then multiply the resulting fraction by the CY 2009 APC payment amount for the procedure with which the new diagnostic radiopharmaceutical is used and, accordingly, reduce the transitional pass-through payment for the diagnostic radiopharmaceutical with pass-through status by this amount.

Table 22 displays the APCs to which nuclear medicine procedures are proposed for assignment in CY 2009 and for which we would expect that an APC radiopharmaceutical offset could be applicable in the case of new diagnostic radiopharmaceuticals with pass-through status.

TABLE 22.—APCS TO WHICH NUCLEAR MEDICINE PROCEDURES ARE PROPOSED FOR CY 2009 ASSIGNMENT

APC	APC title
0307	Myocardial Positron Emission Tomography (PET) imaging.
0308	Non-Myocardial Positron Emission Tomography (PET) imaging.
0377	Level II Cardiac Imaging.
0378	Level II Pulmonary Imaging.
0389	Level I Non-imaging Nuclear Medicine.
0390	Level I Endocrine Imaging.
0391	Level II Endocrine Imaging.
0392	Level II Non-imaging Nuclear Medicine.
0393	Hematologic Processing & Studies.
0394	Hepatobiliary Imaging.
0395	GI Tract Imaging.
0396	Bone Imaging.
0397	Vascular Imaging.
0398	Level I Cardiac Imaging.
0400	Hematopoietic Imaging.
0401	Level I Pulmonary Imaging.
0402	Level II Nervous System Imaging.
0403	Level I Nervous System Imaging.
0404	Renal and Genitourinary Studies.
0406	Level I Tumor/Infection Imaging.
0408	Level III Tumor/Infection Imaging.
0414	Level II Tumor/Infection Imaging.

B. Proposed OPPS Payment for Drugs, Biologicals, and Radiopharmaceuticals Without Pass-Through Status

1. Background

Under the CY 2008 OPPS, we currently pay for drugs, biologicals, and radiopharmaceuticals that do not have pass-through status in one of two ways: Packaged payment into the payment for the associated service or separate payment (individual APCs). We explained in the April 7, 2000, OPPS final rule with comment period (65 FR 18450) that we generally package the cost of drugs and radiopharmaceuticals into the APC payment rate for the procedure or treatment with which the products are usually furnished. Hospitals do not receive separate payment from Medicare for packaged items and supplies, and hospitals may not bill beneficiaries separately for any packaged items and supplies whose costs are recognized and paid within the national OPPS payment rate for the associated procedure or service. (Program Memorandum Transmittal A–01–133, issued on November 20, 2001, explains in greater detail the rules regarding separate payment for packaged services.)

Packaging costs into a single aggregate payment for a service, procedure, or episode of care is a fundamental principle that distinguishes a prospective payment system from a fee schedule. In general, packaging the costs of items and services into the payment for the primary procedure or service with which they are associated encourages hospital efficiencies and also enables hospitals to manage their resources with maximum flexibility.

Section 1833(t)(16)(B) of the Act, as added by section 621(a)(2) of Pub. L. 108–173, sets the threshold for establishing separate APCs for drugs and biologicals at $50 per administration for CYs 2005 and 2006. Therefore, for CYs 2005 and 2006, we paid separately for drugs, biologicals, and radiopharmaceuticals whose per day cost exceeded $50 and packaged the costs of drugs, biologicals, and radiopharmaceuticals whose per day cost was equal to or less than $50 into the procedures with which they were billed. For CY 2007, the packaging threshold for drugs, biologicals, and radiopharmaceuticals that were not new and did not have pass-through status was established at $55. For CY 2008, the packaging threshold for drugs, biologicals, and radiopharmaceuticals that are not new and do not have pass-through status was established at $60. The methodology used to establish the $55 threshold for CY 2007, the $60

threshold for CY 2008, and our proposed approach for CY 2009 are discussed in more detail in section V.B.2. of this proposed rule.

In addition, since CY 2005, we have provided an exemption to this packaging determination for oral and injectable 5HT3 anti-emetic products. We discuss in section V.B.2. of this proposed rule our proposed CY 2009 payment policy for these anti-emetic products.

2. Proposed Criteria for Packaging Payment for Drugs, Biologicals and Radiopharmaceuticals

a. Drugs, Biologicals, and Therapeutic Radiopharmaceuticals

As indicated above, in accordance with section 1833(t)(16)(B) of the Act, the threshold for establishing separate APCs for payment of drugs and biologicals was set to $50 per administration during CYs 2005 and 2006. In CY 2007, we used the fourth quarter moving average Producer Price Index (PPI) levels for prescription preparations to trend the $50 threshold forward from the third quarter of CY 2005 (when the Pub. L. 108–173 mandated threshold became effective) to the third quarter of CY 2007. We then rounded the resulting dollar amount to the nearest $5 increment in order to determine the CY 2007 threshold amount of $55. Using the same methodology as that used in CY 2007 (which is discussed in more detail in the CY 2007 OPPS/ASC final rule with comment period (71 FR 68085 through 68086)), for CY 2008 we set the packaging threshold for establishing separate APCs for drugs and biologicals at $60.

Following the CY 2007 methodology for CY 2009, we used updated fourth quarter moving average PPI levels to trend the $50 threshold forward from the third quarter of CY 2005 to the third quarter of CY 2009 and again rounded the resulting dollar amount ($61.25) to the nearest $5 increment, which yielded a figure of $60. In performing this calculation, we used the most up-to-date forecasted, quarterly PPI estimates from CMS' Office of the Actuary (OACT). As actual inflation for past quarters replaced forecasted amounts, the PPI estimates for prior quarters have been revised (compared with those used in the CY 2007 OPPS/ASC final rule with comment period) and have been incorporated into our calculation. Based on the calculations described above, we are proposing a packaging threshold for CY 2009 of $60. As stated in the CY 2007 OPPS/ASC final rule with comment period (71 FR 68086), we believe that packaging certain items is a fundamental component of a prospective payment system, that packaging these items does not lead to beneficiary access issues and does not create a problematic site of service differential, that the packaging threshold is reasonable based on the initial establishment in law of a $50 threshold for the CY 2005 OPPS, that updating the $50 threshold is consistent with industry and government practices, and that the PPI for prescription preparations is an appropriate mechanism to gauge Part B drug inflation. During the March 2008 APC Panel meeting, the APC Panel made a recommendation supporting CMS' current methodology of adjusting the threshold dollar amount for packaging drugs and biologicals on the basis of the PPI for prescription drugs. We are adopting the APC Panel's recommendation, and we are proposing to continue this methodology for updating the drug packaging threshold for CY 2009.

To determine their CY 2009 proposed packaging status, we calculated the per day cost of all drugs, biologicals, and therapeutic radiopharmaceuticals that had a HCPCS code in CY 2007 and were paid (via packaged or separate payment) under the OPPS using claims data from January 1, 2007, to December 31, 2007. In order to calculate the per day costs for drugs, biologicals, and therapeutic radiopharmaceuticals to determine their packaging status in CY 2009, we are proposing to use the methodology that was described in detail in the CY 2006 OPPS proposed rule (70 FR 42723 through 42724) and finalized in the CY 2006 OPPS final rule with comment period (70 FR 68636 through 70 FR 68638). To calculate the proposed CY 2009 per day costs, we used an estimated payment rate for each drug and biological of ASP+4 percent (which is the payment rate we are proposing for separately payable drugs and biologicals in CY 2009, as discussed in more detail in section V.B.3.b. of this proposed rule). We used the manufacturer submitted ASP data from the fourth quarter of CY 2007 (data that were used for payment purposes in the physician's office setting, effective April 1, 2008) to determine the proposed per day cost.

As is our standard methodology, we are proposing to use payment rates based on the ASP data from the fourth quarter of CY 2007 for budget neutrality estimates, packaging determinations, impact analyses, and completion of Addenda A and B to this proposed rule because these are the most recent data available for use at the time of development of this proposed rule. These data are also the basis for drug payments in the physician's office setting, effective April 1, 2008. For items that did not have an ASP-based payment rate, we used their mean unit cost derived from the CY 2007 hospital claims data to determine their per day cost. We packaged items with a per day cost less than or equal to $60 and identified items with a per day cost greater than $60 as separately payable. Consistent with our past practice, we crosswalked historical OPPS claims data from the CY 2007 HCPCS codes that were reported to the CY 2008 HCPCS codes that we display in Addendum B to this proposed rule for payment in CY 2009.

Our policy during previous cycles of the OPPS has been to use updated ASP and claims data to make final determinations of the packaging status of drugs, biologicals, and radiopharmaceuticals for the final rule with comment period. We note that it is also our policy to make an annual packaging determination only when we develop the OPPS/ASC final rule for the update year. Only items that are identified as separately payable in the final rule would be subject to quarterly updates. For our calculation of per day costs of drugs, biologicals, and therapeutic radiopharmaceuticals in the CY 2009 OPPS/ASC final rule with comment period, we are proposing to use ASP data from the first quarter of CY 2008, which is the basis for calculating payment rates for drugs and biologicals in the physician's office setting using the ASP methodology, effective July 1, 2008, along with updated hospital claims data from CY 2007. We note that we would also use these data for budget neutrality estimates and impact analyses for the CY 2009 OPPS/ASC final rule with comment period. Payment rates for separately payable drugs and biologicals included in Addenda A and B to that final rule with comment period would be based on ASP data from the second quarter of CY 2008, which are the basis for calculating payment rates for drugs and biologicals in the physician's office setting using the ASP methodology, effective October 1, 2008. These rates would then be updated in the January 2009 OPPS update, based on the most recent ASP data to be used for physician's office and OPPS payment as of January 1, 2009.

Consequently, the packaging status for drugs, biologicals, and therapeutic radiopharmaceuticals in the CY 2009 OPPS/ASC final rule with comment period using the updated data may be different from their packaging status determined based on the data used for

this proposed rule. Under such circumstances, we are proposing to apply the following policies to these drugs, biologicals, and therapeutic radiopharmaceuticals whose relationship to the proposed $60 threshold changes based on the final updated data:

- Drugs, biologicals, and therapeutic radiopharmaceuticals that were paid separately in CY 2008, proposed for separate payment in CY 2009, and have per day costs equal to or less than $60 based on the updated ASPs and hospital claims data used for the CY 2009 final rule with comment period, would continue to receive separate payment in CY 2009.
- Drugs, biologicals, and therapeutic radiopharmaceuticals that were packaged in CY 2008 and that were proposed for separate payment in CY 2009, and have per day costs equal to or less than $60 based on the updated ASPs and hospital claims data used for the CY 2009 final rule with comment period, would remain packaged in CY 2009.
- Drugs, biologicals, and therapeutic radiopharmaceuticals for which we proposed packaged payment in CY 2009, but have per day costs greater than $60 based on the updated ASPs and hospital claims data used for the CY 2009 final rule with comment period, would receive separate payment in CY 2009.

For CY 2009, we are also proposing to continue exempting the oral and injectable forms of 5HT3 anti-emetic products from packaging, thereby making separate payment for all of the 5HT3 anti-emetic products. As we stated in the CY 2005 OPPS final rule with comment period (69 FR 65779 through 65780), it is our understanding that chemotherapy is very difficult for many patients to tolerate, as the side effects are often debilitating. In order for Medicare beneficiaries to achieve the maximum therapeutic benefit from chemotherapy and other therapies with side effects of nausea and vomiting, anti-emetic use is often an integral part of the treatment regimen. We believe that we should continue to ensure that Medicare payment rules do not impede a beneficiary's access to the particular anti-emetic that is most effective for him or her as determined by the beneficiary and his or her physician.

TABLE 23.—PROPOSED ANTI-EMETICS TO EXEMPT FROM CY 2009 OPPS DRUG PACKAGING THRESHOLD

HCPCS code	Short descriptor
J1260	Dolasetron mesylate.
J1626	Granisetron HCl injection.
J2405	Ondansetron hcl injection.
J2469	Palonosetron HCl.
Q0166	Granisetron HCl 1 mg oral.
Q0179	Ondansetron HCl 8 mg oral.
Q0180	Dolasetron mesylate oral.

b. Proposed Payment for Diagnostic Radiopharmaceuticals and Contrast Agents

As established in the CY 2008 final rule with comment period (72 FR 66766 through 66768), we began packaging payment for all diagnostic radiopharmaceuticals and contrast agents into the payment for the associated procedure, regardless of their per day costs. Packaging costs into a single aggregate payment for a service, encounter, or episode-of-care is a fundamental principle that distinguishes a prospective payment system from a fee schedule. In general, packaging the costs of items and services into the payment for the primary procedure or service with which they are associated encourages hospital efficiencies and also enables hospitals to manage their resources with maximum flexibility. Prior to CY 2008, we noted that the proportion of drugs, biologicals, and radiopharmaceuticals that were separately paid under the OPPS had increased in recent years, a pattern that we also observed for procedural services under the OPPS. Our final CY 2008 policy that packaged payment for all nonpass-through diagnostic radiopharmaceuticals and contrast agents regardless of their per day costs contributed significantly to expanding the size of the OPPS payment bundles and is consistent with the principles of a prospective payment system.

During the March 2008 meeting of the APC Panel, the APC Panel recommended that CMS continue to package payment for diagnostic radiopharmaceuticals for CY 2009. We are accepting this recommendation and, therefore, for CY 2009, we are proposing to continue packaging payment for all nonpass-through diagnostic radiopharmaceuticals and contrast agents regardless of their per day costs for the reasons discussed below. As we established in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66768), we identify diagnostic radiopharmaceuticals specifically as those Level II HCPCS codes that include the term ''diagnostic'' along with a radiopharmaceutical in their long code descriptors.

We continue to believe that our proposal to continue to treat diagnostic radiopharmaceuticals and contrast agents differently from other specified covered outpatient drugs (SCODs) is appropriate for several reasons. First, the statutory requirement that we must pay separately for drugs and biologicals for which the per day cost exceeds $50 under section 1833(t)(16)(B) of the Act has expired. Therefore, we are not restricted in the extent to which we can package payment for SCODs and other drugs, nor are we required to treat all classes of drugs in the same manner with regard to whether they are packaged or separately paid. We have used this flexibility to make different packaging determinations with regard to specific anti-emetic drugs.

Second, diagnostic radiopharmaceuticals and contrast agents function effectively as supplies that enable the provision of an independent service. More specifically, contrast agents are always provided in support of a diagnostic or therapeutic procedure that involves imaging, and diagnostic radiopharmaceuticals are always provided in support of a diagnostic nuclear medicine procedure. This is different from many other SCODs, such as therapeutic radiopharmaceuticals, where the therapeutic radiopharmaceutical itself is the primary therapeutic modality. Given the inherent function of contrast agents and diagnostic radiopharmaceuticals as supportive to the performance of an independent procedure, we continue to view the packaging of payment for contrast agents and diagnostic radiopharmaceuticals as a logical expansion of packaging for SCODs. As we consider the possibility of moving to additional encounter-based and episode-based payment in future years, we may consider additional options for packaging more SCODs in the future.

Third, section 1833(t)(14)(A)(iii) of the Act requires that payment for SCODs be set prospectively based on a measure of average hospital acquisition cost. We believe our claims data offer an acceptable proxy for average hospital acquisition cost and associated handling and preparation costs for radiopharmaceuticals. We believe that hospitals have adapted to the CY 2006 coding changes for radiopharmaceuticals and responded to our instructions to include charges for radiopharmaceutical handling in their charges for the radiopharmaceutical products. We have relied on mean unit

costs derived from our claims data as one proxy for average acquisition cost and pharmacy overhead, and we use these data to determine the packaging status for SCODs.

In the case of contrast agents, while we have ASP data that could be a proxy for average hospital acquisition cost and associated handling and preparation costs, payment for almost all contrast agents would be packaged under the OPPS for CY 2009 based on the proposed CY 2009 OPPS $60 per day packaging threshold. Therefore, we believe it would be appropriate to continue to package payment for all contrast agents for CY 2009, to provide accurate payment for the associated tests and procedures using an approach that promotes hospital efficiency.

In summary, we view diagnostic radiopharmaceuticals and contrast agents as ancillary and supportive of the diagnostic tests and therapeutic procedures in which they are used. In light of our authority to make different packaging determinations and the improved reporting of hospital charges for radiopharmaceutical handling in the CY 2007 claims data, we are proposing to continue packaging payment for all contrast agents and diagnostic radiopharmaceuticals regardless of their per day costs for CY 2009.

For more information on how we are proposing to set CY 2009 payment rates for nuclear medicine procedures in which diagnostic radiopharmaceuticals are used and echocardiography services provided with and without contrast agents, we refer readers to sections II.A.2.d.(5) and (4), respectively, of this proposed rule.

During the March 2008 APC Panel meeting, the APC Panel also recommended that CMS present data at the first CY 2009 APC Panel meeting on usage and frequency, geographic distribution, and size and type of hospitals performing nuclear medicine studies using radioisotopes in order to ensure that access is preserved for Medicare beneficiaries. We are accepting this recommendation and will present information to the APC Panel at its first CY 2009 meeting when initial claims data from CY 2008 will be available.

3. Proposed Payment for Drugs and Biologicals Without Pass-Through Status That Are Not Packaged

a. Payment for Specified Covered Outpatient Drugs (SCODs)

Section 1833(t)(14) of the Act, as added by section 621(a)(1) of Pub. L. 108–173, requires special classification of certain separately paid radiopharmaceuticals, drugs, and biologicals and mandates specific payments for these items. Under section 1833(t)(14)(B)(i) of the Act, a ''specified covered outpatient drug'' is a covered outpatient drug, as defined in section 1927(k)(2) of the Act, for which a separate APC has been established and that either is a radiopharmaceutical agent or is a drug or biological for which payment was made on a pass-through basis on or before December 31, 2002.

Under section 1833(t)(14)(B)(ii) of the Act, certain drugs and biologicals are designated as exceptions and are not included in the definition of ''specified covered outpatient drugs,'' known as SCODs. These exceptions are—

- A drug or biological for which payment is first made on or after January 1, 2003, under the transitional pass-through payment provision in section 1833(t)(6) of the Act.
- A drug or biological for which a temporary HCPCS code has not been assigned.
- During CYs 2004 and 2005, an orphan drug (as designated by the Secretary).

Section 1833(t)(14)(A)(iii) of the Act, as added by section 621(a)(1) of Pub. L. 108–173, requires that payment for SCODs in CY 2006 and subsequent years be equal to the average acquisition cost for the drug for that year as determined by the Secretary, subject to any adjustment for overhead costs and taking into account the hospital acquisition cost survey data collected by the Government Accountability Office (GAO) in CYs 2004 and 2005. If hospital acquisition cost data are not available, the law requires that payment be equal to payment rates established under the methodology described in section 1842(o), section 1847A, or section 1847B of the Act, as calculated and adjusted by the Secretary as necessary.

In the CY 2006 OPPS proposed rule (70 FR 42728), we discussed the CY 2005 report by MedPAC regarding pharmacy overhead costs in HOPDs and summarized the findings of that study:

- Handling costs for drugs, biologicals, and radiopharmaceuticals administered in the HOPD are not insignificant;
- Little information is available about the magnitude of pharmacy overhead costs;
- Hospitals set charges for drugs, biologicals, and radiopharmaceuticals at levels that reflected their respective handling costs; and
- Hospitals vary considerably in their likelihood of providing services which utilize drugs, biologicals, or radiopharmaceuticals with different handling costs.

As a result of these findings, MedPAC developed seven drug categories for pharmacy and nuclear medicine handling costs based on the estimated level of hospital resources used to prepare the products. Associated with these categories were two recommendations for accurate payment of pharmacy overhead under the OPPS.

1. CMS should establish separate, budget neutral payments to cover the costs hospitals incur for handling separately payable drugs, biologicals and radiopharmaceuticals.

2. CMS should define a set of handling fee APCs that group drugs, biologicals, and radiopharmaceuticals based on attributes of the products that affect handling costs; CMS should instruct hospitals to submit charges for these APCs and base payment rates for the handling fee APCs on submitted charges reduced to costs.

In assigning drugs to the seven categories, MedPAC considered additional characteristics that contribute to differential pharmacy handling costs, such as radioactivity, toxicity, mode of administration, and the need for special handling. While MedPAC was able to include information on a variety of drugs with many of these characteristics, hospitals participating in MedPAC's research were not able to provide sufficient cost information regarding the handling of outpatient radiopharmaceuticals for MedPAC to make a recommendation about overhead categories for these products.

In response to the MedPAC findings, in the CY 2006 OPPS proposed rule (70 FR 42729), we discussed our belief that because of the varied handling resources required to prepare different forms of drugs, it would be impossible to exclusively and appropriately assign a drug to a certain overhead category that would apply to all hospital outpatient uses of the drug. Therefore, our CY 2006 OPPS proposal included a proposal to establish three distinct Level II HCPCS C-codes and three corresponding APCs for drug handling categories to differentiate overhead costs for drugs and biologicals. We also proposed: (1) To combine several overhead categories recommended by MedPAC according to Table 24, as shown below; (2) to establish three drug handling categories, as we believed that larger groups would minimize the number of drugs that may fit into more than one category and would lessen any undesirable payment policy incentives to utilize particular forms of drugs or specific preparation methods; (3) to collect hospital charges for these C-codes for 2 years; and (4) to ultimately base payment for the corresponding drug handling APCs on

CY 2006 claims data available for the CY 2008 OPPS. Both the MedPAC categories and the CY 2006 proposed categories are identified in Table 24 below.

TABLE 24.—DRUG OVERHEAD CATEGORY GROUPINGS DISCUSSED IN THE CY 2006 OPPS PROPOSED RULE

MedPAC drug overhead category	Description	Proposed CY 2006 drug overhead category
Category 1	Orals (oral tablets, capsules, solutions)	Category 1.
Category 2	Injection/Sterile Preparation (draw up a drug for administration)	Category 2.
Category 3	Single IV Solution/Sterile Preparation (adding a drug or drugs to a sterile IV solution) or Controlled Substances.	Category 2.
Category 4	Compounded/Reconstituted IV Preparations (requiring calculations performed correctly and then compounded correctly).	Category 2.
Category 5	Specialty IV or Agents requiring special handling in order to preserve their therapeutic value or Cytotoxic Agents, oral (chemotherapeutic, teratogenic, or toxic) requiring personal protective equipment (PPE).	Category 3.
Category 6	Cytotoxic Agents (chemotherapeutic, teratogenic, or toxic) in all formulations except oral requiring PPE.	Category 3.
Category 7	Radiopharmaceutical: Basic and Complex Diagnostic Agents, PET Agents, Therapeutic Agents, and Radioimmunoconjugates.	

In the CY 2006 OPPS final rule with comment period (70 FR 68659 through 68665), we discussed the public comments we received on our proposal regarding pharmacy overhead. The overwhelming majority of commenters did not support our proposal and urged us not to finalize this policy, as it would be administratively burdensome for hospitals. Therefore, we did not finalize this proposal for CY 2006.

As we noted in the CY 2006 OPPS final rule with comment period (70 FR 68640), findings from a MedPAC survey of hospital charging practices indicated that hospitals set charges for drugs, biologicals, and radiopharmaceuticals high enough to reflect their pharmacy handling costs as well as their acquisition costs. After considering all public comments received, in the CY 2006 OPPS final rule with comment period (70 FR 68642), we established a policy to provide a combined payment rate of ASP+6 percent for both the hospital's drug and biological acquisition costs and associated pharmacy overhead costs, as this was the equivalent average ASP-based amount to the aggregate cost from CY 2004 hospital claims data for separately payable drugs under the OPPS. We acknowledged the limitations of this methodology, namely that pharmacy overhead costs of specific drugs and biologicals are not directly related to their specific acquisition costs. We also solicited additional comments on future options for ways to identify and provide an alternative payment methodology for pharmacy overhead costs under the OPPS.

In the CY 2007 OPPS/ASC final rule with comment period (71 FR 68091), we proposed and finalized a policy that provided a single payment of ASP+6 percent for the hospital's acquisition cost for the drug or biological and all associated pharmacy overhead and handling costs. The ASP+6 percent rate was higher than the equivalent average ASP-based amount calculated from claims of ASP+4 percent, but we adopted this methodology for stability while we continued to examine the issue of the costs of pharmacy overhead in the HOPD.

We continued to meet with interested pharmacy stakeholders regarding the various issues related to hospital charging practices and how these practices would affect our potential proposals for payment of drugs and pharmacy overhead under the OPPS. Many comments from the hospital industry reiterated that hospitals do not attach a specific pharmacy overhead charge to a particular drug. In particular, a more expensive drug with high pharmacy overhead costs does not commonly result in a sufficiently high hospital charge for the drug to account for all of the associated drug acquisition and pharmacy overhead costs. We have been told that hospitals frequently allocate a relatively greater pharmacy overhead charge to the single hospital charge for less expensive drugs to counterbalance the lesser charge for pharmacy overhead for more expensive drugs with high pharmacy overhead costs.

Therefore, the pharmacy overhead costs of one drug may be distributed among charges for many drugs. This practice of unequally distributing pharmacy overhead charges among all drugs provided by the hospital pharmacy makes the single CCR for cost center 5600 (Drugs Charged to Patients) applied for OPPS cost estimation of drugs through the revenue code-to-cost center crosswalk result in less accurate costs for individual drugs. The result is that the charges and estimated costs for less expensive drugs shoulder a higher burden of pharmacy overhead costs as compared to the charges and estimated costs for more expensive drugs. Commenters have suggested that our OPPS methodology of applying a single CCR for the cost estimation of all drugs unfairly reduces payment amounts for separately payable expensive drugs, as the actual CCR varies widely across drugs. The concerns surrounding the impact on payment accuracy of differential hospital charging practices for pharmacy overhead costs resemble the concerns regarding charge compression that have been raised for expensive implantable devices over the past several years of the OPPS (72 FR 66599 through 66602). In general, differential hospital markup policies related to the cost of an item lead to overestimating the cost of inexpensive items and underestimating the cost of expensive items when a single CCR is applied to charges on claims.

In the CY 2008 OPPS/ASC proposed rule (72 FR 42735), in response to ongoing discussions with interested parties, we proposed to continue our methodology of providing a combined payment rate for drug and biological acquisition and pharmacy overhead costs. We also proposed to instruct hospitals to remove the pharmacy overhead charge for both packaged and separately paid drugs and biologicals from the charge for the drug or biological and report the pharmacy overhead charge on an uncoded revenue code line on the claim. We believed that

this would provide us with an avenue for collecting pharmacy handling cost data specific to drugs in order to package the overhead costs of these items into the associated procedures, most likely drug administration services. We believed that this methodology of reporting pharmacy overhead costs on an uncoded revenue center line would increase the accuracy of pharmacy overhead payments for drugs and biologicals as it would package the overhead cost for similar drugs into the commonly associated separately payable services, for example, by packaging the pharmacy overhead cost for a chemotherapy drug with the cost of the chemotherapy drug administration service also included on the claim.

Similar to the public response to our CY 2006 pharmacy overhead proposal, the overwhelming majority of commenters did not support our CY 2008 proposal and urged us to not finalize this policy (72 FR 66761). While MedPAC supported the proposal for improving the accuracy of drug payment by incorporating variability in pharmacy overhead costs, most other commenters cited the increased hospital burden that would be associated with manipulating accounting systems and making manual calculations, along with concerns about making these changes to their billing operations while continuing to set charges for particular services that were the same for all payers. After hearing concerns about the burden of establishing a unique pharmacy overhead charge for every drug, at its September 2007 meeting, the APC Panel recommended that hospitals not be required to separately report charges for pharmacy overhead and handling and that payment for overhead be included as part of drug payment. The APC Panel also recommended that CMS continue to evaluate alternative methods to standardize the capture of pharmacy overhead costs in a manner that is simple to implement at the organizational level (72 FR 66761). Because of these concerns, we did not finalize the proposal to instruct hospitals to separately report pharmacy overhead charges for CY 2008. Instead, in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66763), we finalized a policy of providing payment for separately payable drugs and biologicals and their pharmacy overhead at ASP+5 percent as a transition from their CY 2007 payment of ASP+6 percent to payment based on the equivalent average ASP-based payment rate calculated from hospital claims, which was ASP+3 percent for the CY 2008 OPPS/ASC final rule with comment period. Hospitals continued to include charges for pharmacy overhead costs in the line-item charges for the associated drugs reported on claims.

b. Proposed Payment Policy

The provision in section 1833(t)(14)(A)(iii) of the Act, as described above, continues to be applicable to determining payments for SCODs for CY 2009. This provision requires that, in CY 2009, payment for SCODs be equal to the average acquisition cost for the drug for that year as determined by the Secretary, subject to any adjustment for overhead costs and taking into account the hospital acquisition cost survey data collected by the GAO in CYs 2004 and 2005. If hospital acquisition cost data are not available, the law requires that payment be equal to payment rates established under the methodology described in section 1842(o), section 1847A, or section 1847B of the Act, as calculated and adjusted by the Secretary as necessary. In addition, section 1833(t)(14)(E)(ii) authorizes the Secretary to adjust APC weights for SCODs to take into account the MedPAC report relating to overhead and related expenses, such as pharmacy services and handling costs.

During this past year, we have met with a variety of stakeholders regarding different proposals for collecting pharmacy overhead cost information for setting OPPS payment rates. One such proposal was endorsed by several stakeholders during the March 2008 APC Panel meeting. Presenters to the APC Panel explained that CMS' methodology of using a single CCR to determine the acquisition and pharmacy overhead cost for all drugs attributes a greater relative share of pharmacy overhead cost to the lower-priced packaged drugs and a lower relative share of pharmacy overhead cost to the more expensive, separately payable drugs. Because the OPPS packages payment for drugs and biologicals with an estimated per day cost of $60 or less and estimates the equivalent average ASP-based amount based only on the costs of separately payable drugs, some pharmacy overhead cost that should be associated with separately payable drugs is being packaged into payment for the procedures that are performed with lower cost packaged drugs.

This stakeholder proposal suggested that CMS recalculate the equivalent average ASP-based amount based on the costs of packaged and separately payable drugs with HCPCS codes, rather than on our current methodology of calculating an ASP-based amount solely from claims data for separately payable drugs. CMS would then use this equivalent average ASP-based amount (or the physician's office payment rate of ASP+6 percent) to represent the acquisition and pharmacy overhead cost of all packaged drugs and would substitute this figure for the costs of packaged drugs in ratesetting for their associated procedures. The pool of money under the budget neutral OPPS that would result from this methodology that would package lower drug costs with associated procedures than our current methodology could then be distributed to OPPS payment in a number of ways, such as increasing the combined acquisition and overhead cost payment for separately payable drugs to a higher average ASP-based amount and/or providing separate payment for pharmacy overhead costs for either all drugs or only separately payable drugs based on a flat add-on rate or on tiers of pharmacy service complexity. The stakeholders presented APC median cost estimates demonstrating that their recommendation would significantly impact drug payment rates but would only change the majority of APC median costs by less than 2 percent.

At its March 2008 meeting, the APC Panel recommended that CMS work with stakeholders to further develop recommendations on the validity of this methodology and conduct an impact analysis, with consideration for CY 2009 rulemaking. Because CMS would redistribute pharmacy overhead cost when modeling payment rates for ratesetting, the suggested methodology would be administratively simple for hospitals. This approach also would refine the existing OPPS methodology for estimating pharmacy overhead cost in a budget neutral manner, without redistributing money from the payment for nondrug components of other services to payment for drugs. However, we also believe that substituting an average ASP-based amount (or the physician's office payment rate of ASP+6 percent) on claims for purposes of packaging drug costs into associated procedures would be a highly significant change to our established methodology. It is our longstanding policy to accept hospital charge data as it is reported on claims, in order to capture variability in hospitals' unique charges that is specific to each hospital's charging structure, as well as other potential efficiencies. The stakeholder recommendation would eliminate the expected variability in hospitals' costs of drugs that are packaged into their associated procedures.

While we appreciate the thoughtful approach to OPPS payment for

pharmacy overhead costs as described above, we believe there are several issues to be seriously considered before we could potentially propose the adoption of such a methodology including, but not limited to, its implications for how we would more generally estimate the costs of items packaged into a primary service. We package payment under the OPPS for the costs of many items and services other than relatively inexpensive drugs that are integral to separately payable primary services. In addition, it is not clear to us what approach for redistributing pharmacy overhead dollars would be most accurate and operationally feasible for CMS. We specifically invite public comment on this potential approach for estimating pharmacy overhead costs and redistributing pharmacy overhead payment under the OPPS.

Recently, RTI completed its evaluation of the OPPS cost-based weight methodology in general, and charge compression in particular. Pharmacy stakeholders have already noted that accurately estimating pharmacy overhead cost is intimately related to the CCR used to estimate costs from claims' charges. As discussed above, hospitals have informed us that they redistribute the cost of pharmacy overhead from expensive to inexpensive drugs when setting charges for drugs.

RTI determined that hospitals billing a greater percent of drug charges under revenue code 0636 (Drugs requiring detail coding) out of all revenue codes related to drugs had a significantly higher CCR for cost center 5600 (Drugs Charged to Patients). ''These findings are consistent with the a priori expectation that providers tend to use lower markup rates on these relatively expensive items, as compared with other items in their CCR group.'' (RTI report, ''Refining Cost to Charge Ratios for Calculating APC and MS–DRG Relative Payment Weights,'' July 2008). RTI, in its March 2007 report, noted that hospitals billing a greater percent of drug charges under revenue code 0258 (IV solutions) out of all revenue codes related to drugs had a significantly lower CCR for cost center 5600. In the short term, RTI recommends that CMS adopt regression-adjusted CCRs under the OPPS for drugs requiring detail coding (reported under revenue code 0636) and for IV solutions (reported under revenue code 0258) for purposes of estimating median costs. To eliminate the need for simulated CCRs in the longer term, RTI recommends that CMS create a new standard cost center on the cost report for drugs requiring detail coding (reported under revenue code 0636) to mitigate charge compression by acquiring more specific CCRs (RTI report, ''Refining Cost to Charge Ratios for Calculating APC and MS–DRG Relative Payment Weights,'' July 2008.). RTI's recommendations provide other alternatives to the recent pharmacy stakeholder recommended approach described above for improving the cost estimation of the acquisition and pharmacy overhead costs of drugs under the OPPS.

As discussed further in section II.A.1.c. of this proposed rule and consistent with our proposal for the FY 2009 IPPS, we are not proposing to adopt regression-based CCRs for cost estimation in any area of the CY 2009 OPPS, including drugs requiring detail coding and IV solutions. Instead, we believe that RTI's empirical findings would appropriately be addressed through concrete steps to improve the quality of accounting information used to estimate future costs from drug charges. Cognizant of public comments on past proposals, we also believe that this should be done in a manner that is fairly simple for hospitals to implement.

For CY 2009, we are proposing to continue our policy of making a combined payment for the acquisition and pharmacy overhead costs of separately payable drugs and biologicals at an equivalent average ASP-based amount calculated based on our standard methodology of estimating drug costs from claims. Using updated data for this proposed rule, after determining the proposed CY 2009 packaging status of drugs and biologicals, we estimated the aggregate cost of all drugs and biologicals (excluding therapeutic radiopharmaceuticals for which no ASP data are currently available) that would be separately payable in CY 2009 based on mean costs from hospital claims data and calculated the equivalent average ASP-based payment rate that would equate to the aggregate reported hospital cost. The results of our analysis indicate that setting the payment rates for drugs and biologicals that would be separately payable in CY 2009 based on hospital costs would be equivalent to providing payment, on average, at ASP+4 percent. Therefore, we are proposing to pay for separately payable drugs and biologicals under the CY 2009 OPPS at ASP+4 percent because we believe that this is the best currently available proxy for average hospital acquisition cost and associated pharmacy overhead costs.

In addition, we are also proposing to break the single standard cost center 5600 into two standard cost centers, Drugs with High Overhead Cost Charged to Patients and Drugs with Low Overhead Cost Charged to Patients, to reduce the reallocation of pharmacy overhead cost from expensive to inexpensive drugs and biologicals when setting an equivalent average ASP-based payment amount in the future. This proposal is consistent with RTI's recommendation for creating a new cost center whose CCR would be used to adjust charges to costs for drugs requiring detail coding. We note, however, that while improved CCRs would more accurately estimate the ASP-based amount for combined drug and pharmacy overhead payment, they would not capture within HCPCS code variability in pharmacy handling costs resulting from different methods of drug preparation used by hospitals. As discussed above, we believe that improved and more precise cost reporting is the best way to improve the accuracy of all cost-based payment weights, including relative weights for the IPPS MS–DRGs. Because both the IPPS and the OPPS rely on cost-based weights derived, in part, from data on the Medicare hospital cost report form, public comment on this proposed change to the cost report to break the single standard cost center 5600 into two standard cost centers should address any impact on both the inpatient and outpatient payment systems.

This proposal would not affect OPPS cost estimation for radiopharmaceuticals for several reasons. First, we would not expect the costs and charges for radiopharmaceuticals to be assigned to cost center 5600. Rather cost center 4300 (Radioisotope) is more appropriate for these items. Second, our claims data demonstrate that some hospitals continue to bill radiopharmaceuticals under revenue code 0636, contrary to UB–04 instructions (Official UB04 Data Specifications Manual, AHA 2007, p. 127) specifically noting that radiopharmaceuticals should be billed under revenue codes 0343 (Diagnostic Radiopharmaceuticals) and 0344 (Therapeutic Radiopharmaceuticals). We believe that billing radiopharmaceuticals under revenue code 0636 could be a result of dated CMS' guidance regarding billing radiopharmaceuticals under revenue code 0636. On April 8, 2008, we deleted this guidance from our Claims Processing Manual through administrative issuance (Transmittal 1487, Change Request 5999). Finally, RTI did not observe evidence of differential mark-up in cost center 4300 (for hospitals reporting the cost center) for products reported under revenue

codes 0343 and 0344 (RTI report, ''Refining Cost to Charge Ratios for Calculating APC and MS–DRG Relative Payment Weights,'' July 2008).

In the FY 2009 IPPS proposed rule (73 FR 23544 through 23546), we proposed creating two cost centers, specifically (1) Medical Supplies Charged to Patients and (2) Implantable Devices Charged to Patients, to replace the current cost center Supplies Charged to Patients as part of our initiative to revise and update the Medicare hospital cost report form. We noted that we were only proposing one additional cost center in order to proceed cautiously with changes to the Medicare cost report in order to avoid unintended consequences for hospitals paid on a cost basis and to limit hospitals' administrative burden associated with adapting to new cost reporting forms and instructions. We remain committed to moving cautiously but recognize the need for a judicious number of additional cost centers in specific areas, including drugs and biologicals. As with the items reported in the cost center Supplies Charged to Patients, items reported in Drugs Charged to Patients demonstrate significant variability in the costs of included items.

We noted in the FY 2009 IPPS proposed rule (73 FR 23546 through 23547) that we are updating the cost report form to eliminate outdated requirements in conjunction with the PRA, and that we plan to propose actual changes to the cost reporting form, the attending cost reporting software, and the cost report instructions in Chapter 36 of the Medicare Provider Reimbursement Manual (PRM), Part II. We anticipate proposing these revisions shortly. If we were to adopt as final our proposal to create one cost center for Drugs with High Overhead Cost Charged to Patients and one cost center for Drugs with Low Overhead Cost Charged to Patients in the CY 2009 OPPS/ASC final rule with comment period, the cost report forms and instructions would reflect those changes. We expect the revised cost report may be available for hospitals to use when submitting cost reports during FY 2009, that is, for cost reporting periods beginning after October 1, 2008, and we expect that we would be able to use some of these data for setting drug payment rates for a future OPPS update, generally 2 to 3 years from implementation of the new cost report form.

Currently, to estimate the cost of separately payable drugs and biologicals for purposes of establishing the equivalent average ASP-based amount, we estimate costs from charges billed with UB–04 drug revenue codes 025X (Pharmacy) and 063X (Drugs Require Specific ID) using the CCR for cost center 5600. Our current revenue code-to-cost center crosswalk is available on the CMS Web site: (*http://www.cms.hhs.gov/HospitalOutpatientPPS/03_crosswalk.asp#TopOfPage*). As part of our effort to isolate the costs and charges for drugs with high and low pharmacy overhead costs respectively, as proposed, we would instruct hospitals to report the charges for drugs and biologicals qualifying for the Drugs with High Overhead Cost Charged to Patients cost center under revenue code 0636 and all other drugs and biologicals under other appropriate drug revenue codes.

It is current practice for hospitals to bill only outpatient drug and biological charges with revenue code 0636. Payment for inpatient hospital services through DRGs does not require detailed HCPCS coding for drugs and biologicals. More importantly, CMS claims processing systems currently allow only HCPCS codes for blood clotting factors to be reported with revenue code 0636 on inpatient claims. Under our CY 2009 proposal, we would instruct hospitals to report charges for drugs and biologicals meeting the criteria for the proposed Drugs with High Overhead Costs Charged to Patients cost center under revenue code 0636 for both inpatient and outpatient claims. CMS would need to change its claims processing systems and, because revenue code 0636 requires all charges to be reported in association with HCPCS codes, this approach would require hospitals to report HCPCS codes for drug charges under revenue code 0636 on inpatient claims. We believe that consistent billing of drugs and biologicals across inpatient and outpatient settings in the same hospital would be more appropriate than current practice, in order to refine our cost estimation for drugs with high and low pharmacy overhead costs. Continuing to exclude inpatient hospital charges for drugs and biologicals with high overhead costs from being reported under revenue code 0636 would leave some averaging of high and low pharmacy overhead costs under other pharmacy revenue codes, especially revenue code series 025X that we would map to the proposed new cost center Drugs with Low Overhead Costs Charged to Patients. As a result, there would be no improvement in the accuracy of MS–DRG weights based on the two new cost centers that we are proposing to create. However, we specifically invite public comment on how a CMS requirement to report certain drug and biological charges under revenue code 0636 on hospital inpatient claims would impact hospitals.

There are several ways we could define these new cost centers for purposes of hospital reporting. First, we could adopt the assumptions behind RTI's empirical findings and require that hospitals simply report the costs and charges associated with revenue code 0636 in the proposed new cost center Drugs with High Overhead Costs Charged to Patients. This approach would require hospitals to report charges and costs for all other drugs in the proposed new cost center Drugs with Low Overhead Costs Charged to Patients. We believe this approach would be administratively simple for hospitals to implement because it would easily align revenue code and cost center relationships and would not require hospitals to otherwise categorize drugs or estimate a unique pharmacy overhead cost for each drug. Notwithstanding our requirement for hospitals to report, consistent with CPT and CMS instructions, all services described by HCPCS codes provided in an encounter, to the extent that hospitals report HCPCS codes for drugs that are not packaged, this approach might isolate costs and charges for drugs that are separately paid under the OPPS for purposes of more accurately estimating their costs. While we believe that RTI's findings suggest an increase in the CCR for adjustment of drug charges to costs would result from isolating the costs and charges for drugs billed under revenue code 0636, one limitation of this approach is that it would not fully mitigate the disproportionate allocation of pharmacy overhead cost reflected in differential markup. Although clearly an improvement in accuracy over current cost estimation, it is likely that significant variability in markup and overhead cost for drugs currently billed under revenue code 0636 would remain in the proposed new cost center CCR for Drugs with High Overhead Costs Charged to Patients.

Second, we could set a cost threshold for drug acquisition and pharmacy overhead cost for purposes of including costs and charges for the drug in one of the two proposed new cost centers. If we were to implement this methodology, we potentially could set the threshold at the OPPS drug packaging threshold, which is proposed to be $60 for CY 2009. This would clearly identify those drugs that would be billed in each cost center because all drug and biological HCPCS codes would be assigned either separately payable or

packaged status under the CY 2009 OPPS. However, we believe that using the OPPS drug packaging threshold may be too low, and probably does not identify a cost point that would maximize cost differences between drugs with relatively high pharmacy overhead costs and drugs with relatively low pharmacy overhead costs. This approach has the benefit of considering cost, which appears largely to determine the amount of markup for pharmacy overhead costs a hospital incorporates into drug charges. Although some high cost drugs may have low pharmacy overhead costs, in general this alternative may do a better job of improving cost estimates for drugs with high pharmacy overhead costs through the use of more specific CCRs than the first alternative discussed, a cost center that would include all drugs currently billed under revenue code 0636. On the other hand, we are uncertain as to how we would identify the most appropriate cost threshold amount, or the manner and frequency with which we would update the threshold. More importantly, we are concerned that identifying the unique acquisition and overhead cost for each drug could impose a comparable administrative burden as other prior proposals.

Third, we could also set a cost threshold for pharmacy overhead specifically to define high versus low overhead cost for purposes of reporting costs and charges for drugs in the two new cost centers. This alternative would require hospitals to identify the cost of pharmacy overhead for every drug in order to assign it to a cost center. This approach would most accurately isolate drugs with high and low overhead costs, respectively. The resulting CCRs, therefore, would better estimate the average acquisition and overhead cost for these drugs. On the other hand, as with the second alternative, we are uncertain as to how we would identify the most appropriate pharmacy cost threshold amount, or the manner and frequency with which we would update the threshold. Further, this approach could also impose a significant hospital administrative burden, comparable to the burden identified by commenters regarding other prior proposals.

A fourth approach would be to instruct hospitals to assign those drugs they administer in the OPPS to the two proposed new cost centers according to the categories discussed in the CY 2006 final rule with comment period and presented in Table 24 above. Under this methodology, drugs falling in CMS categories 1 and 2 would be billed under revenue codes 025X or 063X (other than 0636) and captured on the cost report in the proposed new cost center Drugs with Low Overhead Cost Charged to Patients, while drugs falling in CMS category 3 would be billed under revenue code 0636 and reported in the proposed new cost center Drugs with High Overhead Cost Charged to Patients. CMS would provide some examples in the cost report instructions of appropriate drugs for each category. We are aware that some pharmacy stakeholders have already categorized drug and biological HCPCS codes into the three CMS pharmacy overhead categories that were proposed for CY 2006. Because pharmacy overhead costs may vary depending on the preparation of a specific product at an individual hospital and hospital accounting also varies, the same drug could appear in a different cost center across hospitals. However, we do not believe it would be necessary for hospitals to assign exactly the same drugs to each of the two proposed new cost centers, as long as hospitals' assessment of the pharmacy overhead cost category is consistent with their billing of these drugs under revenue codes 063X (other than 0636) and 025X or 0636 and the inclusion of these drugs in the associated cost centers. Prospectively, the OPPS cost estimation methodology would use the CCR calculated for the proposed new cost center Drugs with High Overhead Cost Charged to Patients to adjust drug charges billed under revenue code 0636 to cost and the CCR calculated for the proposed new cost center Drugs with Low Overhead Cost Charged to Patients to adjust drug charges billed under revenue codes 025X and 063X (other than 0636) to cost for determining drug acquisition and pharmacy overhead costs. We believe that this fourth approach would best estimate a CCR for drugs with high pharmacy overhead cost and relatively low markup as reflected in hospitals' charges. Because the number of drugs in pharmacy overhead category three would be limited based on the specific category description, this approach should more accurately address the limited markup for very expensive drugs with high pharmacy overhead costs, where charges do not reflect the hospitals' pharmacy overhead costs for those drugs. We also believe that hospitals would find this alternative easier to implement than any policy requiring hospitals to identify a unique total acquisition and overhead cost or a specific pharmacy overhead cost for each drug for purposes of assigning the drug's costs and charges to one of the two proposed new cost centers. However, we realize that there would still be some additional administrative burden for hospitals that have not yet determined the appropriate pharmacy overhead category for each of their drugs, and that they would need to educate their billing staff, to modify their chargemasters, and to adapt other billing software.

In summary, we are proposing to pay for the combined average acquisition and pharmacy overhead cost of separately payable drugs and biologicals at ASP+4 percent under the CY 2009 OPPS. In addition, we are proposing to create two new cost centers when we revise the Medicare hospital cost report form, specifically Drugs with High Overhead Cost Charged to Patients and Drugs with Low Overhead Cost Charged to Patients. We expect that CCRs from these proposed new cost centers would be available in 2 to 3 years to refine OPPS drug cost estimates by accounting for differential hospital markup practices for drugs with high and low pharmacy overhead costs. We specifically invite public comment on the policy and operational benefits, challenges, and concerns that may be associated with these proposals, specifically as they relate to our proposed approach to distinguishing between drugs and biologicals for purposes of inclusion in the two proposed new cost centers and the other alternatives discussed above.

c. Proposed Payment for Blood Clotting Factors

For CY 2008, we are providing payment for blood clotting factors under the OPPS at ASP+5 percent, plus an additional payment for the furnishing fee that is also a part of the payment for blood clotting factors furnished in physicians' offices under Medicare Part B. The CY 2008 updated furnishing fee increased by 4.0 percent to $0.158 per unit.

For CY 2009, we are proposing to pay for blood clotting factors at ASP+4 percent, consistent with our proposed payment policy for other nonpass-through separately payable drugs and biologicals, and to continue our policy for payment of the furnishing fee using an updated amount for CY 2009. Because the furnishing fee update is based on the percentage increase in the Consumer Price Index (CPI) for medical care for the 12-month period ending with June of the previous year and the Bureau of Labor Statistics releases the applicable CPI data after the MPFS and OPPS/ASC proposed rules are published, we are not able to include the actual updated furnishing fee in this proposed rule. Therefore, in accordance with our policy as finalized in the CY

2008 OPPS/ASC final rule with comment period (72 FR 66765), we will announce the actual figure for the percent change in the applicable CPI and the updated furnishing fee calculated based on that figure through applicable program instructions and posting on the CMS Web site at: *http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/*.

4. Proposed Payment for Therapeutic Radiopharmaceuticals

a. Background

Section 303(h) of Pub. L. 108–173 exempted radiopharmaceuticals from ASP pricing in the physician's office setting. Beginning in the CY 2005 OPPS final rule with comment period, we have exempted radiopharmaceutical manufacturers from reporting ASP data for payment purposes under the OPPS. (For more information, we refer readers to the CY 2005 OPPS final rule with comment period (69 FR 65811) and the CY 2006 OPPS final rule with comment period (70 FR 68655).) Consequently, we did not have ASP data for radiopharmaceuticals for consideration for previous years' OPPS ratesetting. In accordance with section 1833(t)(14)(B)(i)(I) of the Act, we have classified radiopharmaceuticals under the OPPS as SCODs. As such, we have paid for radiopharmaceuticals at average acquisition cost as determined by the Secretary and subject to any adjustment for overhead costs. Radiopharmaceuticals are also subject to the policies affecting all similarly classified OPPS drugs and biologicals, such as pass-through payment for diagnostic and therapeutic radiopharmaceuticals and individual packaging determinations for therapeutic radiopharmaceuticals, discussed earlier in this proposed rule.

For CYs 2006 and 2007, we used mean unit cost data from hospital claims to determine each radiopharmaceutical's packaging status and implemented a temporary policy to pay for separately payable radiopharmaceuticals based on the hospital's charge for each radiopharmaceutical adjusted to cost using the hospital's overall CCR. In addition, in the CY 2006 final rule with comment period (70 FR 68654), we instructed hospitals to include charges for radiopharmaceutical handling in their charges for the radiopharmaceutical products so these costs would be reflected in the CY 2008 ratesetting process. We note that this continues to be our expectation, and we believe that the charges for radiopharmaceuticals in the CY 2007 claims data that we are using for this proposed rule reflect both the acquisition cost of the radiopharmaceutical and its associated overhead. The methodology of providing separate payment based on the individual hospital's overall CCR for CYs 2006 and 2007 was finalized as an interim proxy for average acquisition cost because of the unique circumstances associated with providing radiopharmaceutical products to Medicare beneficiaries. The single OPPS payment represented Medicare payment for both the acquisition cost of the radiopharmaceutical and its associated handling costs.

During the CY 2006 and CY 2007 rulemaking processes, we encouraged hospitals and radiopharmaceutical stakeholders to assist us in developing a viable long-term prospective payment methodology for these products under the OPPS. As reiterated in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66766), we were pleased to note that we had many discussions with interested parties regarding the availability and limitations of radiopharmaceutical cost data.

In considering payment options for therapeutic radiopharmaceuticals for CY 2008, we examined several alternatives which we discussed in our CY 2008 OPPS/ASC proposed rule (72 FR 42738 through 42739) and CY 2008 OPPS/ASC final rule with comment period (72 FR 66769 through 66770). (We refer readers to these rules for a full discussion of all of the options that we considered.) After considering the options and all public comments, we finalized a CY 2008 methodology to provide a prospective payment for therapeutic radiopharmaceuticals (defined as those Level II HCPCS codes that include the term ''therapeutic'' along with a radiopharmaceutical in their long code descriptors) using mean costs derived from the CY 2006 claims data, where the costs are determined using our standard methodology of applying hospital-specific departmental CCRs to radiopharmaceutical charges, defaulting to hospital-specific overall CCRs only if appropriate departmental CCRs are unavailable (72 FR 66772). We additionally finalized a policy to package payment for all diagnostic radiopharmaceuticals (defined as Level II HCPCS codes that include the term ''diagnostic'' along with a radiopharmaceutical in their long code descriptors) for CY 2008. As discussed in the CY 2008 OPPS/ASC proposed rule (72 FR 42739), we believed that adopting prospective payment based on historical hospital claims data was appropriate because it served as our most accurate available proxy for the average hospital acquisition cost of separately payable therapeutic radiopharmaceuticals. In addition, we noted that we have found that our general prospective payment methodology based on historical hospital claims data results in more consistent, predictable, and equitable payment amounts across hospitals and likely provides incentives to hospitals for efficiently and economically providing these outpatient services.

Prior to implementation of our finalized CY 2008 methodology of providing a prospective payment for therapeutic radiopharmaceuticals, section 106(b) of the MMSEA was enacted on December 29, 2007, that provided payment for therapeutic radiopharmaceuticals based on individual hospital charges adjusted to cost. Therefore, hospitals continue to receive payment for therapeutic radiopharmaceuticals by applying the hospital-specific overall CCR to each hospital's charge for a therapeutic radiopharmaceutical from January 1, 2008 through June 30, 2008. Thereafter, the OPPS provides payment for separately payable therapeutic radiopharmaceuticals on a prospective basis, with payment rates based upon mean costs from hospital claims data as set forth in the CY 2008 OPPS/ASC final rule with comment period, unless otherwise required by law.

b. Proposed Payment Policy

Since the start of the temporary cost-based payment methodology for radiopharmaceuticals in CY 2006, we have met with several interested parties on a number of occasions regarding payment under the OPPS for radiopharmaceuticals and have received numerous different suggestions from these stakeholders regarding payment methodologies that we could employ for future use under the OPPS.

In the CY 2008 OPPS/ASC final rule with comment period (72 FR 66771), we solicited comments requesting interested parties to provide information related to if and how the existing ASP methodology could be used to establish payment for specific therapeutic radiopharmaceuticals under the OPPS. We received several responses to our request for comments.

Similar to the recommendations we received during the CY 2008 OPPS/ASC proposed rule comment period (72 FR 66770), we received several suggestions regarding the establishment of an OPPS-specific methodology for radiopharmaceutical payment that would be similar to the ASP methodology, without following the

established ASP procedures referenced at 1847A of the Act and implemented through rulemaking. Some commenters recommended using external data submitted by a variety of sources other than manufacturers. Along this line, commenters suggested gathering information from nuclear pharmacies using methodologies with a variety of names such as Nuclear Pharmacy Calculated Invoiced Price (Averaged) (CIP) and Calculated Pharmacy Sales Price (CPSP). Other commenters recommended that CMS base payment for certain radiopharmaceuticals on manufacturer-reported ASP.

As noted in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66771), a ratesetting approach based on external data would be administratively burdensome for us because we would be required to collect, process, and review external information to ensure that it was valid, reliable, and representative of a diverse group of hospitals so that it could be used to establish rates for all hospitals. However, we specifically requested additional comments regarding the use of the existing ASP reporting structure for therapeutic radiopharmaceuticals as this established methodology is already used for payment of other drugs provided in the hospital outpatient setting (72 FR 66771). While we received several recommendations from commenters on the CY 2008 OPPS/ASC final rule with comment period regarding payment of therapeutic radiopharmaceuticals based on estimated costs provided by manufacturers or other parties, we believe that the use of external data for payment of therapeutic radiopharmaceuticals should only be adopted if those external data are subject to the same well-established regulatory framework as the ASP data currently used for payment of separately payable drugs and biologicals under the OPPS. We have previously indicated that nondevice external data used for setting payment rates should be publicly available and representative of a diverse group of hospitals both by location and type, while it should also identify its data sources. We do not believe that external therapeutic radiopharmaceutical cost data voluntarily provided outside of the established ASP methodology, either by manufacturers or nuclear pharmacies, would generally satisfy these criteria that are minimum standards for setting OPPS payment rates.

Another commenter on the CY 2008 OPPS/ASC final rule with comment period recommended that CMS identify the therapeutic radiopharmaceutical used for Zevalin therapy (A9543 (Yttrium Y–90 ibritumomab tiuxetan, therapeutic, per treatment dose, up to 40 millicuries)) as a biological for payment purposes, instead of treating it as a radiopharmaceutical. As discussed in the CY 2003 OPPS final rule with comment period (67 FR 66757), Zevalin treatment consists of a radioactive isotope that is delivered to its target tissue by a monoclonal antibody. At that time, we explained that because of the specific requirements associated with delivery of radioactive isotope therapy, any product containing a therapeutic radioisotope, including Y–90 Zevalin, would be considered to be covered and paid under the category of benefits described under section 1861(s)(4) of the Act for radioactive isotope therapy. We stated that we would not consider therapeutic radiopharmaceuticals to be drugs as described in section 1861(t) and, therefore, the OPPS payment methodology for separately payable drugs and biologicals would not be applicable to payment for Y–90 Zevalin. We continue to believe that the most appropriate Medicare benefit category for Y–90 Zevalin is provided in section 1861(s)(4) of the Act because this product is a specific radioactive isotope therapy. Therefore, the CY 2009 OPPS proposal for nonpass-through payment of separately payable biologicals that is described in section V.B.3.b. of this proposed rule would not apply to payment for Y–90 Zevalin.

As noted in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66770), at its September 2007 meeting, the APC Panel recommended that CMS create a composite APC for Bexxar or related therapies and present it for the APC Panel's consideration at the next APC Panel meeting. We accepted this recommendation and modeled a radioimmunotherapy (RIT) composite APC for both Bexxar and Zevalin therapies using our final rule CY 2008 claims database. We discussed this analysis with the APC Panel at its March 2008 meeting.

To perform this analysis for the APC Panel, we first identified all claims that had an occurrence of a case-defining therapeutic radiopharmaceutical HCPCS code used for a RIT treatment: A9545 (Iodine I–131 tositumomab, therapeutic, per treatment dose) and A9543 (Yttrium Y–90 ibritumomab tiuxetan, therapeutic, per treatment dose, up to 40 millicuries). We then identified what we considered to be the HCPCS codes for services and products associated with RIT, based on information from the manufacturers and suggestions from CMS medical advisors and identified associated claims (using beneficiary health insurance claim (HIC) numbers) to develop the total median cost for a RIT composite APC.

We note that very few hospitals billed all of the HCPCS codes for an individual beneficiary that we expected to be reported for a case of RIT treatment. We used this ''HIC-linked'' file consisting of all associated claims for each beneficiary from one hospital that we considered to be part of a single case of RIT treatment to develop a composite APC cost estimate for a course of RIT treatment, where a case required: (1) HCPCS code A9545 or A9543; (2) an HCPCS code for either nonradiolabeled tositumomab (G3001 (Administration or supply of tositumomab, 450 mg)) or rituximab (J9310 (Rituximab, 100 mg)) (which would also indicate the start of a RIT case); (3) a HCPCS code for the corresponding diagnostic radiopharmaceutical (A9544 (Iodine I–131 tositumomab, diagnostic, per study dose) or A9542 (Indium In–111, ibritumomab tiuxetan, diagnostic, per study dose, up to 5 millicuries)); and (4) at least one instance of a diagnostic imaging service (CPT code 78804 (Radiopharmaceutical localization of tumor or distribution of radiopharmaceutical agent(s); whole body, requiring two or more days imaging)) prior to the administration of the therapeutic radiopharmaceutical. In addition, in order to further define the case for an estimate of a composite APC cost, we did not include the costs of services occurring on dates before the provision of the nonradiolabeled tositumomab or rituximab or after the administration of the therapeutic radiopharmaceutical.

Other services we expected to be reported for a case, such as CPT code 79403 (Radiopharmaceutical therapy, radiolabeled monoclonal antibody by intravenous infusion) and CPT code 77300 (Basic radiation dosimetry calculation, central axis depth dose calculation, TDF, NSD, gap calculation, off axis factor, tissue inhomogeneity factors, calculation of non-ionizing radiation surface and depth dose, as required during course of treatment, only when prescribed by the treating physician), were considered optional and, although they were not required in order to determine the RIT case, the costs of these associated services were included when we established the median cost of the RIT composite APC.

We determined that the median cost for the RIT composite APC, including required and optional additional services directly related to the RIT treatment, would be approximately $19,000. This figure represents, at a minimum, the estimated cost of the nonradiolabeled tositumomab (or

rituximab), the diagnostic radiopharmaceutical, the therapeutic radiopharmaceutical, and the imaging, based on costs from hospital claims data.

Upon review of this study, the APC Panel, at its March 2008 meeting, recommended that CMS pursue a RIT composite APC that uses existing claims and stakeholder data to establish appropriate payment rates for RIT protocols. In addition, the APC Panel recommended that CMS provide specific guidance to hospitals on appropriate billing for RIT under a composite APC methodology. We are not accepting these recommendations of the APC Panel. First, we do not believe it would be appropriate to incorporate external data into a composite APC methodology, when composite APC median costs for a comprehensive service that the composite APC describes are based upon reported hospital costs on claims as described in section II.A.2.e. of this proposed rule. As we have hospital costs from CY 2007 claims for the services that would be paid through a RIT composite APC, we would have no reason to use external stakeholder data instead of reported hospital costs for ratesetting for such an APC. In addition, as the APC Panel alluded to in its second recommendation regarding billing guidance to hospitals, our claims analysis demonstrated that, according to hospital claims data, apparently few patients actually received all the component services associated with RIT treatment from a single hospital, or many RIT treatments were incorrectly reported by hospitals. A composite APC payment provides more accurate payment for a set of major services with only limited variation from hospital to hospital or from case to case and relies on correctly coded claims for the comprehensive service to develop the composite cost, whereas RIT treatment does not appear to have these characteristics. Stakeholders have confirmed that a proportion of patients receiving a diagnostic radiopharmaceutical and imaging in preparation for RIT treatment do not go on to receive the therapeutic radiopharmaceutical for a variety of specific clinical reasons. Furthermore, the whole course of RIT treatment may occur over a several week period, and the challenges associated with instructing hospitals to report component services in a timely fashion that would allow the I/OCE to determine whether a composite payment would be appropriate are significant. Therefore, we believe it would be premature to propose payment of a composite APC for RIT treatment for CY 2009.

We received comments on the CY 2008 OPPS/ASC final rule with comment period from certain radiopharmaceutical manufacturers who indicated that the standard ASP methodology could be used for payment of certain therapeutic radiopharmaceutical products. Specifically, these manufacturers expressed interest in providing ASP for their therapeutic radiopharmaceutical products as a basis for payment under the OPPS. We appreciate the willingness of these manufacturers to provide ASP data, but we recognize that payment based on the ASP methodology may not be possible for all therapeutic radiopharmaceuticals if manufacturers are unable or unwilling to voluntarily submit ASP data. Therefore, we are proposing the following payment methodology for therapeutic radiopharmaceuticals under the CY 2009 OPPS. For therapeutic radiopharmaceuticals where ASP information is submitted through the established ASP process by all manufacturers of the specific therapeutic radiopharmaceutical, we would provide payment for the average acquisition and associated handling costs of the therapeutic radiopharmaceutical at the same relative ASP-based amount (proposed at ASP+4 percent for CY 2009) that we would pay for separately payable drugs and biologicals in CY 2009 under the OPPS. If sufficient ASP information is not submitted or appropriately certified by the manufacturer for a given calendar year quarter, then for that quarter we are proposing that the OPPS would provide a prospective payment based on the mean cost from hospital claims data as displayed in Table 25 below, as this was the methodology finalized in the CY 2008 OPPS/ASC final rule with comment period. Further, we are proposing to continue the methodology, as discussed in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66772), of eliminating claims from providers who consistently (more than 2 times) reported charges in the CY 2007 claims data that were less than $100 when converted to costs for HCPCS codes A9543 and A9545 as part of the usual ratesetting process. We believe that this would mitigate the effects of using incorrectly coded claims from several providers in our standard ratesetting methodology which calculates the mean costs for these two products from the claims available for the update year.

Because we do not have ASP data for therapeutic radiopharmaceuticals that were used for payment in April 2008, the proposed payment rates included in Addenda A and B to this proposed rule are based on mean costs from historical hospital claims data available for this proposed rule. Under our proposal that initially looks to ASP data to establish the payment rates for separately payable therapeutic radiopharmaceuticals, beginning in CY 2009, we would update the payment rates for therapeutic radiopharmaceuticals quarterly as new ASP data become available, just as we would update the payment rates for separately payable drugs and biologicals under the OPPS.

We are proposing to allow manufacturers to submit ASP information for any separately payable therapeutic radiopharmaceutical for payment purposes under the OPPS. However, we are not proposing to compel manufacturers to submit ASP information. The ASP data submitted would need to be provided for a patient-specific dose, or patient-ready form, of the therapeutic radiopharmaceutical in order to properly calculate the ASP amount for a given HCPCS code. In addition, in those instances where there is more than one manufacturer of a particular therapeutic radiopharmaceutical, we note that all manufacturers would need to submit ASP information in order for payment to be made on an ASP basis. We are specifically requesting public comment on the development of a crosswalk, similar to the NDC/HCPCS crosswalk for separately payable drugs and biologicals posted on the CMS Web site at: *http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/01a_2008aspfiles.asp*, for use for therapeutic radiopharmaceuticals. We believe that the use of ASP information for OPPS payment would provide an opportunity to improve payment accuracy for these products by applying an established methodology that has already been successfully implemented under the OPPS for other separately payable drugs and biologicals. As is the case with other drugs and biologicals subject to ASP reporting, in order for a therapeutic radiopharmaceutical to receive payment based on ASP beginning January 1, 2009, we would need to receive ASP information from the manufacturer in October 2008 that would reflect therapeutic radiopharmaceutical sales in the third quarter of CY 2008 (July 1, 2008 through September 30, 2008). These data would not be available for publication in the CY 2009 OPPS/ASC final rule with

comment period but would be included in the January 2009 OPPS quarterly release that would update the payment rates for separately payable drugs, biologicals, and therapeutic radiopharmaceuticals based on the most recent ASP data, consistent with our customary practice over the past 3 years when we have used the ASP methodology for payment of separately payable drugs and biologicals under the OPPS. In addition, we would need to receive information from radiopharmaceutical manufacturers that would allow us to calculate a unit dose cost estimate based on the applicable HCPCS code for the therapeutic radiopharmaceutical.

We realize that not all therapeutic radiopharmaceutical manufacturers may be willing or able to submit ASP information for a variety of reasons. We are proposing to provide payment at the ASP rate if ASP information is available for a given calendar year quarter or, if ASP information is not available, we are proposing to provide payment based on the most recent hospital mean unit cost data that we have available. We believe that both methodologies represent an appropriate and adequate proxy for average hospital acquisition cost and associated handling costs for these products. Therefore, if ASP information for the appropriate period of sales related to payment in any CY 2009 quarter is not available, we would rely on the CY 2007 mean unit cost data derived from hospital claims to set the payment rates for therapeutic radiopharmaceuticals. We note that this is not the usual OPPS process that relies on alternative data sources, such as WAC or AWP, when ASP information is temporarily unavailable, prior to defaulting to the mean unit cost from hospital claims data. We are proposing this methodology specifically for therapeutic radiopharmaceuticals whereby we would immediately default to the mean unit cost from hospital claims if sufficient ASP data were not available because we are not proposing to require therapeutic radiopharmaceutical manufacturers to report ASP data at this time. We do not believe that WAC or AWP is an appropriate proxy for OPPS payment for average therapeutic radiopharmaceutical acquisition cost and associated handling costs when manufacturers are not required to submit ASP data and, therefore, payment based on WAC or AWP could continue for the full calendar year.

Similar to the ASP process already in place for drugs and biologicals, we are proposing to update ASP data for therapeutic radiopharmaceuticals through our quarterly process as updates become available. In addition, we are proposing to assess the availability of ASP data for therapeutic radiopharmaceuticals quarterly, and if ASP data become available midyear, we would transition at the next available quarter to ASP-based payment. For example, if ASP data are not available for the quarter beginning January 2009 (that is, ASP information reflective of third quarter CY 2008 sales are not submitted in October 2008), then the next opportunity to begin payment based on ASP data for a therapeutic radiopharmaceutical would be April 2009 if ASP data reflective of fourth quarter CY 2008 sales were submitted in January 2009.

TABLE 25.—PROPOSED CY 2009 SEPARATELY PAYABLE THERAPEUTIC RADIOPHARMACEUTICALS

HCPCS code	Short descriptor	Proposed CY 2009 APC	Proposed CY 2009 SI	Proposed CY 2009 payment rate based on mean cost from claims
A9517	I131 iodide cap, rx	1064	K	$514.52
A9530	I131 iodide sol, rx	1150	K	424.97
A9543	Y90 ibritumomab, rx	1643	K	15,159.66
A9545	I131 tositumomab, rx	1645	K	10,554.47
A9563	P32 Na phosphate	1675	K	164.98
A9564	P32 chromic phosphate	1676	K	560.36
A9600	Sr89 strontium	0701	K	1,308.96
A9605	Sm 153 lexidronm	0702	K	2,655.52

5. Proposed Payment for Nonpass-Through Drugs, Biologicals, and Radiopharmaceuticals With HCPCS Codes, but Without OPPS Hospital Claims Data

Pub. L. 108–173 does not address the OPPS payment in CY 2005 and after for drugs, biologicals, and radiopharmaceuticals that have assigned HCPCS codes, but that do not have a reference AWP or approval for payment as pass-through drugs or biologicals. Because there is no statutory provision that dictated payment for such drugs and biologicals in CY 2005, and because we had no hospital claims data to use in establishing a payment rate for them, we investigated several payment options for CY 2005 and discussed them in detail in the CY 2005 OPPS final rule with comment period (69 FR 65797 through 65799).

For CYs 2005 to 2007, we implemented a policy to provide separate payment for new drugs, biologicals, and radiopharmaceuticals with HCPCS codes, but which did not have pass-through status, at a rate that was equivalent to the payment they received in the physician's office setting, established in accordance with the ASP methodology. For CY 2008, we finalized a policy to provide payment for new drugs and biologicals with HCPCS codes but which do not have pass-through status and are without OPPS hospital claims data, at ASP+5 percent, consistent with the final OPPS payment methodology for other separately payable drugs and biologicals. We are proposing to continue this methodology for CY 2009. Therefore, for CY 2009, we are proposing to provide payment for new drugs and biologicals with HCPCS codes, but which do not have pass-through status and are without OPPS hospital claims data, at ASP+4 percent, consistent with the CY 2009 proposed payment methodology for other separately payable nonpass-through drugs and biologicals. It is our belief that this policy ensures that new nonpass-through drugs and biologicals are treated like other drugs and biologicals under the OPPS, unless they are granted pass-through status. Only if

they are pass-through drugs and biologicals would they receive a different payment for CY 2009, generally equivalent to the payment these drugs and biologicals would receive in the physician's office setting, consistent with the requirements of the statute. We are proposing to continue packaging payment for all new nonpass-through diagnostic radiopharmaceuticals in CY 2009.

In accordance with the ASP methodology, in the absence of ASP data, we are proposing, for CY 2009, to continue the policy we implemented beginning in CY 2005 of using the WAC for the product to establish the initial payment rate for new nonpass-through drugs and biologicals with HCPCS codes, but which are without OPPS claims data. However, we note that if the WAC is also unavailable, we would make payment at 95 percent of the product's most recent AWP. We are also proposing to assign status indicator ''K'' to HCPCS codes for new drugs and biologicals for which we have not received a pass-through application. We further note that with respect to new items for which we do not have ASP data, once their ASP data become available in later quarter submissions, their payment rates under the OPPS would be adjusted so that the rates are based on the ASP methodology and set to the finalized ASP-based amount (proposed for CY 2009 at ASP+4 percent) for items that have not been granted pass-through status.

For CY 2009, we also are proposing to base payment for new therapeutic radiopharmaceuticals with HCPCS codes as of January 1, 2009, but which do not have pass-through status, on the WACs for these products if ASP data for these therapeutic radiopharmaceuticals are not available. If the WACs are also unavailable, we would make payment for new therapeutic radiopharmaceuticals at 95 percent of their most recent AWPs because we would not have mean costs from hospital claims data upon which to base payment. Analogous to new drugs and biologicals, we are proposing to assign status indicator ''K'' to HCPCS codes for new therapeutic radiopharmaceuticals for which we have not received a pass-through application.

Consistent with other ASP-based payments, for CY 2009, we are proposing to make any appropriate adjustments to the payment amounts for new drugs and biologicals in the CY 2009 OPPS/ASC final rule with comment period and also on a quarterly basis on our Web site during CY 2009 if later quarter ASP submissions (or more recent WACs or AWPs) indicate that adjustments to the payment rates for these drugs and biologicals are necessary. The payment rates for new therapeutic radiopharmaceuticals would also be adjusted accordingly. We note, the new CY 2009 HCPCS codes for drugs, biologicals, and therapeutic radiopharmaceuticals are not available at the time of development of this proposed rule; however, they will be included in the CY 2009 OPPS/ASC final rule with comment period where they will be assigned comment indicator ''NI'' to reflect that their interim final OPPS treatment is open to comment in the CY 2009 OPPS/ASC final rule with comment period.

There are several nonpass-through drugs and biologicals that were payable in CY 2007 and/or CY 2008 for which we do not have any CY 2007 hospital claims data. In order to determine the packaging status of these items for CY 2009, we calculated an estimate of the per day cost of each of these items by multiplying the payment rate for each product based on ASP+4 percent, similar to other nonpass-through drugs and biologicals paid separately under the OPPS, by an estimated average number of units of each product that would typically be furnished to a patient during one administration in the hospital outpatient setting. We are proposing to package items for which we estimate the per administration cost to be less than or equal to $60, which is the general packaging threshold that we are proposing for drugs, biologicals, and therapeutic radiopharmaceuticals in CY 2009. We are proposing to pay separately for items with an estimated per administration cost greater than $60 (with the exception of diagnostic radiopharmaceuticals and contrast agents which we are proposing to continue to package regardless of cost, as discussed in more detail in section V.B.2.b. of this proposed rule) in CY 2009. We are proposing that the CY 2009 payment for separately payable items without CY 2007 claims data would be based on ASP+4 percent, similar to other separately payable nonpass-through drugs and biologicals under the OPPS. In accordance with the ASP methodology used in the physician's office setting, in the absence of ASP data, we would use the WAC for the product to establish the initial payment rate. However, we note that if the WAC is also unavailable, we would make payment at 95 percent of the most recent AWP available.

Table 26 lists all of the nonpass-through drugs and biologicals without available CY 2007 claims data to which these policies would apply in CY 2009.

TABLE 26.—DRUGS AND BIOLOGICALS WITHOUT CY 2007 CLAIMS DATA

HCPCS code	Short descriptor	Proposed ASP-based payment rate	Estimated average number of units per administration	Proposed CY 2009 SI	Proposed CY 2009 APC
C9237	Inj, lanreotide acetate	$23.90	90	K	9237
J0400	Aripiprazole injection	.....	39	N	.....
J1573	Hepagam B intravenous, inj	47.43	8	K	1138
J2724	Protein C concentrate	11.96	630	K	1139
J3355	Urofollitropin, 75 iu	48.25	2	K	1741
Q4096	VWF complex, not Humate-P	0.64	6825	K	1213
Q4097	Inj IVIG Privigen 500 mg	33.54	84	K	1214

In the CY 2008 OPPS/ASC final rule with comment period (72 FR 66776), we began recognizing, for OPPS payment purposes, multiple HCPCS codes indicating different dosages for covered Part B drugs. In general, prior to CY 2008, the OPPS recognized the lowest available administrative dose of a drug if multiple HCPCS codes existed for the drug; for the remainder of the doses, the HCPCS codes were assigned status indicator ''B'' indicating that another code existed for OPPS purposes. For example, if drug X has 2 HCPCS codes, 1 for a 1 ml dose and a second for a 5

ml dose, prior to CY 2008, the OPPS would have assigned a payable status indicator to the 1 ml dose and status indicator ''B'' to the 5 ml dose. Hospitals were then responsible for billing the appropriate number of units for the 1 ml dose in order to receive payment for the drug under the OPPS.

As these HCPCS codes were previously unrecognized under the OPPS prior to CY 2008, we do not have claims data to determine their appropriate packaging status for CY 2009. For the CY 2008 OPPS/ASC final rule with comment period (72 FR 66775), we implemented a policy that assigned the status indicator of the previously recognized HCPCS code to the associated newly recognized code(s). For CY 2009, we are again proposing to continue to use this methodology. Table 27 below shows the CY 2007 unrecognized HCPCS code, the CY 2007 status indicator for the unrecognized HCPCS code, the CY 2008 short descriptor for the unrecognized HCPCS code, the associated recognized CY 2007 HCPCS code, and the proposed status indicator for the newly recognized code. As noted in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66775), we believe that this approach is the most appropriate and reasonable way to implement this change in HCPCS code recognition under the OPPS without impacting payment. However, once claims data are available for these previously unrecognized HCPCS codes, we would determine the packaging status and resulting status indicator for each HCPCS code according to the general code-specific methodology for determining a code's packaging status for a given update year. As we stated in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66775), we plan to closely follow our claims data to ensure that our annual packaging determinations for the different HCPCS codes describing the same drug do not create inappropriate payment incentives for hospitals to report certain HCPCS codes instead of others.

TABLE 27.—HCPCS CODES UNRECOGNIZED IN CY 2007, ASSOCIATED RECOGNIZED HCPCS CODES, AND PROPOSED STATUS INDICATORS FOR CY 2009

HCPCS codes not recognized in CY 2007	CY 2007 SI	CY 2008 short descriptor	Associated HCPCS recognized in CY 2007	Proposed CY 2009 SI for HCPCS code newly recognized in CY 2008
J1470	B	Gamma globulin 2 CC inj	J1460	K
J1480	B	Gamma globulin 3 CC inj	J1460	K
J1490	B	Gamma globulin 4 CC inj	J1460	K
J1500	B	Gamma globulin 5 CC inj	J1460	K
J1510	B	Gamma globulin 6 CC inj	J1460	K
J1520	B	Gamma globulin 7 CC inj	J1460	K
J1530	B	Gamma globulin 8 CC inj	J1460	K
J1540	B	Gamma globulin 9 CC inj	J1460	K
J1550	B	Gamma globulin 10 CC inj	J1460	K
J1560	B	Gamma globulin > 10 CC inj	J1460	K
J8521	B	Capecitabine, oral, 500 MG	J8520	K
J9062	B	Cisplatin 50 MG injection	J9060	N
J9080	B	Cyclophosphamide 200 MG inj	J9070	N
J9090	B	Cyclophosphamide 500 MG inj	J9070	N
J9091	B	Cyclophosphamide 1.0 Grm inj	J9070	N
J9092	B	Cyclophosphamide 2.0 Grm inj	J9070	N
J9094	B	Cyclophosphamide lyophilized	J9093	N
J9095	B	Cyclophosphamide lyophilized	J9093	N
J9096	B	Cyclophosphamide lyophilized	J9093	N
J9097	B	Cyclophosphamide lyophilized	J9093	N
J9110	B	Cytarabine hcl 500 MG inj	J9100	N
J9140	B	Dacarbazine 200 MG inj	J9130	N
J9182	B	Etoposide 100 MG inj	J9181	N
J9260	B	Methotrexate sodium inj	J9250	N
J9290	B	Mitomycin 20 MG inj	J9280	N
J9291	B	Mitomycin 40 MG inj	J9280	N
J9375	B	Vincristine sulfate 2 MG inj	J9370	N
J9380	B	Vincristine sulfate 5 MG inj	J9370	N

Finally, there are 8 drugs and biologicals, shown in Table 28 below, that were payable in CY 2007 for which we lack CY 2007 claims data and for which we are unable to determine the per day cost based on the ASP methodology. As we are unable to determine the packaging status and subsequent payment rates, if applicable, for these drugs and biologicals for CY 2009 based on the ASP methodology or claims data, we are proposing to package payment for these drugs and biologicals in CY 2009.

TABLE 28.—DRUGS AND BIOLOGICALS WITHOUT INFORMATION ON PER DAY COST THAT ARE PROPOSED FOR PACKAGING IN CY 2009

HCPCS code	Short descriptor	Proposed CY 2009 SI
90393	Vaccina ig, im	N

TABLE 28.—DRUGS AND BIOLOGICALS WITHOUT INFORMATION ON PER DAY COST THAT ARE PROPOSED FOR PACKAGING IN CY 2009—Continued

HCPCS code	Short descriptor	Proposed CY 2009 SI
90581	Anthrax vaccine, sc	N
J0350	Injection anistreplase 30 u	N
J0395	Arbutamine HCl injection	N
J1452	Intraocular Fomivirsen na	N
J2670	Totazoline hcl injection	N
J3530	Nasal vaccine inhalation	N
Q0174	Thiethylperazine maleate 10 mg	N

VI. Proposed Estimate of OPPS Transitional Pass-Through Spending for Drugs, Biologicals, Radiopharmaceuticals, and Devices

A. Background

Section 1833(t)(6)(E) of the Act limits the total projected amount of transitional pass-through payments for drugs, biologicals, radiopharmaceuticals, and categories of devices for a given year to an ''applicable percentage'' of projected total Medicare and beneficiary payments under the hospital OPPS. For a year before CY 2004, the applicable percentage was 2.5 percent; for CY 2004 and subsequent years, we specify the applicable percentage up to 2.0 percent.

If we estimate before the beginning of the calendar year that the total amount of pass-through payments in that year would exceed the applicable percentage, section 1833(t)(6)(E)(iii) of the Act requires a uniform reduction in the amount of each of the transitional pass-through payments made in that year to ensure that the limit is not exceeded. We make an estimate of pass-through spending to determine not only whether payments exceed the applicable percentage, but also to determine the appropriate reduction to the conversion factor for the projected level of pass-through spending in the following year.

For devices, developing an estimate of pass-through spending in CY 2009 entails estimating spending for two groups of items. The first group of items consists of device categories that were recently made eligible for pass-through payment and that would continue to be eligible for pass-through payment in CY 2009. The CY 2008 OPPS/ASC final rule with comment period (72 FR 66778) describes the methodology we have used in previous years to develop the pass-through spending estimate for known device categories continuing into the applicable update year. The second group contains items that we know are newly eligible, or project would be newly eligible, for device pass-through payment in the remainder of CY 2008 or beginning in CY 2009. The sum of the CY 2009 pass-through estimates for these two groups of device categories would equal the total CY 2009 pass-through spending estimate for device categories with pass-through status.

For drugs and biologicals, section 1833(t)(6)(D)(i) of the Act establishes the pass-through payment amount for drugs and biologicals eligible for pass-through payment as the amount by which the amount authorized under section 1842(o) of the Act (or, if the drug or biological is covered under a competitive acquisition contract under section 1847B of the Act, an amount determined by the Secretary equal to the average price for the drug or biological for all competitive acquisition areas and year established under such section as calculated and adjusted by the Secretary) exceeds the portion of the otherwise applicable fee schedule amount that the Secretary determines is associated with the drug or biological. Because we are proposing to pay for nonpass-through separately payable drugs and biologicals under the CY 2009 OPPS at ASP+4 percent, which represents the otherwise applicable fee schedule amount associated with a pass-through drug or biological, and we would pay for pass-through drugs and biologicals at ASP+6 percent or the Part B drug CAP rate, if applicable, our estimate of drug and biological pass-through payment for CY 2009 is not zero. Similar to estimates for devices, the first group of drugs and biologicals requiring a pass-through payment estimate consists of those products that were recently made eligible for pass-through payment and that would continue to be eligible for pass-through payment in CY 2009. The second group contains drugs and biologicals that we know are newly eligible, or project would be newly eligible, beginning in CY 2009. The sum of the CY 2009 pass-through estimates for these two groups of drugs and biologicals would equal the total CY 2009 pass-through spending estimate for drugs and biologicals with pass-through status.

B. Proposed Estimate of Pass-Through Spending

We are proposing to set the applicable percentage limit at 2.0 percent of the total OPPS projected payments for CY 2009, consistent with our OPPS policy from CY 2004 through CY 2008.

As discussed in section IV.A. of this proposed rule, there are currently no known device categories receiving pass-through payment in CY 2008 that would continue for payment during CY 2009. Therefore, there are no device categories in the first group, that is, device categories recently made eligible for pass-through payment and continuing into CY 2009, and the estimate for this group is $0.

In estimating CY 2009 pass-through spending for device categories in the second group (that is, device categories that we know at the time of the development of this proposed rule would be newly eligible for pass-through payment in CY 2009 (of which there are none), additional device categories that we estimate could be approved for pass-through status subsequent to the development of this proposed rule and before January 1, 2009, and contingent projections for new categories in the second through fourth quarters of CY 2009), we are proposing to use the general methodology described in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66778), while also taking into account recent OPPS experience in approving new pass-through device categories. The estimate of CY 2009 pass-through spending for this second group is $10.0 million. Employing our established methodology that the estimate of pass-through device spending in CY 2009 incorporates CY 2009 estimates of pass-through spending for known device categories continuing in CY 2009, those first effective January 1, 2009, and those device categories projected to be approved during subsequent quarters of CY 2008 and CY 2009, our proposed total pass-through estimate for device categories for CY 2009 is $10.0 million.

To estimate CY 2009 pass-through spending for drugs and biologicals in the first group, specifically those drugs and biologicals recently made eligible for pass-through payment and continuing into CY 2009, we are proposing to utilize the most recent Medicare physician's office data regarding their utilization, information provided in the respective pass-through applications, historical hospital claims data, pharmaceutical industry information, and clinical information regarding the drugs or biologicals, in order to project the CY 2009 OPPS utilization of the products. For the known drugs and biologicals that would continue on pass-through status in CY 2009, we then estimate the total pass-through payment amount as the difference between ASP+6 percent or the Part B drug CAP rate, as applicable, and ASP+4 percent, aggregated across the projected CY 2009 OPPS utilization of these products. If payment for the drug or biological would be packaged if the product were not paid separately because of its pass-through status, we include in the pass-through estimate the full payment for the drug or biological at ASP+6 percent. Based on these analyses, we are proposing the estimated pass-through spending attributable to the first group (that is, the known drugs and biologicals continuing with pass-through eligibility in CY 2009) described above to be about $3.4 million for CY 2009. This $3.4 million estimate of CY 2009 pass-through spending for the first group of pass-through drugs and biologicals reflects the current pass-through drugs and biologicals that are continuing on pass-through status into CY 2009, which are displayed in Table 21 in section V.A.3. of this proposed rule.

To estimate CY 2009 pass-through spending for drugs and biologicals in the second group (that is, drugs and biologicals that we know at the time of development of this proposed rule would be newly eligible for pass-through payment in CY 2009 (of which there are none), additional drugs and biologicals that we estimate could be approved for pass-through status subsequent to the development of this proposed rule and before January 1, 2009, and projections for new drugs and biologicals that could be initially eligible for pass-through payment in the second through fourth quarters of CY 2009), we are proposing to use utilization estimates from applicants, pharmaceutical industry data, and clinical information as the basis for pass-through spending estimates for these drugs and biologicals for CY 2009, while also considering the most recent OPPS experience in approving new pass-through drugs and biologicals. Based on these analyses, we are proposing the estimated pass-through spending attributable to this second group of drugs and biologicals to be about $5.5 million for CY 2009.

In the CY 2005 OPPS final rule with comment period (69 FR 65810), we indicated that we are accepting pass-through applications for new radiopharmaceuticals that are assigned a HCPCS code on or after January 1, 2005. (Prior to this date, radiopharmaceuticals were not included in the category of drugs paid under the OPPS, and, therefore, were not eligible for pass-through status.) There are no radiopharmaceuticals that are eligible for pass-through payment at the time of publication of this proposed rule. In addition, we have no information identifying new radiopharmaceuticals to which a HCPCS code might be assigned on or after January 1, 2009, for which pass-through payment status would be sought. We also have no historical data regarding payment for new radiopharmaceuticals with pass-through status under the methodology that we specified for the CY 2005 OPPS or the CY 2009 methodology that we are proposing as discussed in section V.A.3. of this proposed rule. However, we do not believe that pass-through spending for new radiopharmaceuticals in CY 2009 would be significant enough to materially affect our estimate of total pass-through spending in CY 2009. Therefore, we are not including radiopharmaceuticals in our proposed estimate of pass-through spending for CY 2009. We discuss the proposed methodology for determining the CY 2009 payment amount for new therapeutic radiopharmaceuticals without pass-through status in section V.B.5. of this proposed rule. We discuss our proposal to package payment for all new diagnostic radiopharmaceuticals without pass-through status in CY 2009 in section V.B.2.b. of this proposed rule.

In accordance with the comprehensive methodology described above, we estimate that total pass-through spending for the device categories and the drugs and biologicals that are continuing for pass-through payment into CY 2009 and those devices, drugs, biologicals, and radiopharmaceuticals that first become eligible for pass-through status subsequent to this proposed rule in CY 2008 or during CY 2009 would approximate $18.9 million, which represents 0.07 percent of total OPPS projected payments for CY 2009.

Because we estimate that pass-through spending in CY 2009 would not amount to 2.0 percent of total projected OPPS CY 2009 spending, we are proposing to return 1.93 percent of the pass-through pool to adjust the conversion factor, as we discuss in section II.B. of this proposed rule.

VII. Proposed OPPS Payment for Brachytherapy Sources

A. Background

Section 1833(t)(2)(H) of the Act, as added by section 621(b)(2)(C) of Public Law 108–173, mandated the creation of separate groups of covered OPD services that classify brachytherapy devices separately from other services or groups of services. The additional groups must reflect the number, isotope, and radioactive intensity of the devices of brachytherapy furnished, including separate groups for palladium-103 and iodine-125 devices.

Section 1833(t)(16)(C) of the Act, as added by section 621(b)(1) of Public Law 108–173, established payment for devices of brachytherapy consisting of a seed or seeds (or radioactive source) based on a hospital's charges for the service, adjusted to cost. The period of payment under this provision is for brachytherapy sources furnished from January 1, 2004, through December 31, 2006. Under section 1833(t)(16)(C) of the Act, charges for the brachytherapy devices may not be used in determining any outlier payments under the OPPS for that period of payment. Consistent with our practice under the OPPS to exclude items paid at cost from budget neutrality consideration, these items were excluded from budget neutrality for that time period as well.

Section 621(b)(3) of Pub. L. 108–173 required the GAO to conduct a study to determine appropriate payment amounts for devices of brachytherapy, and to submit a report on its study to the Congress and the Secretary, including recommendations on the appropriate payments for such devices. This report was due to Congress and to the Secretary no later than January 1, 2005. The GAO's final report, ''Medicare Outpatient Payments: Rates for Certain Radioactive Sources Used in Brachytherapy Could Be Set Prospectively'' (GAO–06–635), was published on July 24, 2006. We summarized and discussed the report's findings and recommendations in the CY 2007 OPPS/ASC final rule with comment period (71 FR 68103 through 68105). The GAO report principally recommended that we use OPPS historical claims data to determine prospective payment rates for two of the

most frequently used brachytherapy sources, iodine-125 and palladium-103, and also recommended that we consider using claims data for the third source studied, high dose rate (HDR) iridium-192.

In our CY 2007 annual OPPS rulemaking, we proposed and finalized a policy of prospective payment based on median costs for the 11 brachytherapy sources for which we had claims data. We based the prospective payment rates on median costs for each source from our CY 2005 claims data (71 FR 68102 through 71 FR 68114).

Subsequent to publication of the CY 2007 OPPS/ASC final rule with comment period, section 107(a) of the MIEA–TRHCA amended section 1833(t)(16)(C) of the Act by extending the payment period for brachytherapy sources based on a hospital's charges adjusted to cost for 1 additional year, through December 31, 2007. Therefore, we continued to pay for brachytherapy sources on charges adjusted to cost for CY 2007.

Section 107(b)(1) of the MIEA–TRHCA amended section 1833(t)(2)(H) of the Act by adding a requirement for the establishment of separate payment groups for ''stranded and non-stranded'' brachytherapy devices beginning July 1, 2007. Section 107(b)(2) of the MIEA–TRHCA authorized the Secretary to implement this new requirement by ''program instruction or otherwise.'' This new requirement is in addition to the requirement for separate payment groups based on the number, isotope, and radioactive intensity of brachytherapy devices that was previously established by section 1833(t)(2)(H) of the Act. We note that commenters who responded to the CY 2007 proposed rule asserted that stranded sources, which they described as embedded into the stranded suture material and separated within the strand by material of an absorbable nature at specified intervals, had greater production costs than non-stranded sources (71 FR 68113 through 68114).

As a result of the statutory requirement to create separate groups for stranded and non-stranded sources as of July 1, 2007, we established several coding changes via program transmittal, effective July 1, 2007 (Transmittal 1259, dated June 1, 2007). Based upon comments on our CY 2007 proposed rule and industry input, we were aware of three sources available in stranded and non-stranded forms at that time: iodine-125; palladium-103; and cesium-131 (72 FR 42746). We created six new HCPCS codes to differentiate the stranded and non-stranded versions of iodine, palladium and cesium sources.

The first partial year claims data for separately coded stranded and non-stranded iodine, palladium, and cesium sources are now available in the CY 2007 claims data that we are using for CY 2009 ratesetting for brachytherapy sources included in this proposed rule.

In Transmittal 1259, we indicated that if we receive information that any of the other sources now designated as non-stranded are marketed as a stranded source, we would create a code for the stranded source. We also established two ''Not Otherwise Specified'' (NOS) codes for billing stranded and non-stranded sources that are not yet known to us and for which we do not have source-specific codes, that is, C2698 (Brachytherapy source, stranded, not otherwise specified, per source) for stranded NOS sources, or C2699 (Brachytherapy source, non-stranded, not otherwise specified, per source) for non-stranded NOS sources.

In the CY 2008 OPPS/ASC final rule with comment period (72 FR 66783 through 66784), we again finalized prospective payment for brachytherapy sources, beginning in CY 2008, with payment rates determined using the CY 2006 claims-based costs per source for each brachytherapy source. Consistent with our policy regarding APC payments made on a prospective basis, we finalized our policy in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66686) to subject the cost of brachytherapy sources to the outlier provision of section 1833(t)(5) of the Act, and to also subject brachytherapy source payment weights to scaling for purposes of budget neutrality. Therefore, brachytherapy sources could receive outlier payments if the costs of furnishing brachytherapy sources met the criteria for outlier payment. In addition, as noted in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66683), implementation of prospective payment for brachytherapy sources provides opportunities for hospitals to receive additional payments under certain circumstances through the 7.1 percent rural SCH adjustment.

We proposed and finalized a policy for CY 2008 to pay the two NOS codes, C2698 and C2699, based on a rate equal to the lowest stranded or non-stranded prospective payment rate for such sources, respectively, on a per source basis (as opposed, for example, to per mci). We reasoned that this payment methodology for NOS sources would provide payment to a hospital for new sources, while encouraging interested parties to quickly bring new sources to our attention so specific coding and payment could be established (72 FR 66785).

After we finalized our proposal to pay for brachytherapy sources in CY 2008 based on median costs, section 106(a) of the MMSEA extended the charges adjusted to cost payment methodology for an additional 6 months, through June 30, 2008. On January 18, 2008, we issued Transmittal R1417CP to indicate how we are implementing this provision. At this time, the prospective payment rates for brachytherapy sources finalized in the CY 2008 OPPS/ASC final rule with comment period will become effective July 1, 2008.

Status indicator ''H'' (defined in the CY 2008 OPPS/final rule with comment period as ''Pass-Through Device Categories. Separate cost-based pass-through payment; not subject to copayment.'') is currently assigned to brachytherapy sources through June 30, 2008, for claims processing purposes, although a beneficiary copayment is being applied to payment for these sources. We finalized a policy in the CY 2008 OPPS/ASC final rule with comment period to assign status indicator ''K'' (defined as ''Nonpass-Through Drugs and Biologicals; Therapeutic Radiopharmaceuticals; Brachytherapy Sources; Blood and Blood Products. Paid under OPPS; separate APC payment.'') to all brachytherapy source APCs because the sources would be paid based on prospective payment. The definition of status indicator ''K'' was initially changed for CY 2007 to accommodate prospective payment for brachytherapy sources and this change was continued for CY 2008 (72 FR 66785). Brachytherapy source APCs will be assigned status indicator ''K'' beginning July 1 through December 31, 2008.

For CY 2008, we also adopted the policy we established in the CY 2007 OPPS/ASC final rule with comment period (which was superseded by section 107 of the MIEA–TRHCA) regarding payment for new brachytherapy sources for which we have no claims data. We assign future new HCPCS codes for new brachytherapy sources to their own APCs, with prospective payment rates set based on our consideration of external data and other relevant information regarding the expected costs of the sources to hospitals (72 FR 66785). When section 106(a) of the MMSEA extended the charges adjusted to cost payment methodology for brachytherapy sources through June 30, 2008, this policy was not implemented as of January 1, 2008. We anticipate implementing this policy as of July 1, 2008.

At its March 2008 meeting, the APC Panel recommended that CMS use

median cost data to pay for brachytherapy sources in CY 2009, as presented by the CMS staff and reviewed by the APC Panel Data Subcommittee.

B. Proposed OPPS Payment Policy

As we have stated in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66780), we believe that adopting prospective payment for brachytherapy sources would be appropriate for a number of reasons. The general OPPS payment methodology is a prospective payment system using median costs based on claims data to set the relative payment weights for hospital outpatient services. This prospective payment methodology would result in more consistent, predictable, and equitable payment amounts per source across hospitals by eliminating some of the extremely high and low payment amounts resulting from payment based on hospitals' charges adjusted to cost. Prospective payment would also provide hospitals with incentives for efficiency in the provision of brachytherapy services to Medicare beneficiaries. Moreover, this approach is consistent with our payment methodology for the vast majority of items and services paid under the OPPS. Indeed, section 1833(t)(2)(C) of the Act requires us to establish prospective payment rates for the OPPS system based on median costs (or mean costs if elected by the Secretary). Only pass-through devices continue to be paid at charges adjusted to cost for all of CY 2008, while brachytherapy sources and therapeutic radiopharmaceuticals are paid at charges adjusted to cost for the first 6 months of CY 2008.

We are proposing to use CY 2007 claims data for setting the CY 2009 rates for brachytherapy sources, as we are proposing for most other items and services that will be paid under the CY 2009 OPPS, using our standard OPPS ratesetting methodology. We believe that we have sufficiently robust CY 2007 claims data for all payable brachytherapy sources, including stranded and non-stranded iodine, palladium, and cesium sources. As indicated earlier, at the March 2008 APC Panel meeting, the APC Panel Data Subcommittee reviewed the CY 2007 claims data for brachytherapy sources and the APC Panel recommended using the median cost data for CY 2009 rates. We are accepting the APC Panel's recommendation, which is consistent with our proposal.

We are proposing to pay for the stranded and non-stranded NOS codes, C2698 and C2699, based on a rate equal to the lowest stranded or non-stranded prospective payment rate for such sources, respectively, on a per source basis (as opposed, for example, to per mci). This proposed payment methodology for NOS sources would provide payment to a hospital for new sources, while encouraging interested parties to quickly bring new sources to our attention so specific coding and payment could be established.

We are proposing to establish new status indicator ''U'' (Brachytherapy Sources. Paid under OPPS; separate APC payment) for brachytherapy sources as of January 1, 2009. Status indicator ''H'' is currently used for the periods when brachytherapy sources are paid based on the charges adjusted to cost payment methodology, while status indicator ''K'' is used for brachytherapy source payment as of July 1, 2008 through December 31, 2008, in accordance with the policy we finalized in the CY 2008 OPPS/ASC final rule with comment period. Status indicator ''K'' currently encompasses nonpass-through drugs and biologicals, therapeutic radiopharmaceuticals, brachytherapy sources, and blood and blood products. Assigning status indicator ''K'' to several types of items and services with potentially differing payment policies has added unnecessary complexity to our operations. In addition, in CY 2009 we are implementing section 1833(t)(17)(A) of the Act that specifies payment to hospitals based on a reduced conversion factor when those hospitals fail to submit timely hospital outpatient quality data as required. Therefore, to facilitate implementation of this payment change and streamline operations, we are proposing to assign new status indicator ''U'' to brachytherapy source HCPCS codes beginning in CY 2009.

We are, therefore, proposing to pay for brachytherapy sources at prospective rates based on their source-specific median costs for CY 2009. The separately payable brachytherapy source codes, descriptors, APCs, approximate median costs, and status indicators are presented in Table 29.

TABLE 29.—PROPOSED SEPARATELY PAYABLE BRACHYTHERAPY SOURCES FOR CY 2009

HCPCS code	Long descriptor	Proposed CY 2009 APC	Proposed CY 2009 median cost	Proposed CY 2009 status indicator
A9527	Iodine I–125, sodium iodide solution, therapeutic, per millicurie	2632	$36	U
C1716	Brachytherapy source, non-stranded, Gold-198, per source	1716	34	U
C1717	Brachytherapy source, non-stranded, High Dose Rate Iridium-192, per source	1717	212	U
C1719	Brachytherapy source, non-stranded, Non-High Dose Rate Iridium-192, per source.	1719	65	U
C2616	Brachytherapy source, non-stranded, Yttrium-90, per source	2616	13,426	U
C2634	Brachytherapy source, non-stranded, High Activity, Iodine-125, greater than 1.01 mCi (NIST), per source.	2634	43	U
C2635	Brachytherapy source, non-stranded, High Activity, Palladium-103, greater than 2.2 mCi (NIST), per source.	2635	27	U
C2636	Brachytherapy linear source, non-stranded, Palladium-103, per 1MM	2636	60	U
C2638	Brachytherapy source, stranded, Iodine-125, per source	2638	40	U
C2639	Brachytherapy source, non-stranded, Iodine-125, per source	2639	36	U
C2640	Brachytherapy source, stranded, Palladium-103, per source	2640	66	U
C2641	Brachytherapy source, non-stranded, Palladium-103, per source	2641	63	U
C2642	Brachytherapy source, stranded, Cesium-131, per source	2642	100	U
C2643	Brachytherapy source, non-stranded, Cesium-131, per source	2643	59	U
C2698	Brachytherapy source, stranded, not otherwise specified, per source	2698	40	U
C2699	Brachytherapy source, non-stranded, not otherwise specified, per source	2699	27	U

In addition, in CY 2009, we are proposing to continue the policy we established in the CY 2007 OPPS/ASC final rule with comment period (which was superseded by section 107 of the MIEA–TRHCA) regarding payment for new brachytherapy sources for which we have no claims data. In accordance with that policy, we would assign future new HCPCS codes for new brachytherapy sources to their own APCs, with prospective payment rates set based on our consideration of external data and other relevant information regarding the expected costs of the sources to hospitals.

We continue to invite hospitals and other parties to submit recommendations to us for new HCPCS codes to describe new sources consisting of a radioactive isotope, including a detailed rationale to support recommended new sources. Such recommendations should be directed to the Division of Outpatient Care, Mail Stop C4–05–17, Centers for Medicare and Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244. We will continue to add new brachytherapy source codes and descriptors to our systems for payment on a quarterly basis.

VIII. Proposed OPPS Payment for Drug Administration Services

A. Background

In CY 2005, in response to the recommendations made by commenters and the hospital industry, OPPS transitioned to the use of CPT codes for drug administration services. These CPT codes allowed specific reporting of services regarding the number of hours for an infusion and provided consistency in coding between Medicare and other payers. (For a discussion regarding coding and payment for drug administration services prior to CY 2005, we refer readers to the CY 2008 OPPS/ASC final rule with comment period (72 FR 66787).)

While hospitals began adopting CPT codes for outpatient drug administration services in CY 2005, physicians paid under the MPFS were using HCPCS G-codes in CY 2005 to report office-based drug administration services. These G-codes were developed in anticipation of substantial revisions to the drug administration CPT codes by the CPT Editorial Panel that were expected for CY 2006.

In CY 2006, as anticipated, the CPT Editorial Panel revised its coding structure for drug administration services, incorporating new concepts such as initial, sequential, and concurrent services into a structure that previously distinguished services based on type of administration (chemotherapy/nonchemotherapy), method of administration (injection/infusion/push), and for infusion services, first hour and additional hours. For CY 2006, we implemented the CY 2006 drug administration CPT codes that did not reflect the concepts of initial, sequential, and concurrent services under the OPPS, and we created HCPCS C-codes that generally paralleled the CY 2005 CPT codes for reporting these other services.

For CY 2007, as a result of comments on our proposed rule and feedback from the hospital community and the APC Panel, we implemented the full set of CPT codes, including codes incorporating the concepts of initial, sequential, and concurrent. In addition, the CY 2007 update process offered us the first opportunity to consider data gathered from the use of CY 2005 CPT codes for purposes of ratesetting. For CY 2007, we used CY 2005 claims data to implement a six-level APC structure for drug administration services. This six-level APC structure for drug administration services was continued in CY 2008.

B. Proposed Coding and Payment for Drug Administration Services

The CY 2009 ratesetting process affords us the first opportunity to examine hospital claims data for the full set of CPT codes that reflect the concepts of initial, concurrent, and sequential services. We performed our standard annual OPPS review of the clinical and resource characteristics of the drug administration HCPCS codes assigned to APCs 0436 (Level I Drug Administration), 0437 (Level II Drug Administration), 0438 (Level III Drug Administration), 0439 (Level IV Drug Administration), 0440 (Level V Drug Administration), and 0441 (Level VI Drug Administration) for CY 2008 based on the CY 2007 claims data available for this proposed rule. Under the CY 2008 APC configurations for drug administration services, we observed several 2 times violations among the 6 APCs. Therefore, we are proposing to reconfigure the drug administration APCs for CY 2009 to improve the clinical and resource homogeneity of the APCs. (We refer readers to section III.B. of this proposed rule for further discussion of the 2 times rule.)

As a result of our hospital cost analysis and detailed clinical review, we are proposing a five-level APC structure for CY 2009 drug administration services to more appropriately reflect their resource utilization in APCs that also group clinically similar services. These APCs generally demonstrate the clinically expected and actually observed comparative relationships between the median costs of different types of drug administration services, including initial and additional services, chemotherapy and other diagnostic, prophylactic, or therapeutic services, injections and infusions, and simple and complex methods of drug administration. We do not believe that six drug administration APCs continue to be necessary to pay appropriately for drug administration services based on the significant clinical and resource differences among services. Instead, we believe that the proposed five-level APC structure for CY 2009, displayed in Table 30 below, is the more appropriate structure based on hospital claims data for the full range of CPT drug administration codes.

We presented a potential four-level drug administration APC structure to the APC Panel during the March 2008 APC Panel meeting. After reviewing the data, the APC Panel recommended that CMS not implement this configuration until more data are available and that CMS provide the APC Panel with a crosswalk analysis of the data. We appreciate the recommendation of the APC Panel. We are accepting this recommendation, and we are not proposing to implement a four-level APC structure for drug administration services in CY 2009.

We last reconfigured the drug administration APCs for CY 2007 when we first had 1 year of claims data reflecting the costs of predecessor drug administration CPT codes. Therefore, in parallel fashion we believe it is appropriate to propose to reconfigure the drug administration APCs for CY 2009 when we first have a year of hospital claims data for the full range of CPT codes. Our prior assignments of CPT codes without data were based only on estimates of hospital resource costs, and our usual practice is to closely examine the APC assignments of all HCPCS codes once we have actual claims data. We note that, for most of the drug administration services, we have thousands of single bills available for ratesetting from the claims submitted by thousands of hospitals, increasing our confidence in the accuracy and stability of the claims data. In addition, our bypass code methodology as described in section II.A.1.b. of this proposed rule, which specifically incorporates packaged costs into the costs of the initial drug administration service and not into the additional drug administration services provided in the same hospital encounter, ensures that

the single claims used for ratesetting represent a large proportion of total hospital claims for most drug administration services. Therefore, we believe that this proposed five-level drug administration APC structure would be most appropriate after examination of the robust set of drug administration claims available for CY 2009 ratesetting because the proposed structure would result in payment groups with greater clinical and resource homogeneity. In addition, we do not believe that a crosswalk analysis of the cost data would be pertinent because, for a number of the CPT codes, our APC assignments prior to CY 2009 were based only on our estimates of their expected costs, and not based on hospitals' actual costs for services reported according to the current CPT code descriptors and guidelines.

We believe that the proposed five-level drug administration APC structure presented below in Table 30 accurately refines the drug administration APCs based on updated and comprehensive hospital claims data. Therefore, we are proposing to implement the APC structure displayed in Table 30 below for CY 2009. In addition to adopting this drug administration APC structure for payment of services, we are proposing to continue the use of drug administration CPT codes for OPPS reporting in CY 2009. As described earlier, APC reconfiguration is a regular part of the annual OPPS update in response to our assessment of the most recent hospital claims data. Although changes to the APC assignments of HCPCS codes, including the drug administration CPT codes, affect hospital payment for services, they do not require any coding changes by hospitals.

TABLE 30.—PROPOSED CY 2009 DRUG ADMINISTRATION APCS

Proposed CY 2009 APC	Proposed CY 2009 APC median cost	HCPCS code	Long descriptor
0436	$24.98	90471	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); one vaccine (single or combination vaccine/toxoid).
		90472	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); each additional vaccine (single or combination vaccine/toxoid)(List separately in addition to code for primary procedure).
		90473	Immunization administration by intranasal or oral route; one vaccine (single or combination vaccine/toxoid).
		90474	Immunization administration by intranasal or oral route; each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure).
		90761	Intravenous infusion, hydration; each additional hour (List separately in addition to code for primary procedure).
		90766	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); each additional hour (List separately in addition to code for primary procedure).
		90771	Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); additional pump set-up with establishment of new subcutaneous infusion site(s) (List separately in addition to code for primary procedure).
		90772	Therapeutic, prophylactic or diagnostic injection (specify substance or drug); subcutaneous or intramuscular.
		90779	Unlisted therapeutic, prophylactic or diagnostic intravenous or intra-arterial injection or infusion.
		95115	Professional services for allergen immunotherapy not including provision of allergenic extracts; single injection.
		95117	Professional services for allergen immunotherapy not including provision of allergenic extracts; two or more injections.
		95145	Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy (specify number of doses); single stinging insect venom.
		95165	Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy; single or multiple antigens (specify number of doses).
		95170	Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy; whole body extract of biting insect or other arthropod (specify number of doses).
		96549	Unlisted chemotherapy procedure.
		G0008	Administration of influenza virus vaccine.
		G0009	Administration of pneumococcal vaccine.
		90767	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); additional sequential infusion, up to 1 hour (List separately in addition to code for primary procedure).
		90770	Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); each additional hour (List separately in addition to code for primary procedure)
		90773	Therapeutic, prophylactic or diagnostic injection (specify substance or drug); intra-arterial.
		90774	Therapeutic, prophylactic or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug.
0437	$36.59	90775	Therapeutic, prophylactic or diagnostic injection (specify substance or drug); each additional sequential intravenous push of a new substance/drug (List separately in addition to code for primary procedure).
		95144	Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy, single dose vial(s) (specify number of vials).
		95148	Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy (specify number of doses); four single stinging insect venoms.
		96401	Chemotherapy administration, subcutaneous or intramuscular; non-hormonal anti-neoplastic.
		96402	Chemotherapy administration, subcutaneous or intramuscular; hormonal anti-neoplastic.
		96405	Chemotherapy administration; intralesional, up to and including 7 lesions.
		96415	Chemotherapy administration, intravenous infusion technique; each additional hour (List separately in addition to code for primary procedure).

TABLE 30.—PROPOSED CY 2009 DRUG ADMINISTRATION APCS—Continued

Proposed CY 2009 APC	Proposed CY 2009 APC median cost	HCPCS code	Long descriptor
0438	$74.19	90760	Intravenous infusion, hydration; initial, 31 minutes to 1 hour.
		90769	Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); initial, up to one hour, including pump set-up and establishment of subcutaneous infusion site(s).
		95146	Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy (specify number of doses); two single stinging insect venoms.
		95147	Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy (specify number of doses); three single stinging insect venoms.
		96406	Chemotherapy administration; intralesional, more than 7 lesions.
		96411	Chemotherapy administration; intravenous, push technique, each additional substance/drug (List separately in addition to code for primary procedure).
		96417	Chemotherapy administration, intravenous infusion technique; each additional sequential infusion (different substance/drug), up to 1 hour (List separately in addition to code for primary procedure).
		96423	Chemotherapy administration, intra-arterial; infusion technique, each additional hour (List separately in addition to code for primary procedure).
		90765	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour.
		95149	Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy (specify number of doses); five single stinging insect venoms.
0439	$126.58	96409	Chemotherapy administration; intravenous, push technique, single or initial substance/drug.
		96420	Chemotherapy administration, intra-arterial; push technique.
		96522	Refilling and maintenance of implantable pump or reservoir for drug delivery, systemic (e.g., intravenous, intra-arterial).
		96542	Chemotherapy injection, subarachnoid or intraventricular via subcutaneous reservoir, single or multiple agents.
0440	$190.72	95990	Refilling and maintenance of implantable pump or reservoir for drug delivery, spinal (intrathecal, epidural) or brain (intraventricular).
		95991	Refilling and maintenance of implantable pump or reservoir for drug delivery, spinal (intrathecal, epidural) or brain (intraventricular); administered by a physician.
		96413	Chemotherapy administration, intravenous infusion technique; up to 1 hour, single or initial substance/drug.
		96416	Chemotherapy administration, intravenous infusion technique; initiation of prolonged chemotherapy infusion (more than 8 hours), requiring use of a portable or implantable pump.
		96422	Chemotherapy administration, intra-arterial; infusion technique, up to one hour.
		96425	Chemotherapy administration, intra-arterial; infusion technique, initiation of prolonged infusion (more than 8 hours), requiring the sue of a portable or implantable pump.
		96440	Chemotherapy administration into pleural cavity, requiring and including thoracentesis.
		96445	Chemotherapy administration into peritoneal cavity, requiring and including peritoneocentesis.
		96450	Chemotherapy administration, into CNS (eg, intrathecal), requiring and including spinal puncture.
		96521	Refilling and maintenance of portable pump.
		C8957	Intravenous infusion for therapy/diagnosis; initiation of prolonged infusion (more than eight hours), requiring use of portable or implantable pump.

IX. Proposed OPPS Payment for Hospital Outpatient Visits

A. Background

Currently, hospitals report visit HCPCS codes to describe three types of OPPS services: clinic visits, emergency department visits, and critical care services. CPT indicates that office or other outpatient visit codes are used to report evaluation and management (E/M) services provided in the physician's office or in an outpatient or other ambulatory facility. For OPPS purposes, we refer to these as clinic visit codes. CPT also indicates that emergency department visit codes are used to report E/M services provided in the emergency department, which is defined as an ''organized hospital-based facility for the provision of unscheduled episodic services to patients who present for immediate medical attention. The facility must be available 24 hours a day.'' For OPPS purposes, we refer to these as emergency department visit codes that specifically apply to the reporting of visits to Type A emergency departments. Furthermore, for CY 2007 we established five new Level II HCPCS codes to report visits to Type B emergency departments (defined as dedicated emergency departments that incur Emergency Medical Treatment and Labor Act (EMTALA) of 1986 (Pub. L. 99–272) obligations but that do not meet the Type A emergency department definition, as described in more detail below). These new Level II HCPCS codes were developed because there were no CPT codes at that time that fully described services provided in this type of facility. CPT defines critical care services to be reported with critical care CPT codes as the ''direct delivery by a physician(s) of medical care for a critically ill or critically injured patient.'' Under the OPPS, in Transmittal 1139, Change Request 5438, dated December 22, 2006, we have stated that the time that can be reported as critical care is the time spent by a physician and/or hospital staff engaged in active face-to-face critical care of a critically ill or critically injured patient. We also established HCPCS code G0390 (Trauma response team associated with hospital critical care service) in CY 2007 for the reporting of a trauma response in association with critical care services. We refer readers to section III.D.1. of this proposed rule for further discussion of payment for a trauma response associated with hospital critical care services.

Currently, CMS instructs hospitals to report the CY 2008 CPT codes that describe new and established clinic visits, Type A emergency department

visits, and critical care services, and the six Level II HCPCS codes to report Type B emergency department visits and trauma activation provided in association with critical care services. These codes are listed below in Table 31. We are not proposing to change the visit HCPCS codes that hospitals report for CY 2009.

TABLE 31.—CY 2008 CPT E/M AND LEVEL II HCPCS CODES USED TO REPORT CLINIC AND EMERGENCY DEPARTMENT VISITS AND CRITICAL CARE SERVICES

HCPCS Code	Descriptor
	Clinic Visit HCPCS Codes
99201	Office or other outpatient visit for the evaluation and management of a new patient (Level 1).
99202	Office or other outpatient visit for the evaluation and management of a new patient (Level 2).
99203	Office or other outpatient visit for the evaluation and management of a new patient (Level 3).
99204	Office or other outpatient visit for the evaluation and management of a new patient (Level 4).
99205	Office or other outpatient visit for the evaluation and management of a new patient (Level 5).
99211	Office or other outpatient visit for the evaluation and management of an established patient (Level 1).
99212	Office or other outpatient visit for the evaluation and management of an established patient (Level 2).
99213	Office or other outpatient visit for the evaluation and management of an established patient (Level 3).
99214	Office or other outpatient visit for the evaluation and management of an established patient (Level 4).
99215	Office or other outpatient visit for the evaluation and management of an established patient (Level 5).
	Emergency Department Visit HCPCS Codes
99281	Emergency department visit for the evaluation and management of a patient (Level 1).
99282	Emergency department visit for the evaluation and management of a patient (Level 2).
99283	Emergency department visit for the evaluation and management of a patient (Level 3).
99284	Emergency department visit for the evaluation and management of a patient (Level 4).
99285	Emergency department visit for the evaluation and management of a patient (Level 5).
G0380	Type B emergency department visit (Level 1).
G0381	Type B emergency department visit (Level 2).
G0382	Type B emergency department visit (Level 3).
G0383	Type B emergency department visit (Level 4).
G0384	Type B emergency department visit (Level 5).
	Critical Care Services HCPCS Codes
99291	Critical care, evaluation and management of the critically ill or critically injured patient; first 30–74 minutes.
99292	Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes.
G0390	Trauma response associated with hospital critical care service.

The majority of CPT code descriptors are applicable to both physician and facility resources associated with specific services. However, we have acknowledged from the beginning of the OPPS that we believe that CPT E/M codes were defined to reflect the activities of physicians and do not necessarily fully describe the range and mix of services provided by hospitals during visits of clinic or emergency department patients or critical care encounters. While awaiting the development of a national set of facility-specific codes and guidelines, we have advised hospitals that each hospital's internal guidelines that determine the levels of clinic and emergency department visits to be reported should follow the intent of the CPT code descriptors, in that the guidelines should be designed to reasonably relate the intensity of hospital resources to the different levels of effort represented by the codes.

During its March 2008 APC Panel meeting, the APC Panel recommended that CMS provide, for review by the Visits and Observation Subcommittee at the next CY 2008 APC Panel meeting: (1) Frequency and median cost data on new and established patient clinic visits and Type A and Type B emergency department visits; (2) data on CPT code 99291 (Critical care, evaluation and management of the critically ill or critically injured patient; first 30–74 minutes) and APC 617 (Critical Care); and (3) frequency and median cost data on the extended assessment and management composite APCs (that is, APCs 8002 and 8003). We are adopting all three of these recommendations and will provide frequency and cost data related to these services at the next CY 2008 APC Panel meeting. The complete discussion related to visits is provided below. A complete discussion related to the extended assessment and management composite APCs can be found in section II.A.2.e.(1) of this proposed rule.

B. Proposed Policies for Hospital Outpatient Visits

1. Clinic Visits: New and Established Patient Visits

CPT defines an established patient as ''one who has received professional services from the physician or another physician of the same specialty who belongs to the same group practice, within the past 3 years.'' To apply this definition to hospital clinic visits, we stated in the April 7, 2000 OPPS final rule with comment period (65 FR 18451), that the meanings of ''new'' and ''established'' pertain to whether or not the patient already has a hospital medical record number. If the patient has a hospital medical record that was created within the past 3 years, that patient is considered an established patient to the hospital. The same patient could be ''new'' to the physician but an ''established'' patient to the hospital. The opposite could be true if the physician has a longstanding relationship with the patient, in which case the patient would be an ''established'' patient with respect to the physician and a ''new'' patient with respect to the hospital. Our resource cost data continue to show that new patient visits are consistently more costly than established patient visits of the same level.

Since the implementation of the OPPS, we have received very few

comments related to the definitions of new and established patient visits. However, during the past year, we have heard from several provider groups that hospitals cannot easily distinguish between new and established patients for purposes of correctly reporting clinic visits under the OPPS, based on the definition above. We considered several options for refining the definitions of new and established patients as they would apply under the CY 2009 OPPS in order to reduce hospitals' administrative burden associated with reporting appropriate clinic visit CPT codes.

We considered proposing to eliminate the distinction between new and established patient visits under the OPPS, as had previously been recommended by the APC Panel for CY 2008. We considered instructing hospitals to bill all visits as established patient visits and the hospital would determine the appropriate code level based on the resources expended during the visit. However, because hospital claims data continue to show significant cost differences between new and established patient visits, we believe it is most appropriate to continue to recognize the CPT codes for both new and established patient visits and, in some cases, provide differential payment for new and established patient visits of the same level. In addition, we continue to believe it is important that CPT codes be reported consistent with their code descriptors, and some patients will always be new to the hospital, regardless of any potential refinement in the definition of ''new'' for reporting clinical visits under the OPPS. Therefore, we are not proposing this approach for CY 2009.

Another alternative we considered was proposing to define an established patient as a patient who already had a hospital medical record number at the hospital where he or she is currently receiving services, regardless of when this medical record was created. Several commenters to the CY 2008 OPPS/ASC proposed rule preferred this distinction rather than the current policy, which requires hospitals to determine if the patient's hospital medical record was created within the past 3 years (72 FR 66793). However, one commenter noted an extreme example in which a patient who was born at a hospital and assigned a medical record number would always be considered an established patient to that hospital, even if the patient was not treated again at that hospital until decades later. We continue to believe it is appropriate to include a time limit when determining whether a patient is new or established from the hospital's perspective because we would expect that care of a patient who was not treated at the hospital for several years prior to a visit could require significantly greater hospital resources than care for a patient who was recently treated at the hospital. Therefore, we are not proposing this alternative for CY 2009.

We considered proposing to modify the new and established patient definitions for reporting clinic visits under the OPPS so they would pertain to whether or not the patient was registered in a specific hospital clinic within the past 3 years. However, we believe this approach could be problematic because we do not believe that every clinic has clear administrative boundaries that define whether the patient was previously seen in that particular clinic. For example, a hospital-based clinic may have several locations, including on-campus and off-campus sites, or a specific area of the hospital may house two or more specialty clinics that treat disparate types of clinical conditions.

We considered and are not proposing to adopt the three alternatives described above, for CY 2009, but are instead proposing to modify the definitions of ''new'' and ''established'' patients as they apply to hospital outpatient visits. Specifically, the meanings of ''new'' and ''established'' would pertain to whether or not the patient was registered as an inpatient or outpatient of the hospital within the past 3 years. Under this proposal, hospitals would not need to determine the specific clinic where the patient was previously treated because the proposed approach would not rely upon when the medical record was initially created but rather, would depend upon whether the individual had been registered as a hospital inpatient or outpatient within the previous 3 years.

Hospitals would also not need to determine when the medical record was initially created. If the patient were registered as an inpatient or outpatient of the hospital within the past 3 years, that patient would be considered an ''established'' patient to the hospital. If a patient were registered as an outpatient in a hospital's off-campus provider-based clinic or emergency department within the past 3 years, that patient would still be an ''established'' patient to the hospital for an on-campus or off-campus clinic visit even if the medical record was initially created by the hospital prior to the past 3 years. Consistent with past policy, the same patient could be ''new'' to the physician but an ''established'' patient to the hospital. The opposite could be true if the physician has a longstanding relationship with the patient, in which case the patient would be an ''established'' patient with respect to the physician and a ''new'' patient with respect to the hospital. We believe that our proposed refinement of the new and established patient definitions for reporting visits under the OPPS would be administratively straightforward for hospitals to apply, while continuing to capture differences in hospital resources required to provide new and established patient clinic visits. Furthermore, we believe that costs from historical hospital claims data for services reported under the past OPPS interpretation of new and established patient visits could simply be crosswalked to the expected costs of the corresponding visit level reported under our proposed framework, thereby providing appropriate payment for new and established clinic visits of all five levels until CY 2009 claims data reflecting the refined definitions would be available for CY 2011 ratesetting. We would expect only minimal cost differences for clinic visits if these new definitions were finalized for CY 2009.

In summary, for CY 2009, we are proposing to modify the definitions of new and established patient visits as they relate to reporting hospital outpatient visits under the OPPS. We welcome public comment related to the proposed definitions of new and established patient visits under the OPPS. For CY 2009, we are proposing to continue our usual policy of calculating median costs for clinic visits under the OPPS using historical hospital claims data.

As discussed further in section II.A.2.e.(1) of this proposed rule and consistent with our CY 2008 policy, when calculating the median costs for the clinic visit APCs (0604 through 0608), we would utilize our methodology that excludes those claims for visits that are eligible for payment through the extended assessment and management composite APC 8002 (Level I Extended Assessment and Management Composite). We believe that this approach would result in the most accurate cost estimates for APCs 0604 through 0608 for CY 2009.

2. Emergency Department Visits

As described in section IX.A. of this proposed rule, CPT defines an emergency department as ''an organized hospital-based facility for the provision of unscheduled episodic services to patients who present for immediate medical attention. The facility must be available 24 hours a day.'' Prior to CY 2007, under the OPPS we restricted the

billing of emergency department CPT codes to services furnished at facilities that met this CPT definition. Facilities open less than 24 hours a day should not have reported the emergency department CPT codes for visits.

Sections 1866(a)(1)(I), 1866(a)(1)(N), and 1867 of the Act impose specific obligations on Medicare-participating hospitals and CAHs that offer emergency services. These obligations concern individuals who come to a hospital's dedicated emergency department and request examination or treatment for medical conditions, and apply to all of these individuals, regardless of whether or not they are beneficiaries of any program under the Act. Section 1867(h) of the Act specifically prohibits a delay in providing required screening or stabilization services in order to inquire about the individual's payment method or insurance status. Section 1867(d) of the Act provides for the imposition of civil monetary penalties on hospitals and physicians responsible for failing to meet the provisions listed above. These provisions, taken together, are frequently referred to as the EMTALA provisions.

Section 489.24 of the EMTALA regulations defines ''dedicated emergency department'' as any department or facility of the hospital, regardless of whether it is located on or off the main hospital campus, that meets at least one of the following requirements: (1) It is licensed by the State in which it is located under applicable State law as an emergency room or emergency department; (2) It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or (3) During the calendar year immediately preceding the calendar year in which a determination under the regulations is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment.

In the CY 2008 OPPS/ASC proposed rule (72 FR 42756), we reiterated our belief that every emergency department that meets the CPT definition of emergency department also qualifies as a dedicated emergency department under EMTALA. However, we indicated that we were aware that there are some departments or facilities of hospitals that meet the definition of a dedicated emergency department under the EMTALA regulations, but that do not meet the more restrictive CPT definition of an emergency department. For example, a hospital department or facility that meets the definition of a dedicated emergency department may not be available 24 hours a day, 7 days a week. Nevertheless, hospitals with such departments or facilities incur EMTALA obligations with respect to an individual who presents to the department and requests, or has requested on his or her behalf, examination or treatment for an emergency medical condition. However, because they did not meet the CPT requirements for reporting emergency visit E/M codes, prior to CY 2007, these facilities were required to bill clinic visit codes for the services they furnished under the OPPS. We had no way to distinguish in our hospital claims data the costs of visits provided in dedicated emergency departments that did not meet the CPT definition of emergency department from the costs of clinic visits.

Prior to CY 2007, some hospitals requested that they be permitted to bill emergency department visit codes under the OPPS for services furnished in a facility that met the CPT definition for reporting emergency department visit E/M codes, except that the facility was not available 24 hours a day. These hospitals believed that their resource costs for visits were more similar to those of emergency departments that met the CPT definition than they were to the resource costs of clinics. Representatives of such facilities argued that emergency department visit payments would be more appropriate, on the grounds that their facilities treated patients with emergency conditions whose costs exceeded the resources reflected in the clinic visit APC payments, even though these emergency departments were not available 24 hours per day. In addition, these hospital representatives indicated that their facilities had EMTALA obligations and should, therefore, be able to receive emergency department visit payments. While these emergency departments may have provided a broader range and intensity of hospital services, and required significant resources to assure their availability and capabilities in comparison with typical hospital outpatient clinics, the fact that they did not operate with all capabilities full-time suggested that hospital resources associated with visits to emergency departments or facilities available less than 24 hours a day might not be as great as the resources associated with emergency departments or facilities that were available 24 hours a day, and that fully met the CPT definition.

In the CY 2007 OPPS/ASC final rule with comment period (71 FR 68132), we finalized the definition of Type A emergency departments to distinguish them from Type B emergency departments. A Type A emergency department must be available to provide services 24 hours a day, 7 days a week, and meet one or both of the following requirements related to the EMTALA definition of a dedicated emergency department, specifically: (1) It is licensed by the State in which it is located under the applicable State law as an emergency room or emergency department; or (2) It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment. For CY 2007 (71 FR 68140), we assigned the five CPT E/M emergency department visit codes for services provided in Type A emergency departments to the five newly created Emergency Visit APCs, specifically 0609 (Level 1 Emergency Visits), 0613 (Level 2 Emergency Visits), 0614 (Level 3 Emergency Visits), 0615 (Level 4 Emergency Visits), and 0616 (Level 5 Emergency Visits).

We defined a Type B emergency department as any dedicated emergency department that incurred EMTALA obligations under § 489.24 of the EMTALA regulations but that did not meet the Type A emergency department definition. To determine whether visits to Type B emergency departments have different resource costs than visits to either clinics or Type A emergency departments, in the CY 2007 OPPS/ASC final rule with comment period (71 FR 68132), we finalized a set of five G-codes for use by hospitals to report visits to all entities that meet the definition of a dedicated emergency department under the EMTALA regulations in § 489.24, but that are not Type A emergency departments. These codes are called ''Type B emergency department visit codes.'' In the CY 2007 OPPS/ASC final rule with comment period (71 FR 68132), we explained that these new G-codes would serve as a vehicle to capture median cost and resource differences among visits provided by Type A emergency departments, Type B emergency departments, and clinics. For CYs 2007 and 2008, we assigned the five new Type B emergency department visit codes for services provided in a Type B emergency department to the five Clinic

Visit APCs, specifically 0604 (Level 1 Hospital Clinic Visits), 0605 (Level 2 Hospital Clinic Visits), 0606 (Level 3 Hospital Clinic Visits), 0607 (Level 4 Hospital Clinic Visits), and 0608 (Level 5 Hospital Clinic Visits). This payment policy for Type B emergency department visits was similar to our previous policy, which required that services furnished in emergency departments that had an EMTALA obligation but did not meet the CPT definition of emergency department be reported using CPT clinic visit E/M codes, resulting in payments based upon clinic visit APCs. While maintaining the same payment policy for Type B emergency department visits in CYs 2007 and 2008, we believe the reporting of specific G-codes for emergency department visits provided in Type B emergency departments would permit us to specifically collect and analyze the hospital resource costs of visits to these facilities in order to determine if in the future a proposal for an alternative payment policy might be warranted. We expected hospitals to adjust their charges appropriately to reflect differences in Type A and Type B emergency department visit costs. We noted that the OPPS rulemaking cycle for CY 2009 would be the first year that we would have cost data for these new Type B emergency department HCPCS codes available for analysis.

We now have CY 2007 cost data for CY 2009 ratesetting for the Type B emergency department HCPCS codes G0380 through G0384. Based on these data, 342 hospitals billed at least one Type B emergency department visit code in CY 2007, with a total frequency of visits provided in Type B emergency departments of approximately 200,000. All except 2 of the 342 hospitals reporting Type B emergency department visits in CY 2007 also reported Type A emergency department visits. Overall, many more hospitals (approximately 2,911 total hospitals) reported Type A emergency department visits than Type B emergency department visits. For comparison purposes, the total frequency of visits provided in hospital outpatient clinics and Type A emergency departments is approximately 14.5 million and 10.3 million, respectively. The median costs for the Type B emergency department visit HCPCS codes, as compared to the clinic visit and Type A emergency visit APC median costs, are shown in Table 32 below.

TABLE 32.—COMPARISON OF MEDIAN COSTS FOR CLINIC VISIT APCS, TYPE B EMERGENCY DEPARTMENT VISIT HCPCS CODES, AND TYPE A EMERGENCY VISIT APCS

Visit level	Clinic visit APCs	Type B emergency department visit HCPCS code	Type A emergency visit APCs
Level 1	$55	$48	$54
Level 2	68	65	87
Level 3	88	92	136
Level 4	117	156	219
Level 5	155	326	325

The median costs of the lowest level visit are similar across all settings, including clinic and Type A and B emergency departments. Visit levels 2 and 3 share similar resource costs in the clinic and Type B emergency department settings, while visits provided in Type A emergency departments have higher estimated resource costs at these levels. The level 4 clinic visit APC is less resource intensive than the level 4 Type B emergency department visit, which is similarly less resource intensive than the level 4 Type A emergency department visit. The Type A and B emergency department level 5 visit median costs are similar to each other and significantly exceed the level 5 clinic visit cost.

We performed additional data analyses in preparation for this proposed rule to gather more information for our proposal for payment of Type B emergency department visits. This included studying the emergency department visit charges and costs of hospitals that billed Type B emergency department visits, analyzing the cost data for various subsets of hospitals that billed the Type B emergency department visit codes, and comparing visit cost data for hospitals that did and did not bill Type B emergency department visit codes. Hospitals that reported both Type A and Type B emergency department visits billed lower charges for Type B emergency department visits than Type A emergency department visits, presumably reflecting the lower costs for Type B emergency department visits. Moreover, hospitals that billed both Type A and Type B emergency department visits also had lower costs for Type B emergency department visits than Type A emergency department visits at all levels except for the level 5 Type B emergency department visit. The Type A emergency department visit costs for hospitals that billed both Type A and Type B emergency department visits resemble the Type A emergency department visit costs of hospitals that billed only Type A emergency department visits and did not bill any Type B emergency department visits. We also determined that the majority of Type B emergency department visits were reported under an emergency department revenue code. In summary, our further analyses confirmed that the median costs of Type B emergency department visits are less than the median costs of Type A emergency department visits for all but the level 5 visit, and that the observed differences are not attributable to provider-level differences in the visit costs of the different groups of hospitals reporting Type A and Type B emergency department visits. In other words, the median costs from CY 2007 hospital claims represent real differences in the hospital resource costs for the same level of visit in a Type A or Type B emergency department. As noted earlier, the CY 2007 claims data are the first year of claims data that include providers' cost data for the Type B emergency department visits. We will perform additional analyses to monitor patterns of billing and costs of these services throughout the CY 2009 rulemaking cycle, and in preparation for the CY 2010 rulemaking cycle, as additional cost data become available.

We shared preliminary cost and frequency data with the Visits and Observation Subcommittee of the APC Panel and the full APC Panel during its March 2008 meeting. The APC Panel recommended that CMS continue to pay

levels 1, 2, and 3 Type B emergency department visits at the corresponding clinic visit levels. The APC Panel also recommended that CMS consider using the clinic visit level 5 APC as the basis of payment for the level 4 Type B emergency department visit and the level 5 Type A emergency department visit APC as the basis of payment for the level 5 Type B emergency department visit. Given the limited data presently available for Type B emergency department visits, the APC Panel also recommended that CMS reconsider payment adjustments as more claims data become available. In general, the APC Panel's recommended configuration would pay appropriately for each level of Type B emergency department visit, based on the resource costs of Type B emergency department visits that are reflected in claims data.

In accordance with the APC Panel's assessment, we are proposing to pay for Type B emergency department visits in CY 2009 consistent with their median costs, although we are not fully adopting the APC Panel's recommended payment configuration. Specifically, we are proposing to pay levels 1, 2, 3, and 4 Type B emergency department visits through four levels of newly created APCs, 0626 (Level 1 Type B Emergency Visits), 0627 (Level 2 Type B Emergency Visits), 0628 (Level 3 Type B Emergency Visits), and 0629 (Level 4 Type B Emergency Visits). We are proposing to assign HCPCS codes G0380, G0381, G0382, and G0383, the levels 1, 2, 3, and 4 Type B emergency department visit Level II HCPCS codes, to APCs 0626, 0627, 0628, and 0629, respectively, for CY 2009. These HCPCS codes would be the only HCPCS codes assigned to these newly created APCs. Furthermore, to distinguish these new APCs from the APCs for levels 1, 2, 3, and 4 Type A emergency visits, we are proposing to modify the titles of the current APCs for these visits to incorporate Type A in their names. Therefore, their proposed revised titles would be: APC 0609, Level 1 Type A Emergency Visits; APC 0613, Level 2 Type A Emergency Visits; APC 0614, Level 3 Type A Emergency Visits; and APC 0615, Level 4 Type A Emergency Visits. Finally, we are proposing to map the level 5 Type B emergency department visit code, HCPCS code G0384, to APC 0616 (Level 5 Emergency Visits), which is the same APC that contains CPT code 99285, the level 5 Type A emergency department visit code. Consistent with the APC Panel recommendation, the level 5 Type B emergency department visit payment rate would be the same as the level 5 Type A emergency department visit payment rate, based upon the similar median costs for these visits. For this highest level of emergency department visits, the costs of these relatively uncommon visits to Type A and Type B emergency departments are comparable, reflecting the considerable hospital resources required to care for these sick patients in both settings.

Table 33 below displays the proposed APC median costs for each level of Type B emergency department visit, under our proposed CY 2009 configuration. We believe the CY 2009 proposed assignments of the levels 1 through 4 Type B emergency department visits to their own new clinical APCs, and the proposed assignment of the level 5 Type B emergency department visit to APC 0616, would pay appropriately for all levels of Type B emergency department visits, taking into consideration the hospital costs for these visits.

As more cost data become available and hospitals gain additional experience with reporting visits to Type B emergency departments, we would continue to regularly reevaluate patterns of Type A and Type B emergency visit reporting at varying levels of disaggregation below the national level to ensure that hospitals continue to bill appropriately and differentially for these services. In addition, according to our usual practice, we would examine trends in cost data over time and consider alternative emergency department visit APC configurations in the future if updated data indicate that changes to the proposed payment structure for CY 2009 should be considered.

TABLE 33.—PROPOSED CY 2009 TYPE B EMERGENCY DEPARTMENT VISIT APC ASSIGNMENTS AND MEDIAN COSTS

Type B emergency department visit level	Proposed CY 2009 APC assignment	Proposed CY 2009 APC median cost
Level 1	0626	$48
Level 2	0627	65
Level 3	0628	92
Level 4	0629	156
Level 5	0616	325

For the CY 2009 OPPS, we are also proposing to include HCPCS code G0384 in the criteria that determine eligibility for payment of composite APC 8003 (Level II Extended Assessment and Management Composite). We refer the readers to section II.A.2.e.(1) of this proposed rule for further discussion related to the extended assessment and management composite APCs. As discussed in detail in sections II.A.2.e.(1) and III.D.1. of this proposed rule and consistent with our CY 2008 practice, when calculating the median costs for the Type A and Type B emergency visit APCs (0609 through 0616 and 0626 through 0629), we would utilize our methodology that excludes those claims for visits that are eligible for payment through the extended assessment and management composite APC 8003. We believe that this approach would result in the most accurate cost estimates for APCs 0609 through 0616 and 0626 through 0629 for CY 2009.

3. Visit Reporting Guidelines

As described in section IX.A. of this proposed rule, since April 7, 2000, we have instructed hospitals to report facility resources for clinic and emergency department hospital outpatient visits using the CPT E/M codes and to develop internal hospital guidelines for reporting the appropriate visit level.

As noted in detail in sections IX.C. of the CY 2008 OPPS/ASC final rule with comment period (72 FR 66802 through 66805), we observed a normal and stable distribution of clinic and emergency department visit levels in hospital claims over the past several years. The data indicated that hospitals, on average, were billing all five levels of visit codes with varying frequency, in a consistent pattern over time. Overall, both the clinic and emergency department visit distributions indicated that hospitals were billing consistently over time and in a manner that distinguished between visit levels,

resulting in relatively normal distributions nationally for the OPPS, as well as for specific classes of hospitals. The results of these analyses were generally consistent with our understanding of the clinical and resource characteristics of different levels of hospital outpatient clinic and emergency department visits. In the CY 2008 OPPS/ASC proposed rule (72 FR 42764 through 42765), we specifically invited public comment as to whether a pressing need for national guidelines continued at this point in the maturation of the OPPS, or if the current system where hospitals create and apply their own internal guidelines to report visits was currently more practical and appropriately flexible for hospitals. We explained that although we have reiterated our goal since CY 2000 of creating national guidelines, this complex undertaking for these important and common hospital services was proving more challenging than we initially thought as we received new and expanded information from the public on current hospital reporting practices that led to appropriate payment for the hospital resources associated with clinic and emergency department visits. We believed that many hospitals had worked diligently and carefully to develop and implement their own internal guidelines that reflected the scope and types of services they provided throughout the hospital outpatient system. Based on public comments, as well as our own knowledge of how clinics operate, it seemed unlikely that one set of straightforward national guidelines could apply to the reporting of visits in all hospitals and specialty clinics. In addition, the stable distribution of clinic and emergency department visits reported under the OPPS over the past several years indicated that hospitals, both nationally in the aggregate and grouped by specific hospital classes, were generally billing in an appropriate and consistent manner as we would expect in a system that accurately distinguished among different levels of service based on the associated hospital resources.

Therefore, we did not propose to implement national visit guidelines for clinic or emergency department visits for CY 2008. Since publication of the CY 2008 OPPS/ASC final rule with comment period, we have once again examined the distribution of clinic and Type A emergency department visit levels based upon updated CY 2007 claims data available for this proposed rule and confirmed that we continue to observe a normal and stable distribution of clinic and emergency department visit levels in hospital claims. We continue to believe that, based on the use of their own internal guidelines, hospitals are generally billing in an appropriate and consistent manner that distinguishes among different levels of visits based on their required hospital resources. As a result of our updated analyses, we are proposing that hospitals should continue to report visits during CY 2009 according to their own internal hospital guidelines.

In the absence of national guidelines, we would continue to regularly reevaluate patterns of hospital outpatient visit reporting at varying levels of disaggregation below the national level to ensure that hospitals continue to bill appropriately and differentially for these services. We do not expect to see an increase in the proportion of visit claims for high level visits as a result of the new extended assessment and management composite APCs 8002 and 8003 adopted for CY 2008 and proposed for CY 2009. Similarly, we expect that hospitals will not purposely change their visit guidelines or otherwise upcode clinic and emergency department visits reported with observation care solely for the purpose of composite APC payment. As stated in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66648), we expect to carefully monitor any changes in billing practices on a service-specific and hospital-specific level to determine whether there is reason to request that QIOs review the quality of care furnished, or to request that Benefit Integrity contractors or other contractors review the claims against the medical record.

In addition, we note our continued expectation that hospitals' internal guidelines would comport with the principles listed in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66805). We encourage hospitals with more specific questions related to the creation of internal guidelines to contact their local fiscal intermediary or Medicare Administrative Contractor (MAC).

We appreciate all of the comments we have received in the past from the public on visit guidelines, and we encourage continued submission of comments throughout the year that would assist us and other stakeholders interested in the development of national guidelines. Until national guidelines are established, hospitals should continue using their own internal guidelines to determine the appropriate reporting of different levels of clinic and emergency department visits. While we understand the interest of some hospitals in our moving quickly to promulgate national guidelines that would ensure standardized reporting of hospital outpatient visit levels, we believe that the issues and concerns identified both by us and others that may arise are important and require serious consideration prior to the implementation of national guidelines. Because of our commitment to provide hospitals with 6 to 12 months' notice prior to implementation of national guidelines, we would not implement national guidelines prior to CY 2010. Our goal is to ensure that OPPS national or hospital-specific visit guidelines continue to facilitate consistent and accurate reporting of hospital outpatient visits in a manner that is resource-based and supportive of appropriate OPPS payments for the efficient and effective provision of visits in hospital outpatient settings.

X. Proposed Payment for Partial Hospitalization Services

A. Background

Partial hospitalization is an intensive outpatient program of psychiatric services provided to patients as an alternative to inpatient psychiatric care for beneficiaries who have an acute mental illness. Section 1833(t)(1)(B)(i) of the Act provides the Secretary with the authority to designate the hospital outpatient department services to be covered under the OPPS. The Medicare regulations at § 419.21(c) that implement this provision specify that payments under the OPPS will be made for partial hospitalization services furnished by CMHCs as well as those furnished to hospital outpatients. Section 1833(t)(2)(C) of the Act requires that we establish relative payment weights based on median (or mean, at the election of the Secretary) hospital costs determined by 1996 claims data and data from the most recent available cost reports. Because a day of care is the unit that defines the structure and scheduling of partial hospitalization services, we established a per diem payment methodology for the PHP APC, effective for services furnished on or after August 1, 2000 (65 FR 18452).

Historically, the median per diem cost for CMHCs greatly exceeded the median per diem cost for hospital-based PHPs and fluctuated significantly from year to year, while the median per diem cost for hospital-based PHPs remained relatively constant ($200–$225). We believe that CMHCs may have increased and decreased their charges in response to Medicare payment policies. As discussed in more detail in section X.B. of this proposed rule and in the CY 2004

OPPS final rule with comment period (68 FR 63470), we also believe that some CMHCs manipulated their charges in order to inappropriately receive outlier payments.

In the CY 2005 OPPS update, the CMHC median per diem cost was $310, the hospital-based PHP median per diem cost was $215, and the combined CMHC and hospital-based median per diem cost was $289, a reduction in median cost from previous years. We believed the reduction indicated that the use of updated CCRs had accounted for the previous increase in CMHC charges and represented a more accurate estimate of CMHC per diem costs for PHP.

For the CY 2006 OPPS final rule with comment period, the median per diem cost for CMHCs dropped to $154, while the median per diem cost for hospital-based PHPs was $201. We believed that a combination of reduced charges and slightly lower CCRs for CMHCs resulted in a significant decline in the CMHC median per diem cost between CY 2003 and CY 2004.

The CY 2006 OPPS updated combined hospital-based and CMHC median per diem cost was $161, a decrease of 44 percent compared to the CY 2005 combined median per diem amount. Due to concern that this amount may not cover the cost for PHPs, as stated in the CY 2006 OPPS final rule with comment period (70 FR 68548 and 68549), we applied a 15-percent reduction to the combined hospital-based and CMHC median per diem cost to establish the CY 2006 PHP APC. (We refer readers to the CY 2006 OPPS final rule with comment period for a full discussion of how we established the CY 2006 PHP rate (70 FR 68548).) In that rule, we stated our belief that a reduction in the CY 2005 median per diem cost would strike an appropriate balance between using the best available data and providing adequate payment for a program that often spans 5–6 hours a day. We stated that 15 percent was an appropriate reduction because it recognized decreases in median per diem costs in both the hospital data and the CMHC data, and also reduced the risk of any adverse impact on access to these services that might result from a large single-year rate reduction. However, we adopted this policy as a transitional measure, and stated in the CY 2006 OPPS final rule with comment period that we would continue to monitor CMHC costs and charges for these services and work with CMHCs to improve their reporting so that payments could be calculated based on better empirical data (70 FR 68548). To apply this methodology for CY 2006, we reduced the CY 2005 combined unscaled hospital-based and CMHC median per diem cost of $289 by 15 percent, resulting in a combined median per diem cost of $245.65 for CY 2006.

For the CY 2007 OPPS/ASC final rule with comment period, we analyzed hospital and CMHC PHP claims for services furnished between January 1, 2005, and December 31, 2005, and used the most currently available CCRs to estimate costs. The median per diem cost for CMHCs was $173, while the median per diem cost for hospital-based PHPs was $190.

The combined hospital-based and CMHC median per diem cost would have been $175 for CY 2007. Rather than allowing the PHP per diem rate to drop to this level, we proposed to reduce the PHP median cost by 15 percent, similar to the methodology used for the CY 2006 update. However, after considering all public comments received concerning the proposed CY 2007 PHP per diem rate and results obtained using more current data, we modified our proposal. We made a 5-percent reduction to the CY 2006 median per diem rate to provide a transitional path to the per diem cost indicated by the data. This approach accounted for the downward direction of the data and addressed concerns raised by commenters about the magnitude of another 15-percent reduction in 1 year. Thus, to calculate the CY 2007 APC PHP per diem cost, we reduced $245.65 (the CY 2005 combined hospital-based and CMHC median per diem cost of $289 reduced by 15 percent) by 5 percent, which resulted in a combined per diem cost of $233.37.

For the CY 2008 OPPS/ASC final rule with comment period, we analyzed 12 months of current data for hospital-based PHP claims (condition code 41) and CMHC PHP claims for PHP services furnished between January 1, 2006, and December 31, 2006. We also used the most currently available CCRs to estimate costs for a day of PHP services. The median per diem cost for CMHCs was $172, while the median per diem cost for hospital-based PHPs was $177. The combined median per diem cost, which is computed from both hospital-based and CMHC PHP data was $172.

For the past 3 years, we have been concerned that we did not have sufficient evidence to support using the median per diem cost produced by the most current year's PHP data. As discussed in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66671), after extensive data analysis we now believe the data reflect the level of cost for the type of services that are being provided. This analysis included an examination of revenue-to-cost center mapping, refinements to the per diem methodology, and an in-depth analysis of the number of units of services per day. (We refer readers to the CY 2008 OPPS/ASC final rule with comment period (72 FR 66671 through 66675) for a detailed discussion of the data analysis.)

Thus, for CY 2008, we proposed and finalized two refinements to the methodology for computing the PHP median; however, these refinements did not appreciably impact the median per diem cost. We remapped the 10 revenue codes to the most appropriate cost centers and computed the median using a per day methodology (as described below). As noted in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66671), after extensive analysis, we now believe the data reflected the level of cost for the type of services that are being provided. We continued to observe a clear downward trend in the CY 2006 data used to develop the CY 2008 OPPS/ASC final rule with comment period.

Thus, for CY 2008, we refined our methodology for computing PHP per diem costs. We developed an alternate method to determine median cost by computing a separate per diem cost for each day rather than for each bill. Under this method, we computed a cost separately for each day of PHP care. When there are multiple days of care entered on a claim, a unique cost is computed for each day of care. We only assigned costs for line items on days when a payment is made. All of these costs were then arrayed from lowest to highest and the middle value of the array would be the median per diem cost. A complete discussion of the refined method of computing the PHP median cost can be found in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66672).

Because partial hospitalization is provided in lieu of inpatient care, it should be a highly structured and clinically-intensive program, usually lasting most of the day. Our goal is to improve the level of service furnished in a PHP day. For CY 2008, we were concerned that the proposed decrease in PHP payment may not reflect the mix and quantity of services that should be provided under such an intensive program. In an effort to ensure access to this needed service to vulnerable populations, we mitigated the proposed reduction to 50 percent of the difference between the CY 2007 APC amount ($233) and the computed amount based on the PHP data ($172), resulting in an APC median cost of $203 for CY 2008. As stated in the CY 2008 OPPS/ASC

final rule with comment period (72 FR 66673), we believe this payment amount would give the providers an opportunity to increase the intensity of their programs and maintain partial hospitalization as part of the continuum of mental health care.

In the CY 2008 OPPS/ASC final rule with comment period (72 FR 66673), we reiterated our expectation that hospitals and CMHCs will provide a comprehensive program consistent with the statutory intent. We also indicated that we intend to explore changes to our regulations and claims processing systems in order to deny payment for low intensity days and we specifically invited public comment on the most appropriate threshold. We received no public comments on this issue.

B. Proposed PHP APC Update

In the CY 2008 OPPS/ASC final rule with comment period (72 FR 66672 through 66674), we presented our analysis of the number of units of service provided in a day of care, as a possible explanation for the low per diem cost for PHP. Both hospital-based and CMHC PHPs had a significant number of days where fewer than 4 units of service were provided. As noted in the CY 2008 OPPS/ASC final rule with comment period, review of CY 2006 data showed that 64 percent of the CMHC days were days where fewer than 4 units of service were provided, and 31 percent of the hospital-based PHP days were days where fewer than 4 units of service were provided (72 FR 66672).

We have updated this analysis using CY 2007 claims and found that the results and trends have continued. In fact, there are even more days with less than four services provided in CMHCs, but there were fewer days with less than 4 units of service provided in hospital-based PHPs compared to the CY 2006 data. Using CY 2007 claims, 73 percent of CMHC days have fewer than 4 units of service, and 28 percent of hospital-based PHP days have fewer than 4 units of service. Based on these updated findings, we computed median per diem costs in the following three categories: (1) All days; (2) Days with 3 units of service; and (3) Days with 4 units or more. These updated median per diem costs were computed separately for CMHCs and hospital-based PHPs and are shown in the table below:

	CMHCs	Hospital-based PHPs	Combined
All Days	$145	$177	$146
Days with 3 units	139	151	140
Days with 4 units or more	171	205	174

Using CY 2007 data and our refined methodology for computing PHP per diem costs adopted in our CY 2008 OPPS/ASC final rule with comment period (72 FR 66672), the median per diem cost calculated from all claims is $146. The data indicate that CMHCs provide far fewer days with 4 or more units of service and that CMHC median per diem cost ($145) is substantially lower than the comparable data from hospital-based PHPs ($177). Medians for claims containing 4 or more units of service are $205 for hospital-based PHPs and $174 for all PHP claims regardless of site of service. Medians for claims containing 3 units of service are $139 for CMHCs, $151 for hospital-based PHPs, and $140 for all PHP claims regardless of site of service.

As we stated in our CY 2008 OPPS/ASC final rule with comment period (72 FR 66672), it was never our intention that days with three services represented the number of services provided in a typical day. Our intention was to cover days that consisted of only three services in certain limited circumstances. For example, we note there are days when a patient is transitioning towards discharge (or days when a patient who is transitioning at the beginning of his or her PHP stay). Another example of when it may be appropriate for a program to provide only three services in a day is when a patient is required to leave the PHP early for the day due to an unexpected medical appointment. Therefore, we recognize there may be limited circumstances when it is appropriate for PHPs to receive payment for days when only three services are provided. However, we believe that programs that provide four or more services should be paid an amount that recognizes that they have provided a more intensive day of care. A higher rate for more intensive days is consistent with our goal that hospitals and CMHCs provide a comprehensive program in keeping with the statutory intent.

Accordingly, as there are circumstances when three services provided may be appropriate, but to reflect our general belief that the data trend that four or more services more appropriately indicated the comprehensive nature of PHP services, for CY 2009, we are proposing to create two separate APC payment rates for PHP: one for days with three services and one for days with four or more services. We are proposing to create two new APCs for PHP as follows:

Proposed APC	Group title	Proposed per diem rate
0172	Level I Partial Hospitalization (3 services)	$140
0173	Level II Partial Hospitalization (4 or more services)	174

For APC 0172, we are proposing to use the median per diem cost for CMHC and hospital-based PHP days with 3 units of services ($140). For APC 00173, we are proposing to use the median per diem cost for CMHC and hospital-based PHP days with 4 or more units of service ($174). As noted previously, these proposed payment rates are derived from both PHP-based and CMHC-based claims, and represent the median cost of providing PHP services for the unit of services described. We believe that $140 is an appropriate payment rate for less intensive days because it is derived from both hospital-based PHP and CMHC claims data using all days with three services. We believe that $174 is an appropriate payment rate for more intensive days because it is derived from both hospital-based PHP and CMHC claims data, using all days with four or more services. We believe that creating a rate specific to days with

three services is consistent with our proposal to require CMHCs and hospital-based PHPs to provide a minimum of 3 units of service per day in order to receive payment as discussed below in section X.C.1. of this proposed rule. Our proposal to use two separate PHP rates provides a lower payment for days with only three services, while not penalizing programs that provide four or more services by excluding days with three services in the computation of APC 0173. We believe our proposal appropriately balances our concern that a PHP program is an intensive program and should generally consist of five to six services provided, with the realization that there may nonetheless be appropriate circumstances where three services may be provided.

C. Proposed Policy Changes

1. Proposal to Deny Payment for Low Intensity Days

In the CY 2008 OPPS/ASC final rule with comment period (72 FR 66673), we reiterated our expectation that hospitals and CMHCs will provide a comprehensive program consistent with the statutory intent. We also indicated that we intend to explore changes to our regulations and claims processing systems in order to deny payment for low intensity days and we specifically invited public comment on the most appropriate threshold. We received no public comments on this subject. Our analysis of claims data indicates that CMHCs (and to a lesser extent hospital-based PHPs) are furnishing a substantial number of low unit days. We consider providing only one or two services to be a low unit day. Although we currently consider the acceptable minimum number of PHP services required in a PHP day to be three, it was never our intention that three or fewer services should represent the number of services to be provided in a typical PHP day. PHP is furnished in lieu of an inpatient psychiatric hospitalization and is intended to be more intensive than a half-day program. We believe the typical PHP day should include five to six services with a break for lunch. As indicated in section X.B. above, we are proposing two PHP per diem rates that reflect the level of care provided.

In conjunction with and to conform to our proposed CY 2009 PHP per diem rates that account for a minimum of 3 units of service provided, we also are proposing changes to the existing PHP logic portion of the I/OCE to require that CMHCs and hospital-based PHPs provide a minimum of three services per day in order to receive PHP payment. Currently, the PHP logic portion of the I/OCE results in a ''suspension of claim for medical review'' for claims with fewer than three services provided in a day. For CY 2009, we are proposing to deny payment for any PHP claims for days when fewer than three therapeutic services are provided. We believe that three services should be the minimum number of services allowed in a PHP day because a day with one or two services does not meet the statutory intent of a PHP program. Three services are a minimum threshold that permits unforeseen circumstances, such as medical appointments, while allowing payment, but still maintains the integrity of a comprehensive program. As noted previously, we also believe that a day where a patient receives only three services should only occur under certain circumstances. As we explained in section X.B. of this proposed rule, an example of when it may be appropriate to bill only three services a day would be when a patient might need to leave early for a medical appointment and, therefore, would be unable to complete a full day of PHP treatment. However, PHP programs that provide three services in a day should be the exception, as we expect PHP programs to generally provide a more intensive day of services as PHP is a more comprehensive program than three services. CMS will be observing trends and assessing this proposed two payment rate approach in its continued review to protect the integrity of the PHP program.

2. Proposal to Strengthen PHP Patient Eligibility Criteria

As discussed in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66671), we established the current PHP payment rate of $203. As part of our ongoing review of ensuring the most appropriate payment is made for these intensive, service-oriented programs, we also explored changes that could enhance and strengthen the integrity of the PHP benefit overall. As part of this review, we looked at existing instructions to providers, including current regulations, manuals, and other guidance. We are proposing to codify existing policy regarding PHP patient eligibility as we believe it will help strengthen the integrity of the PHP benefit by conforming our regulations to our longstanding policy and making available the general program requirements in one regulatory section. These requirements are currently stated in the Medicare Benefit Policy Manual, Pub. 100–02, Chapter 6, section 70.3, available on the CMS Web site at: *http://www.cms.hhs.gov/manuals/Downloads/bp102c06.pdf*) and in Transmittal 10, Change Request 3298, dated May 7, 2004, but not codified. The regulatory text changes that we are proposing are intended to strengthen PHP requirements by adding the existing patient eligibility conditions to the existing PHP regulations, and do not reflect a change in policy. Specifically, we are proposing to revise 42 CFR 410.43 to add a reference to current regulations at § 424.24(e) that requires that PHP services are furnished pursuant to a physician certification and plan of care. While the requirements at § 424.24(e) are not new, we believe the addition of this reference to § 410.43 will provide a more complete description of our expectations for PHP programs in § 410.43.

We also are proposing to revise 42 CFR 410.43 to add the following patient eligibility criteria. We are proposing to state that partial hospitalization programs are intended for patients who—

(1) Require 20 hours per week of therapeutic services;

(2) Are likely to benefit from a coordinated program of services and require more than isolated sessions of outpatient treatment;

(3) Do not require 24-hour care;

(4) Have an adequate support system while not actively engaged in the program;

(5) Have a mental health diagnosis;

(6) Are not judged to be dangerous to self or others; and

(7) Have the cognitive and emotional ability to participate in the active treatment process and can tolerate the intensity of the partial hospitalization program.

We would like to generally note that partial hospitalization is the level of intervention that falls between inpatient hospitalization and episodic treatment in the continuum of care for the mentally ill. While we require a patient to have a mental health diagnosis, we caution that the diagnosis in itself is not the sole determining factor for coverage.

Because partial hospitalization is provided in lieu of inpatient care, it should be a highly structured and clinically-intensive program. Our goal is to improve the level of service furnished in a PHP day, while also ensuring that the partial hospitalization benefit is being utilized by the appropriate population. For example, a PHP candidate should be able to tolerate a day of PHP and benefit from the intense treatment provided in the program. In addition, for the program to be fully beneficial, a PHP participant should have a strong support system outside of the PHP program helping to ensure success. Moreover, the safety of all PHP

patients is extremely important and, therefore, all PHP participants should be able to live safely in the community, and not be a danger to self or others. For these reasons, it has been our longstanding policy that these criteria are vital in determining the patient's eligibility to participate in a PHP and believe it necessary to propose to codify the above list of basic patient eligibility requirements in § 410.43.

In the CY 2008 OPPS/ASC final rule with comment period (72 FR 66673), we reiterated our expectation that hospitals and CMHCs will provide a comprehensive program consistent with the statutory intent. We believe the addition of these requirements to the regulations helps provide a clear and consistent description of our expectations for PHP programs and would strengthen the integrity of the PHP benefit by noting such in the PHP regulations.

3. Proposed Partial Hospitalization Coding Update

As part of our ongoing evaluation of partial hospitalization codes, we are proposing several coding changes. We identified several CPT codes that we believe are inappropriate for billing PHP claims. Upon further study and after consultation with CMS medical advisors, we are proposing to eliminate use of the following three CPT codes for billing PHP claims: 90846 (Family psychotherapy (without the patient present)), 90849 (Multi-family group psychotherapy), and 90899 (Unlisted psychiatric service or procedure). While these three CPT codes constitute 0.157 percent of the total PHP claims for CY 2006, we believe there are similar and more appropriate HCPCS codes to use to bill for these services. We specifically request public comment on our proposed elimination of these three CPT codes from use in the PHP benefit.

Our review of the claims data associated with CPT code 90846 found that this code accounts for approximately 0.004 percent of the total services billed on PHP claims in CY 2006. We also believe that CPT code 90846 is not an appropriate code for the PHP benefit, because it excludes the beneficiary. Rather, we believe that another available PHP code CPT code 90847 (Family psychotherapy (conjoint psychotherapy with patient present)), which is currently a billable PHP code, is the more appropriate CPT code to use to bill for family psychotherapy services because it requires the presence of the patient as part of the family psychotherapy session.

In addition, our review of the CY 2006 claims data associated with CPT code 90849 found that this code accounts for approximately 0.058 percent of the total services billed on PHP claims in CY 2006. We also believe that the intended use of this code, which is for the reporting of multiple family group therapy sessions, is not appropriate for our use under PHP because PHP care is centered on the beneficiary. As stated earlier, we believe that CPT code 90847 is the more appropriate code to use for PHP payment of family psychotherapy services, because it provides for the conduct of individualized family psychotherapy with the patient present. Therefore, for CY 2009, we are proposing to eliminate CPT code 90849 for use as a PHP code.

In addition, evaluation of the CY 2006 claims data found that CPT code 90899 accounted for approximately 0.095 percent of total services billed on PHP claims. Upon closer examination, we found that CPT code 90899 is predominantly used to bill for patient education services. This is an unlisted CPT procedure code and such CPT unlisted procedure codes are used to report unlisted psychiatric procedures that are not accurately described by any other, more specific CPT codes. Because of our concerns about the type of services that may be billed using an unlisted CPT code and because a more appropriate code is currently available that better describes the patient education services for which PHP payment may be made, we are proposing to eliminate PHP payment for CPT code 90899 in CY 2009, and are proposing to replace CPT code 90899 with HCPCS code G0177 (Patient Education and Training). We further note that eliminating unlisted CPT procedure codes is consistent with how other payment systems currently treat such codes, in that more specific coding is preferred over general coding.

In addition, we are proposing to eliminate two group therapy CPT codes currently used in a PHP setting, 90853 (Group psychotherapy other than of a multiple-family group) and 90857 (Interactive group psychotherapy), and replace them with two new parallel timed HCPCS G-codes: GXXX1 (Group psychotherapy other than of a multiple-family group, in a partial hospitalization setting, approximately 45 to 50 minutes) and GXXX2 (Interactive group psychotherapy, in a partial hospitalization setting, approximately 45 to 50 minutes). As most of the current PHP codes already include time estimates, we believe in order to maintain consistency with the existing HCPCS codes used in PHP, the group therapy codes should likewise include a time descriptor. We believe the time of 45 to 50 minutes for a group therapy session is reasonable as it approximately reflects the timing of group sessions in current clinical practices. Therefore, we are proposing the two new timed HCPCS G-codes for PHP group therapies: GXXX1 and GXXX2. We note that both CPT code 90853 and 90857 may still be used in a non-PHP setting.

The table of billable PHP revenue and HCPCS codes originally published in the April 7, 2000 OPPS final rule with comment period (65 FR 18454) was updated and published in Transmittal 1487, Change Request 5999, dated April 8, 2008, and is currently located in, the Medicare Claims Processing Manual, Pub. 100–04, Chapter 4, section 260.1, which is available on the CMS Web site at: *http://www.cms.hhs.gov/manuals/downloads/clm104c04.pdf*. Table 34 below displays the revised list of billable PHP revenue codes and HCPCS codes shown in Transmittal 1487. This table also includes the five CPT codes that we are proposing to eliminate for CY 2009 and the two new HCPCS G-codes we are proposing to add for CY 2009. The five CPT codes that we are proposing to eliminate are shown in the HCPCS code column with a line struck through each code. The two new HCPCS G-codes that we are proposing are shown in the HCPCS code column, in the row with revenue code 0915 (Group Therapy).

TABLE 34.--PARTIAL HOSPITALIZATION BILLABLE CODES

Revenue Code	Descriptor	HCPCS Code
043X	Occupational Therapy	G0129
0900	Behavioral Health Treatment/Services	90801 or 90802, ~~*90899*~~
0904	Activity Therapy	G0176
0910	Psychiatric General Services	90801, 90802, 90899 (Dates of Service prior to October 16, 2003)
0914	Individual Psychotherapy	90816, 90817, 90818, 90819, 90821, 90822, 90823, 90824, 90826, 90827, 90828, 90829, 90845, 90865, or 90880
0915	Group Therapy	~~*90849*, 90853, or 90857~~ GXXX1 or GXXX2
0916	Family Psychotherapy	~~*90846*~~, 90847~~, or *90849*~~
0918	Psychiatric Testing	96101, 96102, 96103, 96116, 96118,96119, or 96120
0942	Education Training	G0177

D. Proposed Separate Threshold for Outlier Payments to CMHCs

In the November 7, 2003 final rule with comment period (68 FR 63469), we indicated that, given the difference in PHP charges between hospitals and CMHCs, we did not believe it was appropriate to make outlier payments to CMHCs using the outlier percentage target amount and threshold established for hospitals. There was a significant difference in the amount of outlier payments made to hospitals and CMHCs for PHP. In addition, further analysis indicated that using the same OPPS outlier threshold for both hospitals and CMHCs did not limit outlier payments to high cost cases and resulted in excessive outlier payments to CMHCs. Therefore, beginning in CY 2004, we established a separate outlier threshold for CMHCs. For CYs 2004 and 2005, we designated a portion of the estimated 2.0 percent outlier target amount specifically for CMHCs, consistent with the percentage of projected payments to CMHCs under the OPPS in each of those years, excluding outlier payments. For CY 2006, we set the estimated outlier target at 1.0 percent and allocated a portion of that 1.0 percent, an amount equal to 0.6 percent (or 0.006 percent of total OPPS payments), to CMHCs for PHP outliers. For CY 2007, we set the estimated outlier target at 1.0 percent and allocated a portion of that 1.0 percent, an amount equal to 0.15 percent of outlier payments (or 0.0015 percent of total OPPS payments), to CMHCs for PHP outliers. For CY 2008, we set the estimated outlier target at 1.0 percent and allocated a portion of that 1.0 percent, an amount equal to 0.02 percent of outlier payments (or 0.0002 percent of total OPPS payments), to CMHCs for PHP outliers. The CY 2008 CMHC outlier threshold is met when the cost of furnishing services by a CMHC exceeds 3.40 times the PHP APC payment amount. The CY 2008 OPPS outlier payment percentage is 50 percent of the amount of costs in excess of the threshold.

The separate outlier threshold for CMHCs became effective January 1, 2004, and has resulted in more commensurate outlier payments. In CY 2004, the separate outlier threshold for CMHCs resulted in $1.8 million in outlier payments to CMHCs. In CY 2005, the separate outlier threshold for CMHCs resulted in $0.5 million in outlier payments to CMHCs. In contrast, in CY 2003, more than $30 million was paid to CMHCs in outlier payments. We believe this difference in outlier payments indicates that the separate outlier threshold for CMHCs has been successful in keeping outlier payments to CMHCs in line with the percentage of OPPS payments made to CMHCs.

As noted in section II.F. of this proposed rule, for CY 2009, we are proposing to continue our policy of setting aside 1.0 percent of the aggregate total payments under the OPPS for outlier payments. We are proposing that a portion of that 1.0 percent, an amount equal to 0.07 percent of outlier payments (or 0.0007 percent of total OPPS payments), would be allocated to CMHCs for PHP outliers. As discussed in section II.F. of this proposed rule, we again are proposing to set a dollar threshold in addition to an APC multiplier threshold for OPPS outlier payments. However, because the PHP APC is the only APC for which CMHCs may receive payment under the OPPS, we would not expect to redirect outlier payments by imposing a dollar threshold. Therefore, we are not proposing to set a dollar threshold for CMHC outliers. As noted above, we are proposing to set the outlier threshold for CMHCs for CY 2009 at 3.40 times the APC payment amount and the CY 2009 outlier payment percentage applicable to costs in excess of the threshold at 50 percent.

XI. Proposed Procedures That Will Be Paid Only as Inpatient Procedures

A. Background

Section 1833(t)(1)(B)(i) of the Act gives the Secretary broad authority to determine the services to be covered and paid for under the OPPS. Before implementation of the OPPS in August 2000, Medicare paid reasonable costs for services provided in the outpatient department. The claims submitted were subject to medical review by the fiscal intermediaries to determine the appropriateness of providing certain services in the outpatient setting. We did not specify in regulations those services that were appropriate to provide only in the inpatient setting and that, therefore, should be payable only when provided in that setting.

In the April 7, 2000 final rule with comment period (65 FR 18455), we identified procedures that are typically provided only in an inpatient setting and, therefore, would not be paid by Medicare under the OPPS. These procedures comprise what is referred to as the ''inpatient list.'' The inpatient list specifies those services that are only paid when provided in an inpatient setting because of the nature of the procedure, the need for at least 24 hours of postoperative recovery time or monitoring before the patient can be safely discharged, or the underlying physical condition of the patient. As we discussed in that rule and in the November 30, 2001 final rule (66 FR 59856), we may use any of the following criteria when reviewing procedures to

determine whether or not they should be moved from the inpatient list and assigned to an APC group for payment under the OPPS:

- Most outpatient departments are equipped to provide the services to the Medicare population.
- The simplest procedure described by the code may be performed in most outpatient departments.
- The procedure is related to codes that we have already removed from the inpatient list.

In the November 1, 2002 final rule with comment period (67 FR 66741), we added the following criteria for use in reviewing procedures to determine whether they should be removed from the inpatient list and assigned to an APC group for payment under the OPPS:

- We have determined that the procedure is being performed in numerous hospitals on an outpatient basis; or
- We have determined that the procedure can be appropriately and safely performed in an ASC, and is on the list of approved ASC procedures or has been proposed by us for addition to the ASC list.

We believe that these additional criteria help us to identify procedures that are appropriate for removal from the inpatient list.

The list of codes that we are proposing to be paid by Medicare in CY 2009 only as inpatient procedures is included as Addendum E to this proposed rule.

B. Proposed Changes to the Inpatient List

For the CY 2009 OPPS, we used the same methodology as described in the November 15, 2004 final rule with comment period (69 FR 65835) to identify a subset of procedures currently on the inpatient list that are being performed a significant amount of the time on an outpatient basis. These procedures were then clinically reviewed for possible removal from the inpatient list. We solicited the APC Panel's input at its March 2008 meeting on the appropriateness of removing the following six CPT codes from the CY 2009 OPPS inpatient list: 21172 (Reconstruction superior-lateral orbital rim and lower forehead, advancement or alteration, with or without grafts (includes obtaining autografts)); 21386 (Open treatment of orbital floor blowout fracture; periorbital approach); 21387 (Open treatment of orbital floor blowout fracture; combined approach); 27479 (Arrest, epiphyseal, any method (e.g., epiphysiodesis); combined distal femur, proximal tibia and fibula); 54535 (Orchiectomy, radical, for tumor; with abdominal exploration); and 61850 (Twist drill or burr hole(s) for implantation of neurostimulator electrodes, cortical).

In addition to presenting to the APC Panel the six candidate procedures that we believed could be appropriate for removal from the inpatient list for CY 2009, we also presented utilization data for two procedures, specifically CPT code 64818 (Sympathectomy, lumbar) and CPT code 20660 (Application of cranial tongs caliper, or stereotactic frame, including removal (separate procedure)) that were discussed as possible procedures for removal from the inpatient list during the March 2007 APC Panel meeting. At that meeting, the APC Panel recommended that we obtain additional utilization data for these two procedures for its consideration at a subsequent meeting.

Following discussion, the APC Panel recommended that CMS remove from the inpatient list four of the six procedures (presented as candidates for removal from the list), specifically CPT codes 21172, 21386, 21387, and 27479, and one of the two codes for which additional utilization data were presented, specifically CPT code 20660. The APC Panel also recommended that CMS seek input from relevant physician specialty groups on the removal of two of the six procedures (presented to them as possible candidates for removal from the inpatient list), CPT codes 54535 and 61850. The APC Panel made no recommendation regarding removal of CPT code 64818 from the inpatient list after review of the additional data presented. For CY 2009, we are proposing to remove all of the codes except for CPT code 64818 from the inpatient list that were presented to the APC Panel as candidates for removal during its March 2008 meeting and, as recommended by the APC Panel, are specifically soliciting public comment on the proposed removal of CPT codes 54535 and 61850 from the inpatient list.

In addition to the procedures discussed at the APC Panel's March 2008 meeting, we also reviewed and are proposing to remove three procedures from the inpatient list that were requested for removal during the comment period on the CY 2008 OPPS/ASC proposed rule. We believe that these procedures are appropriate for removal from the inpatient list and are soliciting public comment on our proposal to remove these three procedures: CPT codes 27886 (Amputation, leg, through tibia and fibula; reamputation); 43420 (Closure of esophagostomy or fistula; cervical approach); and 50727 (Revision of urinary-cutaneous anastomosis (any type urostomy)).

Furthermore, during the March 2008 meeting of the APC Panel, a meeting attendee requested removal of several CPT codes from the inpatient list. That verbal request was followed by a letter in which the stakeholder requested that we remove five other procedures from the inpatient list for CY 2009. These procedures are: CPT code 50580 (Renal endoscopy through nephrotomy or pyelotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with removal of foreign body or calculus); CPT code 51845 (Abdomino-vaginal vesical neck suspension, with or without endoscopic control (e.g., Stamey, Raz, modified Pereyra); CPT code 51860 (Cystorrhaphy, suture of bladder wound, injury or rupture; simple); CPT code 54332 (One stage proximal penile or penoscrotal hypospadias repair requiring extensive dissection to correct chordee and urethroplasty by use of skin graft tube and/or island flap); and CPT code 54336 (One stage perineal hypospadias repair requiring extensive dissection to correct chordee and urethroplasty by use of skin graft tube and/or island flap). Based on our utilization data and clinical review, we are proposing to remove one of these procedures from the inpatient list, specifically CPT code 54332, and note that effective January 1, 2008, CPT code 50580 was removed from the inpatient list and assigned to APC 0161.

Consistent with our established policy for removing procedures from the inpatient list, we rely on recommendations from the public and the APC Panel, combined with our utilization data and review by CMS medical advisors, to determine which procedures are candidates for removal. We believe that our policy of proposing the procedures for removal and soliciting comments from the public, which includes physician specialty societies, is the most appropriate process to receive input from the public on this issue. Rather than solicit approval from a select group (for example, specific physician specialty societies), we believe that solicitation of comments from all interested parties is more consistent with meeting our obligation to the public regarding outpatient services provided by hospitals. Therefore, we are accepting both recommendations of the APC Panel from its March 2008 meeting regarding the inpatient list, including (1) proposing to remove the five specific procedures the APC Panel recommended for removal (CPT codes 21172, 21386, 21387, 27479, and 20660)

and (2) seeking input from relevant professional societies regarding our CY 2009 proposal to remove from the inpatient list CPT codes 54535 and 61850.

The utilization data and clinical review findings for the 11 procedures we are proposing to remove from the inpatient list for CY 2009 support our proposal. Therefore, we are proposing that 11 procedures be removed from the OPPS inpatient list for CY 2009 and be assigned to clinically appropriate APCs, as shown in Table 35 below.

TABLE 35.—PROPOSED HCPCS CODES FOR REMOVAL FROM INPATIENT LIST AND THEIR PROPOSED APC ASSIGNMENTS FOR CY 2009

HCPCS code	Long descriptor	Proposed CY 2009 APC	Proposed CY 2009 status indicator
20660	Application of cranial tongs caliper, or stereotactic frame, including removal (separate procedure).	0138	T
21172	Reconstruction superior-lateral orbital rim and lower forehead, advancement or alteration, with or without grafts (includes obtaining autografts).	0256	T
21386	Open treatment of orbital floor blowout fracture; periorbital approach	0256	T
21387	Open treatment of orbital floor blowout fracture; combined approach	0256	T
27479	Arrest, epiphyseal, any method (e.g., epiphysiodesis); combined distal femur proximal tibia and fibula.	0050	T
27886	Amputation, leg, through tibia and fibula; reamputation	0049	T
43420	Closure of esophagostomy or fistula; cervical approach	0254	T
50727	Revision of urinary-cutaneous anastomosis (any type urostomy)	0165	T
54332	One stage proximal penile or penoscrotal hypospadias repair requiring extensive dissection to correct chordee and urethroplasty by use of skin graft tube and/or island flap.	0181	T
54535	Orchiectomy, radical, for tumor; with abdominal exploration	0181	T
61850	Twist drill or burr hole(s) for implantation of neurostimulator electrodes, cortical	0061	S

XII. OPPS Nonrecurring Technical and Policy Clarifications

A. Physician Supervision of HOPD Services

1. Background

The following discussion is a restatement and clarification of the requirements for physician supervision of therapeutic hospital outpatient services. We have received many questions related to physician supervision in hospitals and provider-based departments of hospitals in response to recent changes to the Medicare Benefit Policy Manual, Pub.100–2, issued via Transmittal 82, Change Request 5496, dated February 8, 2008. That change request updated the Medicare Benefit Policy Manual, Chapter 6, sections 20 through 20.6 and 70.5 to clarify existing OPPS policy. The change request incorporated a citation and reference language from 42 CFR 410.27(f) into the text of the manual for the first time since the regulatory language was finalized in the April 7, 2000 OPPS final rule with comment period (65 FR 18524 through 18526). We believe that the updated manual language drew renewed attention to the longstanding OPPS policy on physician supervision. Based on the number and scope of the questions raised to us, and varying interpretations of the existing policy that stakeholders have described, we are including this discussion in this proposed rule to provide up-to-date clarification of the existing policy that may resolve some of the questions brought to our attention.

Section 1861(s)(2)(C) of the Act authorizes payment for diagnostic services, which are furnished to a hospital outpatient for the purpose of diagnostic study. We have further defined the requirements for diagnostic services furnished to hospital outpatients, including requirements for physician supervision of diagnostic services, in §§ 410.28 and 410.32. Section 410.28(e) states that Medicare Part B will make payment for diagnostic services furnished at provider-based departments of hospitals ''only when the diagnostic services are furnished under the appropriate level of physician supervision specified by CMS in accordance with the definitions in §§ 410.32(b)(3)(i), (b)(3)(ii), and (b)(3)(iii).'' In addition, in the April 7, 2000 OPPS final rule with comment period (65 FR 18526), we stated that our model for the requirement was the requirement for physician supervision of diagnostic tests payable under the MPFS that was set forth in the CY 1998 MPFS final rule (62 FR 59048) that was published in the **Federal Register** on October 31, 1998. We also explained with respect to the supervision requirements for individual diagnostic tests that we intended to instruct hospitals and fiscal intermediaries to use the MPFS as a guide pending issuance of updated requirements. For diagnostic services not listed in the MPFS, we stated that fiscal intermediaries, in consultation with their medical directors, would define appropriate supervision levels in order to determine whether claims for these services are reasonable and necessary. We have not subsequently issued new requirements for the physician supervision of diagnostic tests in provider-based departments of hospitals. Instead, we have continued to follow the supervision requirements for individual diagnostic tests as listed each year in the updates to the MPFS.

Section 1861(s)(2)(B) of the Act authorizes payment for hospital services ''incident to physicians' services rendered to outpatients.'' We have further defined the requirements for outpatient hospital therapeutic services and supplies ''incident to'' a physician's service in § 410.27. More specifically, § 410.27(f) states, ''Services furnished at a department of a provider, as defined in § 413.65(a)(2) of this subchapter, that has provider-based status in relation to a hospital under § 413.65 of this subchapter, must be under the direct supervision of a physician. 'Direct supervision' means the physician must be present and on the premises of the location and immediately available to furnish assistance and direction throughout the performance of the procedure. It does not mean that the physician must be present in the room when the procedure is performed.'' This

language makes no distinction between on-campus and off-campus provider-based departments.

However, in the preamble of the April 7, 2000 OPPS final rule with comment period (68 FR 18525), we further discussed the requirement for physician supervision and the finalization of the proposed regulation text. In that discussion, we stated that the language of § 410.27(f) ''applies to services furnished at an entity that is located off the campus of a hospital that we designate as having provider-based status as a department of a hospital in accordance with § 413.65.'' We also stated that for services furnished in a department of a hospital that is located on the campus of a hospital, ''we assume the direct supervision requirement to be met as we explain in section 3112.4(a) of the Intermediary Manual.'' We went on to add that ''we assume the physician supervision requirement is met on hospital premises because staff physicians would always be nearby within the hospital.''

Based on questions received recently, we are concerned that some stakeholders may have misunderstood our use of the term ''assume'' in the April 7, 2000 OPPS final rule with comment period, believing that our statement meant that we do not require any supervision in the hospital or in an on-campus provider-based department for therapeutic OPPS services, or that we only require general supervision for those services. This is not the case. It is our expectation that hospital outpatient therapeutic services are provided under the direct supervision of physicians in the hospital and in all provider-based departments of the hospital, specifically both on-campus and off-campus departments of the hospital. The expectation that a physician would always be nearby predates the OPPS and is related to the statutory authority for payment of hospital outpatient services—that Medicare makes payment for hospital outpatient services ''incident to'' the services of physicians in the treatment of patients as described in section 1861(s)(2)(B) of the Act. Longstanding hospital outpatient policy language states that, ''the services and supplies must be furnished as an integral though incidental part of the physicians' professional services in the course of treatment of an illness or injury.'' We refer readers to § 410.27(a) and to the Medicare Benefit Policy Manual, Pub. 100–2, Chapter 6, section 20.5.1, for further description of hospital outpatient services incident to a physician's service. The Medicare Benefit Policy Manual also states in Chapter 6, section 20.5.1, that services and supplies must be furnished on a physician's order and delivered under physician supervision. However, the manual indicates further that each occasion of a service by a nonphysician does not need also be the occasion of the actual rendition of a personal professional service by the physician responsible for the care of the patient. Nevertheless, as stipulated in that same section of the manual ''during any course of treatment rendered by auxiliary personnel, the physician must personally see the patient periodically and sufficiently often enough to assess the course of treatment and the patient's progress and, where necessary, to change the treatment regimen.''

The expectation that a physician would always be nearby also dates back to a time when inpatient hospital services provided in a single hospital building represented the majority of hospital payments by Medicare. Since that time, advances in medical technology, changes in the patterns of healthcare delivery, and changes in the organizational structure of hospitals have led to the development of extensive hospital campuses, sometimes spanning several city blocks, as well as off-campus and satellite provider-based campuses at different locations. In the April 7, 2000 OPPS final rule with comment period (65 FR 18525), we described the focus of the direct physician supervision requirement on off-campus provider-based departments. We will continue to emphasize the physician supervision requirement for off-campus provider-based departments. However, we note that if there were problems with outpatient care in a hospital or in an on-campus provider-based department where direct supervision was not in place (that is, the expectation of direct physician supervision was not met), we would consider that to be a concern. We want to ensure that OPPS payment is made for high quality hospital outpatient services provided to beneficiaries in a safe and effective manner and consistent with Medicare requirements.

The definition of direct supervision in § 410.27(f) requires that the physician must be present and on the premises of the location and immediately available to furnish assistance and direction throughout the performance of the procedure. In the April 7, 2000 OPPS final rule with comment period (65 FR 18525), we define ''on the premises of the location'' by stating '' * * * a physician must be present on the premises of the entity accorded status as a department of the hospital and therefore, immediately available to furnish assistance and direction for as long as patients are being treated at the site.'' We also stated that this does not mean that the physician must be physically in the room where a procedure or service is furnished. Although we have not further defined the term ''immediately available'' for this specific context, the lack of timely physician response to a problem in the HOPD would represent a quality concern from our perspective that hospitals should consider in structuring their provision of services in ways that meet the direct physician supervision requirement for HOPD services.

2. Summary

In summary, direct physician supervision is the standard set forth in the April 7, 2000 OPPS final rule with comment period for supervision of hospital outpatient therapeutic services covered and paid by Medicare in hospitals and provider-based departments of hospitals. While we have emphasized and will continue to emphasize the direct supervision requirement for off-campus provider-based departments, we are reiterating our expectation of direct physician supervision of all hospital outpatient therapeutic services, regardless of their on-campus or off-campus location. Appropriate supervision is a key aspect of the delivery of safe and high quality hospital outpatient services that are paid based on the statutory authority of the OPPS.

B. Reporting of Pathology Services for Prostate Saturation Biopsy

Prostate saturation biopsy is a technique currently described by Category III CPT code 0137T (Biopsy, prostate, needle, saturation sampling for prostate mapping). Typically this service entails obtaining 40 to 80 core samples from the prostate under general anesthesia. Currently the samples are reviewed by a pathologist, and the pathology service is reported with CPT code 88305 (Level IV—Surgical pathology, gross and microscopic examination). Since the beginning of the OPPS, Medicare has paid for the gross and microscopic pathology examination of prostate biopsy specimens using CPT code 88305. This CPT code has been paid separately under the OPPS and assigned to APC 0343 (Level III Pathology) with status indicator ''X'' since August 2000. For CY 2008, CPT code 88305 is assigned to APC 0343 with a payment rate of approximately $33.

In view of the large number of samples that are taken from a single body organ during prostate saturation biopsy and that must undergo gross and

microscopic examination by a pathologist, for CY 2009, we are proposing to recognize four new more specific Level II HCPCS G-codes under the OPPS for these pathology services, consistent with the CY 2009 proposal for the MPFS. The proposed HCPCS codes are: GXXX1 (Surgical pathology, gross and microscopic examination for prostate needle saturation biopsy sampling, 1–20 specimens); GXXX2 (Surgical pathology, gross and microscopic examination for prostate needle saturation biopsy sampling 21–40 specimens); GXXX3 (Surgical pathology, gross and microscopic examination for prostate needle saturation biopsy sampling, 41–60 specimens); and GXXX4 (Surgical pathology, gross and microscopic examination for prostate needle saturation biopsy sampling, greater than 60 specimens). We believe the descriptors of these proposed HCPCS G-codes more specifically reflect the characteristics of prostate saturation biopsy pathology services so that reporting would result in more accurate cost data for OPPS ratesetting and, ultimately, more appropriate payment. CPT code 88305 would continue to be recognized under the OPPS for those surgical pathology services unrelated to prostate needle saturation biopsy sampling. Consistent with the proposed CY 2009 APC assignment for CPT code 88305, we are proposing to assign these four new HCPCS G-codes to APC 0343, with a proposed APC median cost of approximately $35. We are specifically interested in public comment on the appropriateness of recognizing these proposed new HCPCS G-codes under the OPPS and their proposed APC assignments, specifically with regard to the expected hospital resources required for the preparation of the biopsy specimens that would be reported with the proposed new HCPCS G-codes and the extent to which those resources necessary to provide a single unit of each proposed new HCPCS G-code would differ from the resources required to provide a single unit of CPT code 88305 for a conventional prostate needle biopsy specimen.

XIII. Proposed OPPS Payment Status and Comment Indicators

A. Proposed OPPS Payment Status Indicator Definitions

The OPPS payment status indicators (SIs) that we assign to HCPCS codes and APCs play an important role in determining payment for services under the OPPS. They indicate whether a service represented by a HCPCS code is payable under the OPPS or another payment system and also whether particular OPPS policies apply to the code. Our proposed CY 2009 status indicator assignments for APCs and HCPCS codes are shown in Addendum A and Addendum B, respectively, to this proposed rule. We are proposing to use the status indicators and definitions that are listed in Addendum D1 to this proposed rule, which we discuss below in greater detail.

1. Proposed Payment Status Indicators To Designate Services That Are Paid Under the OPPS

Indicator	Item/code/service	OPPS payment status
G	Pass-Through Drugs and Biologicals	(1) Paid under OPPS; separate APC payment.
H	Pass-Through Device Categories	Separate cost-based pass-through payment; not subject to copayment.
K	(1) Non-Pass-Through Drugs and Biologicals.	(1) Paid under OPPS; separate APC payment.
	(2) Therapeutic Radiopharmaceuticals	(2) Paid under OPPS; separate APC payment.
N	Items and Services Packaged into APC Rates.	Paid under OPPS; payment is packaged into payment for other services. Therefore, there is no separate APC payment.
P	Partial Hospitalization	Paid under OPPS; per diem APC payment.
Q1	STVX-Packaged Codes	Paid under OPPS; Addendum B displays APC assignments when services are separately payable. (1) Packaged APC payment if billed on the same date of service as a HCPCS code assigned status indicator ''S,'' ''T,'' ''V,'' or ''X.'' (2) In all other circumstances, payment is made through a separate APC payment.
Q2	T-Packaged Codes	Paid under OPPS; Addendum B displays APC assignments when services are separately payable. (1) Packaged APC payment if billed on the same date of service as a HCPCS code assigned status indicator ''T.'' (2) In all other circumstances, payment is made through a separate APC payment.
Q3	Codes that may be paid through a composite APC.	Paid under OPPS; Addendum B displays APC assignments when services are separately payable. Addendum M displays composite APC assignments when codes are paid through a composite APC. (1) Composite APC payment based on OPPS composite-specific payment criteria. Payment is packaged into a single payment for specific combinations of service. (2) In all other circumstances, payment is made through a separate APC payment or packaged into payment for other services.
R	Blood and Blood Products	Paid under OPPS; separate APC payment.
S	Significant Procedure, Not Discounted when Multiple.	Paid under OPPS; separate APC payment.
T	Significant Procedure, Multiple Reduction Applies.	Paid under OPPS; separate APC payment.
U	Brachytherapy Sources	Paid under OPPS; separate APC payment.
V	Clinic or Emergency Department Visit	Paid under OPPS; separate APC payment.
X	Ancillary Services	Paid under OPPS; separate APC payment.

For CY 2009, we are proposing to replace current status indicator ''Q'' with three new separate status indicators: ''Q1,'' ''Q2,'' and ''Q3.'' We are proposing that status indicator ''Q1'' would be assigned to all ''STVX-packaged codes;'' status indicator ''Q2'' would be assigned to all ''T-packaged codes;'' and status indicator ''Q3'' would be assigned to all codes that may be paid through a composite APC based on composite-specific criteria or separately through single code APCs when the criteria are not met. We note that a commenter to the CY 2008 OPPS/

ASC proposed rule requested that we assign a distinct status indicator to services that may be subject to a composite APC methodology because the commenter believed that the composite payment policy differed significantly from the policies for payment of ''T-packaged'' and ''STVX-packaged codes'' (72 FR 66824). Therefore, we believe that this proposed change to establish new status indicators ''Q1,'' ''Q2,'' and ''Q3'' would make our policies more transparent to hospitals and would facilitate the use of status indicator-driven logic in our ratesetting calculations, and in hospital billing and accounting systems.

For CY 2009, we are proposing to use new payment status indicator ''R'' for all blood and blood product APCs and to use new payment status indicator ''U'' for all brachytherapy source APCs. Nonpass-through drugs and biologicals which do not require a conversion factor to calculate their payment rates would continue to be assigned status indicator ''K.'' We are proposing to create these new status indicators for blood and blood products and for brachytherapy sources to facilitate implementation of the reduced market basket conversion factor that would apply to payments to hospitals that are required to report quality data but that fail to meet the established quality reporting standards.

This is necessary because we are proposing to continue our final CY 2008 policies of setting prospective payment rates for brachytherapy sources and blood and blood products calculated as the product of scaled relative weights and the conversion factor and, therefore, blood and blood products and brachytherapy sources, but no other services that are currently assigned status indicator ''K'' would be subject to the reduced conversion factor. We refer readers to section XVI. of this proposed rule for discussion of the requirements of the hospital outpatient quality data reporting program and the reduced market basket conversion factor that would apply to payment for specific services when hospitals for which reporting is required fail to meet the reporting standards.

2. Proposed Payment Status Indicators To Designate Services That Are Paid Under a Payment System Other Than the OPPS

We are proposing no changes to the status indicators as listed below for the CY 2009 OPPS.

Indicator	Item/code/service	OPPS payment status
A	Services furnished to a hospital outpatient that are paid under a fee schedule or payment system other than OPPS, for example: • Ambulance Services • Clinical Diagnostic Laboratory Services • Non-Implantable Prosthetic and Orthotic Devices • EPO for ESRD Patients • Physical, Occupational, and Speech Therapy • Routine Dialysis Services for ESRD Patients Provided in a Certified Dialysis Unit of a Hospital • Diagnostic Mammography • Screening Mammography.	Not paid under OPPS. Paid by fiscal intermediaries/MACs under a fee schedule or payment system other than OPPS. Not subject to deductible or coinsurance. Not subject to deductible.
C	Inpatient Procedures	Not paid under OPPS. Admit patient. Bill as inpatient.
F	Corneal Tissue Acquisition; Certain CRNA Services; and Hepatitis B Vaccines.	Not paid under OPPS. Paid at reasonable cost.
L	Influenza Vaccine; Pneumococcal Pneumonia Vaccine	Not paid under OPPS. Paid at reasonable cost; not subject to deductible or coinsurance.
M	Items and Services Not Billable to the Fiscal Intermediary/MAC.	Not paid under OPPS.
Y	Non-Implantable Durable Medical Equipment	Not paid under OPPS. All institutional providers other than home health agencies bill to DMERC.

3. Proposed Payment Status Indicators To Designate Services That Are Not Recognized Under the OPPS But That May Be Recognized by Other Institutional Providers

We are proposing no changes to the status indicators as listed below for the CY 2009 OPPS.

Indicator	Item/code/service	OPPS payment status
B	Codes that are not recognized by OPPS when submitted on an outpatient hospital Part B bill type (12x and13x).	Not paid under OPPS. • May be paid by fiscal intermediaries/MACs when submitted on a different bill type, for example, 75x (CORF), but not paid under OPPS. • An alternate code that is recognized by OPPS when submitted on an outpatient hospital Part B bill type (12x and 13x) may be available.

4. Proposed Payment Status Indicators To Designate Services That Are Not Payable by Medicare

We are proposing no changes to the status indicators as listed below for the CY 2009 OPPS.

Indicator	Item/code/service	OPPS payment status
D	Discontinued Codes	Not paid under OPPS or any other Medicare payment system.
E	Items, Codes, and Services: • That are not covered by Medicare based on statutory exclusion • That are not covered by Medicare for reasons other than statutory exclusion • That are not recognized by Medicare but for which an alternate code for the same item or service may be available • For which separate payment is not provided by Medicare.	Not paid under OPPS or any other Medicare payment system.

To address providers' broader interests and to make the published Addendum B more convenient for public use, we are displaying in Addendum B to this proposed rule all active HCPCS codes for CY 2009 that describe items and services that are: (1) Payable under the OPPS; (2) paid under a payment system other than the OPPS; (3) not recognized under the OPPS but that may be recognized by other institutional providers; and (4) not payable by Medicare. The universe of CY 2009 status indicators that we are proposing for these items and services are listed in the tables above.

Addendum B, with a complete listing of HCPCS codes that includes their proposed payment status indicators and proposed APC assignments for CY 2009, is available electronically on the CMS Web site under supporting documentation for this proposed rule at: *http://www.cms.hhs.gov/HospitalOutpatientPPS/HORD/list.asp#TopOfPage.*

B. Proposed Comment Indicator Definitions

For the CY 2009 OPPS, we are proposing to continue use of the two comment indicators that are in effect for the CY 2008 OPPS. These two comment indicators are listed below.

• ''CH''—Active HCPCS codes in current and next calendar year; status indicator and/or APC assignment have changed or active HCPCS code that will be discontinued at the end of the current calendar year.

• ''NI''—New code, interim APC assignment; Comments will be accepted on the interim APC assignment for the new code.

We are proposing to use the ''CH'' indicator in the CY 2009 OPPS/ASC final rule with comment period to indicate HCPCS codes for which the status indicator or APC assignments, or both, would change in CY 2009 compared to their assignment as of December 31, 2008.

We are using the ''CH'' indicator in this proposed rule to call attention to proposed changes in the payment status indicator and/or APC assignment for HCPCS codes for CY 2009. In this proposed rule, the ''CH'' indicator is appended to HCPCS codes for which we are proposing changes in the payment status indicator and/or APC assignment for CY 2009 compared to their assignment as of June 30, 2008. We believe that using the ''CH'' indicator in this proposed rule would facilitate the public's review of the changes that we are proposing to make final in CY 2009. The use of the comment indicator ''CH'' in association with a composite APC indicates that the configuration of the composite APC is proposed for change in this proposed rule.

''STVX-packaged codes,'' ''T-packaged codes,'' and other HCPCS codes that could be paid through a composite APC with proposed CY 2009 changes in status indicator assignments from ''Q'' to ''Q1,'' from ''Q'' to ''Q2,'' and from ''Q'' to Q3,'' as well as HCPCS codes for blood and blood products and for brachytherapy sources with proposed CY 2009 changes in status indicator assignments from ''K'' to ''R'' and from ''K'' to ''U,'' respectively, are not flagged with comment indicator ''CH'' in Addendum B to this proposed rule. These proposed changes in status indicators are to facilitate policy transparency and operational logic rather than to reflect changes in OPPS payment policy for these services, so we believe that identifying these HCPCS codes with ''CH'' could be confusing to the public.

We are proposing to continue our policy of using comment indicator ''NI'' in the OPPS/ASC final rule with comment period. We are proposing that only HCPCS codes with comment indicator ''NI'' in the CY 2009 OPPS/ASC final rule with comment period would be subject to comment at that time. We are proposing that HCPCS codes that do not appear with comment indicator ''NI'' in the CY 2009 OPPS/ASC final rule with comment period would not be open to public comment, unless we specifically request additional comments at that time. The disposition of HCPCS codes that appear in the CY 2009 OPPS/ASC final rule with comment period to which comment indicator ''NI'' is not appended will have been open to public comment as a result of this proposed rule.

The two comment indicators that we are proposing to continue using in CY 2009 and their definitions are listed in Addendum D2 to this proposed rule.

XIV. OPPS Policy and Payment Recommendations

A. Medicare Payment Advisory Commission (MedPAC) Recommendations

MedPAC was established under section 1805 of the Act to advise the U.S. Congress on issues affecting the Medicare program. As required under the statute, MedPAC submits reports to Congress not later than March and June of each year that present its Medicare payment policy recommendations. The following section describes recent recommendations relevant to the OPPS that have been made by MedPAC.

1. March 2008 Report

The March 2008 MedPAC ''Report to Congress: Medicare Payment Policy'' included the following recommendation relating specifically to the Medicare hospital OPPS:

Recommendation 2A–1: The Congress should increase payment rates for the acute inpatient and outpatient prospective payment systems in 2009 by the projected rate of increase in the hospital market basket index, concurrent with implementation of a quality incentive payment program.

CMS Response: We are proposing to increase payment rates for the CY 2009 OPPS by the projected rate of increase in the hospital market basket through adjustment of the full CY 2009 conversion factor. Simultaneously, we are proposing to implement, effective for CY 2009, the reduction in the annual update factor by 2.0 percentage points for hospitals that are defined under section 1886(d)(1)(B) of the Act and that do not meet the hospital outpatient quality data reporting required by section 1833(t)(17) of the Act, as added by section 109(a) of the MIEA–TRHCA. Specifically, we are proposing to calculate two conversion factors, a full conversion factor based on the full hospital market basket increase and a reduced conversion factor that reflects the 2.0 percentage point reduction to the market basket. Our proposed update of the conversion factor and our proposed adoption and implementation of the reduced conversion factor that would apply to hospitals that fail their quality reporting requirements for the CY 2009 OPPS are discussed in detail in section XVI.D.2. of this proposed rule.

This full MedPAC report can be downloaded from MedPAC's Web site at: *http://www.medpac.gov/documents/Mar08_EntireReport.pdf.*

2. June 2007 Report

In its June 2007 ''Report to the Congress: Promoting Greater Efficiency in Medicare,'' MedPAC included analysis and recommendations on alternatives to the current method for computing the IPPS wage index for FY 2009. (We refer readers to Chapter 6 of the June 2007 MedPAC report to Congress.) In accordance with our established policy, under the OPPS we adopt the IPPS wage indices to adjust the OPPS standard payment amounts for labor market differences. Therefore, MedPAC's analysis and recommendations have implications for the CY 2009 OPPS. We have considered MedPAC's recommendations and analysis in making a proposal to revise the IPPS wage indices in the FY 2009 IPPS proposed rule (73 FR 23617 through 23623), as required by section 106(b)(2) of the MIEA–TRHCA. We discuss our proposed application of changes to the IPPS wage index for the CY 2009 OPPS in section II.C. of this proposed rule.

This full MedPAC report can be downloaded from MedPAC's Web site at *http://www.medpac.gov/document/Jun07_EntireReport.pdf.*

B. APC Panel Recommendations

Recommendations made by the APC Panel at its March 2008 meeting are discussed in sections of this proposed rule that correspond to topics addressed by the APC Panel. The report and recommendations from the APC Panel's March 5–6, 2008 meeting are available on the CMS Web site at: *http://www.cms.hhs.gov/FACA/05_AdvisoryPanelonAmbulatoryPaymentClassificationGroups.asp.*

C. OIG Recommendations

The mission of the OIG, as mandated by Public Law 95–452, as amended, is to protect the integrity of the U.S. Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections. In June 2007 the OIG released a report, entitled ''Impact of Not Retroactively Adjusting Outpatient Outlier Payments,'' that described the OIG's research into sources of error in CMHC outlier payments. The OIG report included the following two recommendations relating specifically to the hospital OPPS under which payment is made for outpatient services provided by CMHCs.

Recommendation 1: The OIG recommended that CMS require adjustments of outpatient outlier payments at final cost report settlement, retroactive to the beginning of the cost report period.

CMS Response: We have been proactive in addressing this issue for partial hospitalization prospective payment by designating a unique outlier threshold for CMHCs beginning in CY 2004. As discussed in the CY 2007 OPPS/ASC final rule with comment period (71 FR 68002 through 68003), differences in total CMHC outlier payments between CY 2004 and CY 2005 demonstrate that designating a separate threshold has successfully restrained CMHC outlier payments. Moreover, until the CY 2005 implementation of a fixed dollar outlier threshold for most other hospital outpatient services that concentrates outlier payments on costly and complex services, we did not believe it would be cost-effective to pursue adjustments of outlier payments for all of the OPPS. However, in addition to the unique outlier threshold for CMHCs that we have recently adopted to address excessive CMHC outlier payments, we are proposing to provide for reconciliation of outlier payments under the OPPS at final cost report settlement as recommended by the OIG, beginning in CY 2009. We discuss our rationale for proposing to reconcile outlier payments in more detail in section II.F. of this proposed rule.

Recommendation 2: The OIG recommended that CMS require retroactive adjustments of outpatient outlier payments when an error caused by the fiscal intermediary or provider is identified after the cost report is settled.

CMS Response: We note that the OIG's findings were based largely on information from the OPPS' early implementation period, between CY 2000 and CY 2003. We believe we have taken several steps since that time in order to improve the accuracy and frequency of the Medicare contractors' CCR calculations, including updating our instructions, increasing the frequency of calculation, and conducting an annual review of CMHC CCRs. However, in light of this OIG recommendation, for the CY 2009 OPPS we are also proposing to provide for reconciliation of outlier payments under the OPPS. We discuss our rationale for proposing to reconcile outlier payments in more detail in section II.F. of this proposed rule.

XV. Proposed Update of the Revised Ambulatory Surgical Center Payment System

A. Background

1. Legislative Authority for the ASC Payment System

Section 1832(a)(2)(F)(i) of the Act provides that benefits under Medicare Part B include payment for facility services furnished in connection with surgical procedures specified by the Secretary that are performed in an ASC. To participate in the Medicare program as an ASC, a facility must meet the standards specified in section 1832(a)(2)(F)(i) of the Act, which are set forth in 42 CFR part 416, subpart B and subpart C of our regulations. The regulations at 42 CFR part 416, subpart B describe the general conditions and requirements for ASCs, and the regulations at subpart C explain the specific conditions for coverage for ASCs.

Section 141(b) of the Social Security Act Amendments of 1994, Public Law 103–432, requires us to establish a process for reviewing the appropriateness of the payment amount provided under section 1833(i)(2)(A)(iii) of the Act for intraocular lenses (IOLs) that belong to a class of new technology intraocular lenses (NTIOLs). That process was the subject of a separate final rule entitled ''Adjustment in Payment Amounts for New Technology Intraocular Lenses Furnished by Ambulatory Surgical Centers,'' published on June 16, 1999, in the **Federal Register** (64 FR 32198).

Section 626(b) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), Public Law 108–173, added section 1833(i)(2)(D) to the Act, which required the Secretary to implement a revised ASC payment system to be effective not later than January 1, 2008. Section 626(c) of the MMA amended section 1833(a)(1) of the Act to require that, beginning with implementation of the revised ASC payment system, payment for surgical procedures furnished in ASCs shall be 80 percent of the lesser of the actual charge for the services or the amount determined by the Secretary under the revised payment system.

Section 5103 of the Deficit Reduction Act of 2005 (DRA), Public Law 109–171, amended section 1833(i)(2) of the Act by adding a new subparagraph (E) to place a limitation on payment amounts for surgical procedures in ASCs. Section 1833(i)(2)(E) of the Act provides that if the standard overhead amount under section 1833(i)(2)(A) of the Act for an ASC facility service for such surgical procedures, without application of any geographic adjustment, exceeds the Medicare payment amount under the hospital OPPS for the service for that year, without application of any geographic adjustment, the Secretary shall substitute the OPPS payment amount for the ASC standard overhead amount. This provision applied to surgical procedures furnished in ASCs on or after January 1, 2007, but before the effective date of the revised ASC payment system (that is, January 1, 2008). Section 109(b) of the Medicare Improvements and Extension Act of 2006 of the Tax Relief and Health Care Act of 2006 (MIEA–TRHCA), Public Law 109–432, amended section 1833(i) of the Act, in part, by adding a new clause (iv) to paragraph (2)(D) and by also adding paragraph (7)(A), which authorize the Secretary to require ASCs to submit data on quality measures and to reduce the annual update by 2 percentage points for an ASC that fails to submit data as required by the Secretary on selected quality measures. Section 109(b) of the MIEA–TRHCA also amended section 1833(i) of the Act by adding new paragraph (7)(B), which requires that certain quality of care reporting requirements mandated for hospitals paid under the OPPS, according to section 109(a) of the MIEA–TRHCA, be applied in a similar manner to ASCs unless otherwise specified by the Secretary.

For a detailed discussion of the legislative history related to ASCs, we refer readers to the June 12, 1998 proposed rule (63 FR 32291 through 32292).

2. Prior Rulemaking

On August 2, 2007, we published in the **Federal Register** (72 FR 42470) the final rule for the revised ASC payment system, effective January 1, 2008. We revised our criteria for identifying surgical procedures that are eligible for Medicare payment when furnished in ASCs and adopted the method we would use to set payment rates for ASC covered surgical procedures and covered ancillary services furnished in association with those covered surgical procedures beginning in CY 2008. In that final rule, we also established a policy for updating on an annual calendar year basis the ASC conversion factor, the relative payment weights and APC assignments, the ASC payment rates, and the list of procedures for which Medicare would not make an ASC payment. We also established a policy for treating new and revised HCPCS and CPT codes under the ASC payment system. This policy is consistent with the OPPS to the extent possible (72 FR 42533).

In the CY 2008 OPPS/ASC final rule with comment period (72 FR 66827), we updated and finalized the CY 2008 ASC rates and lists of covered surgical procedures and covered ancillary services. We also made regulatory changes to 42 CFR parts 411, 414, and 416 related to our final policies to provide payments to physicians who perform noncovered ASC procedures in ASCs based on the facility practice expense (PE) relative value units (RVUs), to exclude covered ancillary radiology services and covered ancillary drugs and biologicals from the categories of designated health services (DHS) that are subject to the physician self-referral prohibition, and to reduce ASC payments for surgical procedures when the ASC receives full or partial credit toward the cost of the implantable device.

3. Policies Governing Changes to the Lists of Codes and Payment Rates for ASC Covered Surgical Procedures and Covered Ancillary Services

The August 2, 2007, final rule established our policies for determining which procedures are ASC covered surgical procedures and covered ancillary services. Under §§ 416.2 and 416.166, subject to certain exclusions, covered surgical procedures are surgical procedures that are separately paid under the OPPS, that would not be expected to pose a significant risk to beneficiary safety when performed in an ASC, and that would not be expected to require an overnight stay. We defined surgical procedures as those described by Category I CPT codes in the surgical range from 10000 through 69999, as well as those Category III CPT codes and Level II HCPCS codes that crosswalk or are clinically similar to ASC covered surgical procedures (72 FR 42478).

In the August 2, 2007, final rule, we also established our policy to make separate ASC payments for the following ancillary services, for which separate payment is made under the OPPS, when they are provided integral to ASC covered surgical procedures: Brachytherapy sources; certain implantable items that have pass-through status under the OPPS; certain items and services that we designate as contractor-priced, including, but not limited to, procurement of corneal tissue; certain drugs and biologicals; and certain radiology services. These covered ancillary services are specified in § 416.164(b) and are eligible for separate ASC payment (72 FR 42495). Payment for ancillary services that are not paid separately under the ASC payment system is packaged into the ASC payment for the covered surgical procedure.

The full CY 2008 lists of ASC covered surgical procedures and covered ancillary services are included in Addendum AA and BB, respectively, to the CY 2008 OPPS/ASC final rule with comment period (72 FR 66945 through 66993 and 67165 through 67188).

We update the lists of, and payment rates for, covered surgical procedures and covered ancillary services, in conjunction with the annual proposed and final rulemaking process to update the OPPS and ASC payment system (§ 416.173; 72 FR 42535). In addition, because we base ASC payment policies for covered surgical procedures, drugs, biologicals, and certain other covered ancillary services on the OPPS payment policies, we also provide quarterly updates for ASC services throughout the year (January, April, July, and October),

just as we do for the OPPS. The updates are to implement newly created Level II HCPCS codes and Category III CPT codes for ASC payment and to update the payment rates for separately paid drugs and biologicals based on the most recently submitted ASP data.

In our annual updates to the ASC list of, and payment rates for, covered surgical procedures and covered ancillary services we undertake a review of excluded surgical procedures, new procedures, and procedures for which there is revised coding, to identify any that we believe meet the criteria for designation as ASC covered surgical procedures or covered ancillary services. Updating the lists of covered surgical procedures and covered ancillary services, as well as their payment rates, in association with the annual OPPS rulemaking cycle is particularly important because the OPPS relative payment weights and, in some cases, payment rates, are used as the basis for the payment of covered surgical procedures and covered ancillary services under the revised ASC payment system. This joint update process ensures that the ASC updates occur in a regular, predictable, and timely manner.

B. Proposed Treatment of New Codes

1. Proposed Treatment of New Category I and III CPT Codes and Level II HCPCS Codes

We finalized a policy in the August 2, 2007, final rule to evaluate each year all new Category I and Category III CPT codes and Level II HCPCS codes that describe surgical procedures to make preliminary determinations in the annual OPPS/ASC final rule with comment period regarding whether or not they meet the criteria for payment in the ASC setting and, if so, whether they are office-based procedures (72 FR 42533). In addition, we identify new codes as ASC covered ancillary services based upon the final payment policies of the revised ASC payment system. New HCPCS codes that are released in the summer through the fall of each year, to be effective January 1, are included in the final rule updating the ASC payment system for the following calendar year. These new codes are flagged with comment indicator ''NI'' in Addenda AA and BB to the OPPS/ASC final rule with comment period to indicate that we are assigning them an interim status which is subject to public comment on that final rule. These interim determinations must be made in the OPPS/ASC final rule with comment period because, in general, the new HCPCS codes and their descriptors for the upcoming calendar year are not available at the time of development of the OPPS/ASC proposed rule. The interim payment indicators assigned to the new codes under the revised ASC payment system are subject to comment in that final rule. We will respond to those comments in the OPPS/ASC update final rule with comment period for the following calendar year. We are proposing to continue this recognition process for CY 2009.

In addition, we are proposing to continue our policy of implementing through the ASC quarterly update process new mid-year CPT codes, generally Category III CPT codes, that the AMA releases in January to become effective the following July. Therefore, we are proposing to include in Addenda AA or BB, as appropriate, to the CY 2009 OPPS/ASC final rule with comment period the new Category III CPT codes released in January 2008 for implementation on July 1, 2008 (through the ASC quarterly update process), that we identify as ASC covered services. Similarly, we are proposing to include in Addenda AA and BB to that final rule any new Category III CPT codes that the AMA releases in July 2008 to be effective on January 1, 2009, that we identify as ASC covered services. However, only those new Category III CPT codes implemented effective January 1, 2009, will be designated by comment indicator ''NI'' in the Addenda to the CY 2009 OPPS/ASC final rule with comment period, to indicate that we have assigned them an interim payment status which is subject to public comment. The Category III CPT codes implemented in July 2008 for ASC payment, which appear in Table 36 below, are subject to comment through this proposed rule, and we are proposing to finalize their payment indicators in the CY 2009 OPPS/ASC final rule with comment period. We are proposing to assign payment indicator ''G2'' (Non office-based surgical procedure added in CY 2008 or later; payment based on OPPS relative payment weight) to each of these three new codes. Because of the timing of this proposed rule, these codes are not listed in Addendum AA to this proposed rule although they will be included in Addendum AA to the CY 2009 OPPS/ASC final rule with comment period.

TABLE 36.—NEW CATEGORY III CPT CODES IMPLEMENTED IN JULY 2008 FOR ASC PAYMENT

HCPCS code	Long descriptor	Proposed CY 2009 ASC payment indicator	Proposed CY 2009 ASC payment
0190T	Placement of intraocular radiation source applicator	G2	$890.60
0191T	Insertion of anterior segment aqueous drainage device, without extraocular reservoir; internal approach.	G2	968.22
0192T	Insertion of anterior segment aqueous drainage device, without extraocular reservoir; external approach.	G2	968.22

2. Proposed Treatment of New Level II HCPCS Codes Implemented in April and July 2008

New Level II HCPCS codes may describe covered surgical procedures or covered ancillary services. All new Level II HCPCS codes implemented in April and July 2008 for ASCs describe covered ancillary services. During the second quarter of CY 2008, we added to the list of covered ancillary services a total of four new Level II HCPCS codes for drugs and biologicals because they are eligible for separate payment under the OPPS. Those HCPCS codes are: C9241 (Injection, doripenem, 10 mg); Q4096 (Injection, von willebrand factor complex, human, ristocetin cofactor (not otherwise specified), per i.u. VWF.RCO); Q4097 (Injection, immune globulin (Privigen), intravenous, non-lyophilized ((e.g., liquid), 500 mg); and Q4098 (Injection, iron dextran, 50 mg). Similarly, for the third quarter of CY 2008, we added a total of four new Level II HCPCS codes to the list of ASC covered ancillary services for drugs and biologicals because they are eligible for separate payment under the OPPS. Those HCPCS codes are: C9242 (Injection, fosaprepitant, 1 mg); C9356 (Tendon, porous matrix of cross-linked collagen and glycosaminoglycan matrix ((TenoGlide Tendon Protector Sheet), per square centimeter); C9357 (Dermal

substitute, granulated cross-linked collagen and glycosaminoglycan matrix ((Flowable Wound Matrix), 1 cc); and C9358 (Dermal substitute, native, non-denatured collagen ((SurgiMend Collagen Matrix), per 0.5 square centimeters). We assigned the payment indicator ''K2'' (Drugs and biologicals paid separately when provided integral to a surgical procedure on ASC list; payment based on OPPS rate) for all of these new Level II HCPCS codes and added them to the list of covered ancillary services either through the April update (Transmittal 1488, Change Request 5994, dated April 9, 2008) or the July update of the CY 2008 ASC payment system. In this CY 2009 OPPS/ASC proposed rule, we are soliciting public comment on the proposed ASC payment indicators and payment rates for these codes, as listed in Tables 37 and 38. The codes listed in Table 37 also are included in Addendum BB of this proposed rule. These HCPCS codes are paid in ASCs beginning in April and July 2008, respectively, based on the ASC rates posted for the appropriate calendar quarter on the CMS Web site at: *http://www.cms.hhs.gov/ASCPayment/*. However, because of the timing of this proposed rule, the codes implemented by the July 2008 ASC update and their proposed CY 2009 payment rates (based on July 2008 ASP data) that are displayed in Table 38 are not included in Addendum BB to this proposed rule. We are proposing to include the new HCPCS codes displayed in Tables 37 and 38 and, for the codes in Table 37, in Addendum BB to the list of covered ancillary services and to incorporate all of them into Addendum BB to our final rule with comment period for CY 2009, consistent with our annual update policy.

TABLE 37.—NEW LEVEL II HCPCS CODES IMPLEMENTED IN APRIL 2008

HCPCS code	Long descriptor	Proposed CY 2009 ASC payment indicator
C9241	Injection, doripenem, 10 mg	K2
Q4096	Injection, von willebrand factor complex, human, ristocetin cofactor (not otherwise specified), per i.u. VWF:RCO.	K2
Q4097	Injection, immune globulin (Privigen), intravenous, non-lyophilized (e.g., liquid), 500 mg	K2
Q4098	Injection, iron dextran, 50 mg	K2

TABLE 38.—NEW LEVEL II HCPCS CODES IMPLEMENTED IN JULY 2008

HCPCS code	Long descriptor	Proposed CY 2009 ASC payment indicator	Proposed CY 2009 ASC payment
C9242*	Injection, fosaprepitant, 1 mg	K2	$1.61
C9356*	Tendon, porous matrix of cross-linked collagen and glycosaminoglycan matrix (TenoGlide Tendon Protector Sheet), per square centimeter.	K2	16.92
C9357*	Dermal substitute, granulated cross-linked collagen and glycosaminoglycan matrix (Flowable Wound Matrix), 1 cc.	K2	883.33
C9358*	Dermal substitute, native, non-denatured collagen (SurgiMend Collagen Matrix), per 0.5 square centimeters.	K2	10.38

*The payment rates displayed in Table 38 reflect the July 2008 ASP data.

C. Proposed Update to the Lists of ASC Covered Surgical Procedures and Covered Ancillary Services

1. Covered Surgical Procedures

a. Proposed Additions to the List of ASC Covered Surgical Procedures

We are proposing to update the ASC list of covered surgical procedures by adding nine procedures to the list. Three of the nine procedures, specifically CPT code 0190T (Placement of intraocular radiation source applicator), CPT code 0191T (Insertion of anterior segment aqueous drainage device, without extraocular reservoir; internal approach), and CPT code 0192T (Insertion of anterior segment aqueous drainage device, without extraocular reservoir; external approach) are new Category III CPT codes that became effective July 1, 2008, and were implemented in the July 2008 ASC update. The other six procedures were excluded from the ASC list for CY 2008 because we believed they did not meet the definition of a covered surgical procedure based on our expectation that they would pose a significant safety risk to Medicare beneficiaries or would require an overnight stay if performed in ASCs. During our annual review of excluded codes in which we used most recent utilization data, we identified the following six procedures that we believe should no longer be excluded from the ASC list: CPT code 31293 (Nasal/sinus endoscopy, surgical; with medial orbital wall and inferior orbital wall decompression); CPT code 34490 (Thrombectomy, direct or with catheter; axillary and subclavian vein, by arm incision); CPT code 36455 (Exchange transfusion, blood; other than newborn); CPT code 49324 (Laparoscopy, surgical; with drainage of lymphocele to peritoneal cavity); CPT code 49325 (Laparoscopy, surgical; with revision of previously placed intraperitoneal cannula or catheter, with removal of intraluminal obstructive material if performed); and CPT code 49326 (Laparoscopy, surgical; with omentopexy (omental tacking procedure)). The nine codes that we are proposing to add to the ASC list of covered surgical procedures and their proposed CY 2009 payment indicator ''G2'' (Non office-based surgical procedure added in CY 2008 or later; payment based on OPPS relative payment weight) are displayed in Table 39, below.

TABLE 39.—PROPOSED NEW ASC COVERED SURGICAL PROCEDURES FOR CY 2009

HCPCS code	Short descriptor	Proposed CY 2009 ASC payment indicator
31293	Nasal/sinus endoscopy, surg	G2
34490	Removal of vein clot	G2
36455	Bl exchange/transfuse non-nb	G2
49324	Lap insertion perm ip cath	G2
49325	Lap insertion perm ip cath	G2
49326	Lap w/omentopexy add-on	G2
0190T	Place intraoc radiation src	G2
0191T	Insert ant segment drain int	G2
0192T	Insert ant segment drain ext	G2

b. Covered Surgical Procedures Designated as Office-Based

(1) Background

In the August 2, 2007 final rule, we finalized our policy to designate as ''office-based'' those procedures that are added to the ASC list of covered surgical procedures in CY 2008 or later years that we determine are usually performed in physicians' offices based on consideration of the most recent available volume and utilization data for each individual procedure code (that is, performed more than 50 percent of the time in physicians' offices) and/or, if appropriate, the clinical characteristics, utilization, and volume of related codes. In that rule, we also finalized our policy to exempt all procedures on the CY 2007 ASC list from application of the office-based classification (72 FR 42512).

In the August 2, 2007 final rule, we identified a list of procedures as office-based after taking into account the most recently available CY 2005 volume and utilization data for each individual procedure or group of related procedures. We believed that the resulting list accurately reflected Medicare practice patterns and that the procedures were of similar complexity. In Addendum AA to that final rule, each of the office-based procedures was identified by payment indicator ''P2'' (Office-based surgical procedure added to ASC list in CY 2008 or later with MPFS nonfacility PE RVUs; payment based on OPPS relative payment weight); ''P3'' (Office-based surgical procedure added to ASC list in CY 2008 or later with MPFS nonfacility PE RVUs; payment based on MPFS nonfacility PE RVUs); or ''R2'' (Office-based surgical procedure added to ASC list in CY 2008 or later without MPFS nonfacility PE RVUs; payment based on OPPS relative payment weight), depending on whether we estimated it would be paid according to the standard ASC payment methodology based on its OPPS relative payment weight or at the MPFS nonfacility PE RVU amount.

In the CY 2008 OPPS/ASC final rule with comment period (72 FR 66840 through 66841), we finalized the temporary office-based designations of 4 procedures, while newly designating 19 procedures as permanently office-based. In addition, we designated 3 procedures coded by CPT codes that were new for CY 2008 as temporarily office-based on an interim final basis. Those 3 temporary designations for the new CY 2008 CPT codes were open to comment during the 60-day comment period for the CY 2008 OPPS/ASC final rule with comment period. We indicated that we would respond to public comments on those designations in the OPPS/ASC final rule with comment period for CY 2009.

(2) Proposed Changes to Covered Surgical Procedures Designated as Office-Based for CY 2009

In developing this proposed rule, we followed our final policy to annually review and update the surgical procedures for which ASC payment is made and to identify new procedures that may be appropriate for ASC payment, including their potential designation as office-based. We reviewed the CY 2007 utilization data and clinical characteristics for all those surgical procedures newly added for ASC payment in CY 2008 that were assigned payment indicator ''G2'' in the CY 2008 OPPS/ASC final rule with comment period.

As a result of that review, we identified the following 5 procedures that we are proposing to newly designate as office-based procedures for CY 2009: CPT code 0084T (Insertion of a temporary prostatic urethral stent); CPT code 36515 (Therapeutic apheresis; with extracorporeal immunoadsorption and plasma reinfusion); CPT code 36516 (Therapeutic apheresis; with extracorporeal selective adsorption or selective filtration and plasma reinfusion); CPT code 65436 (Removal of corneal epithelium; with application of chelating agent (e.g., EDTA)); and CPT code 67505 (Retrobulbar injection; alcohol). Of those, we are proposing to make the office-based designation of CPT code 0084T temporary because we do not have adequate data upon which to base a permanent designation. We are proposing to make permanent office-based designations for the remaining four procedures. The codes that we are newly proposing as office-based are displayed in Table 40.

TABLE 40.—CY 2009 PROPOSED NEW DESIGNATIONS OF ASC COVERED SURGICAL PROCEDURES AS OFFICE-BASED

HCPCS code	Short descriptor	CY 2008 ASC payment indicator	Proposed CY 2009 ASC payment indicator
0084T	Temp prostate urethral stent	G2	R2*
36515	Apheresis, adsorp/reinfuse	G2	P2
36516	Apheresis, selective	G2	P2
65436	Curette/treat cornea	G2	P3

TABLE 40.—CY 2009 PROPOSED NEW DESIGNATIONS OF ASC COVERED SURGICAL PROCEDURES AS OFFICE-BASED—Continued

HCPCS code	Short descriptor	CY 2008 ASC payment indicator	Proposed CY 2009 ASC payment indicator
67505	Inject/treat eye socket	G2	P3

* Denotes temporary payment indicator.

Furthermore, we reviewed CY 2007 utilization information for the seven procedures with temporary office-based designations for CY 2008. Of those procedures, we are proposing to make permanent the office-based designation for CPT code 28890 (Extracorporeal shock wave, high energy, performed by a physician, requiring anesthesia other than local, including ultrasound guidance, involving the plantar fascia). In response to comments on the CY 2008 OPPS/ASC proposed rule, in the CY 2008 OPPS/ASC final rule with comment period, we made the office-based designation for CPT code 28890 temporary rather than permanent as was proposed (72 FR 66839 through 66840). Although the CY 2006 utilization data available for development of the CY 2008 OPPS/ASC final rule with comment period showed that the service was provided more than 70 percent of the time in the physician's office setting, we were persuaded by commenters that providers may have been using CPT code 28890, which was new for CY 2006, erroneously to report less intensive extracorporeal shock wave procedures that would be more frequently performed in the physician's office. Our review of the CY 2007 data continues to support our designation of this procedure as office-based and thus, we believe it is appropriate at this time to propose to make that designation permanent for CY 2009.

We are not proposing to make permanent the office-based designations for the 6 other procedures for which the CY 2008 designations are temporary. For those procedures, we do not believe that the currently available utilization data provide an adequate basis for proposing permanent office-based designations. The procedures with temporary office-based status for the CY 2008 ASC payment system that we are proposing to continue to temporarily designate as office-based procedures for CY 2009 are displayed in Table 40A, below. In our review of these codes, we also determined that it would be consistent for the office-based assignment of HCPCS code C9728 (Placement of interstitial device(s) for radiation therapy/surgery guidance (e.g., fiducial markers, dosimeter), other than prostate (any approach), single or multiple) to be temporary. This procedure is paid under the CY 2008 ASC payment system as an office-based procedure but is analogous to CPT code 55876 (Placement of interstitial device(s) for radiation therapy guidance (e.g., fiducial markers, dosimeter), prostate (via needle, any approach), single or multiple), for which we are proposing to maintain the temporary office-based payment indicator for CY 2009. Therefore, we also are proposing to assign a temporary office-based payment indicator to HCPCS code C9728 for CY 2009. All procedures for which the proposed office-based designation for CY 2009 is temporary are indicated by an asterisk in Addendum AA to this proposed rule.

TABLE 40A.—CY 2008 OFFICE-BASED PROCEDURES FOR WHICH THEIR PROPOSED CY 2009 DESIGNATION IS TEMPORARILY OFFICE-BASED

HCPCS code	Short descriptor	Proposed CY 2009 ASC payment indicator
0099T	Implant corneal ring	R2*
0124T	Conjunctival drug placement	R2*
21073	Mnpj of tmj w/anesth	P3*
55876	Place rt device/marker, pros	P3*
67229	Tr retinal les preterm inf	R2*
68816	Probe nl duct w/balloon	P3*
C9728	Place device/marker, non pro	R2*

* Denotes temporary office-based payment indicator.

c. Covered Surgical Procedures Designated as Device-Intensive

(1) Background

As discussed in the August 2, 2007 final rule (72 FR 42503 through 42508), we adopted a modified payment methodology for calculating the ASC payment rates for covered surgical procedures that are assigned to the subset of OPPS device-dependent APCs with a device offset percentage greater than 50 percent under the OPPS, in order to ensure that payment for the procedure is adequate to provide packaged payment for the high-cost implantable devices used in those procedures. We assigned payment indicators ''H8'' (Device-intensive procedure on ASC list in CY 2007; paid at adjusted rate) and ''J8'' (Device-intensive procedure added to ASC list in CY 2008 or later; paid at adjusted rate) to identify the procedures that were eligible for ASC payment calculated according to the modified methodology, depending on whether the procedure was included on the ASC list of covered surgical procedures prior to CY 2008 and therefore, subject to transitional payment as discussed in section XV.D.1.b. of this proposed rule. The 45 ''device-intensive'' procedures for which the modified rate calculation methodology applies in CY 2008 are displayed in Table 56 and in Addendum AA to the CY 2008 OPPS/ASC final rule with comment period (72 FR 66843 and 66945 through 66993).

(2) Proposed Changes to List of Covered Surgical Procedures Designated as Device-Intensive for CY 2009

We are proposing to update the ASC list of covered surgical procedures that are eligible for payment according to the modified methodology for CY 2009 consistent with the proposed update to the device-dependent APCs under the OPPS that reflects the proposed APC assignments of procedures, designation of APCs as device-dependent, and APC device offset percentages based on CY 2007 claims data. OPPS device-dependent APCs are discussed further in section II.A.2.d.(1) of this proposed rule. The ASC covered surgical procedures that we are proposing to designate as device-intensive and that would be subject to the device-intensive procedure payment methodology are listed in Table 41 below. The HCPCS code, the HCPCS code short descriptor, the proposed payment indicator, the proposed CY 2009 OPPS APC assignment, and the proposed CY 2009 OPPS APC device offset percentage are also listed in Table 41. Each proposed device-intensive procedure is assigned payment indicator ''H8'' or ''J8,'' depending on whether it is subject to transitional payment, and all of these codes are included in Addendum AA to this proposed rule.

TABLE 41.—ASC COVERED SURGICAL PROCEDURES PROPOSED FOR DESIGNATION AS DEVICE-INTENSIVE FOR CY 2009

HCPCS code	Short descriptor	Proposed CY 2009 ASC payment indicator	Proposed CY 2009 OPPS APC	OPPS APC title	Proposed CY 2009 device-dependent APC offset percentage
27446	Revision of knee joint	J8	0681	Knee Arthroplasty	74
33206	Insertion of heart pacemaker	J8	0089	Insertion/Replacement of Permanent Pacemaker and Electrodes.	72
33207	Insertion of heart pacemaker	J8	0089	Insertion/Replacement of Permanent Pacemaker and Electrodes.	72
33208	Insertion of heart pacemaker	J8	0655	Insertion/Replacement/Conversion of a permanent dual chamber pacemaker.	75
33212	Insertion of pulse generator	H8	0090	Insertion/Replacement of Pacemaker Pulse Generator.	73
33213	Insertion of pulse generator	H8	0654	Insertion/Replacement of a permanent dual chamber pacemaker.	77
33214	Upgrade of pacemaker system	J8	0655	Insertion/Replacement/Conversion of a permanent dual chamber pacemaker.	75
33224	Insert pacing lead & connect	J8	0418	Insertion of Left Ventricular Pacing Elect.	70
33225	Lventric pacing lead add-on	J8	0418	Insertion of Left Ventricular Pacing Elect.	70
33240	Insert pulse generator	J8	0107	Insertion of Cardioverter-Defibrillator	89
33249	Eltrd/insert pace-defib	J8	0108	Insertion/Replacement/Repair of Cardioverter-Defibrillator Leads.	88
33282	Implant pat-active ht record	J8	0680	Insertion of Patient Activated Event Recorders.	71
53440	Male sling procedure	H8	0385	Level I Prosthetic Urological Procedures	57
53444	Insert tandem cuff	H8	0385	Level I Prosthetic Urological Procedures	57
53445	Insert uro/ves nck sphincter	H8	0386	Level II Prosthetic Urological Procedures	64
53447	Remove/replace ur sphincter	H8	0386	Level II Prosthetic Urological Procedures	64
54400	Insert semi-rigid prosthesis	H8	0385	Level I Prosthetic Urological Procedures	57
54401	Insert self-contd prosthesis	H8	0386	Level II Prosthetic Urological Procedures	64
54405	Insert multi-comp penis pros	H8	0386	Level II Prosthetic Urological Procedures	64
54410	Remove/replace penis prosth	H8	0386	Level II Prosthetic Urological Procedures	64
54416	Remv/repl penis contain pros	H8	0386	Level II Prosthetic Urological Procedures	64
55873	Cryoablate prostate	H8	0674	Prostate Cryoablation	59
61885	Insrt/redo neurostim 1 array	H8	0039	Level I Implantation of Neurostimulator	83
61886	Implant neurostim arrays	H8	0315	Level III Implantation of Neurostimulator	88
62361	Implant spine infusion pump	H8	0227	Implantation of Drug Infusion Device	81
62362	Implant spine infusion pump	H8	0227	Implantation of Drug Infusion Device	81
63650	Implant neuroelectrodes	H8	0040	Percutaneous Implantation of Neurostimulator Electrodes, Excluding Cranial Nerve.	56
63655	Implant neuroelectrodes	J8	0061	Laminectomy, Laparoscopy, or Incision for Implantation of Neurostimulator Electr.	61
63685	Insrt/redo spine n generator	H8	0222	Level II Implantation of Neurostimulator	84
64553	Implant neuroelectrodes	H8	0225	Implantation of Neurostimulator Electrodes, Cranial Nerve.	61
64555	Implant neuroelectrodes	J8	0040	Percutaneous Implantation of Neurostimulator Electrodes, Excluding Cranial Nerve.	56
64560	Implant neuroelectrodes	J8	0040	Percutaneous Implantation of Neurostimulator Electrodes, Excluding Cranial Nerve.	56
64561	Implant neuroelectrodes	H8	0040	Percutaneous Implantation of Neurostimulator Electrodes, Excluding Cranial Nerve.	56

TABLE 41.—ASC COVERED SURGICAL PROCEDURES PROPOSED FOR DESIGNATION AS DEVICE-INTENSIVE FOR CY 2009—Continued

HCPCS code	Short descriptor	Proposed CY 2009 ASC payment indicator	Proposed CY 2009 OPPS APC	OPPS APC title	Proposed CY 2009 device-dependent APC offset percentage
64565	Implant neuroelectrodes	J8	0040	Percutaneous Implantation of Neurostimulator Electrodes, Excluding Cranial Nerve.	56
64573	Implant neuroelectrodes	H8	0225	Implantation of Neurostimulator Electrodes, Cranial Nerve.	61
64575	Implant neuroelectrodes	H8	0061	Laminectomy, Laparoscopy, or Incision for Implantation of Neurostimulator Electr.	61
64577	Implant neuroelectrodes	H8	0061	Laminectomy, Laparoscopy, or Incision for Implantation of Neurostimulator Electr.	61
64580	Implant neuroelectrodes	H8	0061	Laminectomy, Laparoscopy, or Incision for Implantation of Neurostimulator Electr.	61
64581	Implant neuroelectrodes	H8	0061	Laminectomy, Laparoscopy, or Incision for Implantation of Neurostimulator Electr.	61
64590	Insrt/redo pn/gastr stimul	H8	0039	Level I Implantation of Neurostimulator	83
65770	Revise cornea with implant	H8	0293	Level V Anterior Segment Eye Procedures.	68
69930	Implant cochlear device	H8	0259	Level VII ENT Procedures	83

2. Covered Ancillary Services

We are proposing to update the ASC list of covered ancillary services to reflect the services' proposed separate payment status under the CY 2009 OPPS. Maintaining consistency with the OPPS may result in proposed changes to ASC payment indicators because some covered ancillary services that are paid separately under the revised ASC payment system in CY 2008 are proposed for packaged status under the OPPS for CY 2009. Comment indicator ''CH,'' as discussed in section XV.F. of this proposed rule, is used in Addendum BB to this proposed rule to indicate covered ancillary services for which we are proposing a change in the ASC payment indicator that reflects, for example, our proposal to package payment for the service under the CY 2009 ASC payment system consistent with its proposed treatment under the CY 2009 OPPS.

Except for the Level II HCPCS code listed in Table 38 of this proposed rule, all covered ancillary services and their proposed payment indicators for CY 2009 are included in Addendum BB to this proposed rule.

D. Proposed ASC Payment for Covered Surgical Procedures and Covered Ancillary Services

1. Proposed Payment for Covered Surgical Procedures

a. Background

Our final payment policy for covered surgical procedures under the revised ASC payment system is described in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66828 through 66831). In that rule, we updated the CY 2008 rates for covered surgical procedures with payment indicators of ''A2,'' ''G2,'' ''H8,'' and ''J8'' using CY 2006 data, consistent with the CY 2008 OPPS update. We also updated the payment amounts for office-based procedures (payment indicators ''P2,'' ''P3,'' and ''R2'') using the most recent available MPFS and OPPS data. We compared the estimated CY 2008 rate for each of the office-based procedures calculated according to the standard methodology of the revised ASC payment system to the MPFS nonfacility PE RVU amount to determine which was the lower payment amount that, therefore, would be the rate for payment of the procedure according to the final policy of the revised ASC payment system. See § 416.171(d).

Subsequent to publication of that rule, the Congress enacted the Medicare, Medicaid, and SCHIP Extension Act of 2007, Pub. L. 110–173. That law required changes to the rates paid under the MPFS for the first 6 months of CY 2008, and therefore, the ASC rates for some office-based procedures were also affected. We revised the CY 2008 ASC payment rates and made them available by posting them to the CMS Web site at: *http://www.cms.hhs.gov/ASCPayment/*.

b. Proposed Update to ASC Covered Surgical Procedure Payment Rates for CY 2009

We are proposing CY 2009 payment rates for procedures with payment indicator ''G2'' that are calculated according to the standard methodology of multiplying the proposed CY 2009 ASC relative payment weight for the procedure by the proposed CY 2009 ASC conversion factor (72 FR 42492 through 42493). Also, according to our established policy, we are proposing CY 2009 payments for procedures subject to the transitional payment methodology (payment indicators ''A2'' and ''H8'') using a blend of 50 percent of the proposed CY 2009 ASC rate calculated according to the standard or device-intensive methodology, respectively, and 50 percent of the CY 2007 ASC payment rate (72 FR 42519).

We are proposing payment rates for office-based procedures (payment indicators ''P2,'' ''P3,'' and ''R2'') and device-intensive procedures (payment indicators ''J8'' and ''H8'') calculated according to our established policies (72 FR 42504 and 42511). Thus, we are proposing to update the payment

amounts for device-intensive procedures based on the CY 2009 OPPS proposal that reflects updated OPPS claims data and to make payment for office-based procedures at the lesser of the proposed CY 2009 MPFS nonfacility PE RVU amount or the CY 2009 ASC payment amount calculated according to the standard methodology. Similarly, ASC payment rates for the device-intensive procedures would be based on the proposed updated CY 2009 OPPS device-offset amounts as displayed in Table 41 above.

c. Proposed Adjustment to ASC Payments for Partial or Full Device Credit

Under § 416.179, our ASC policies with regard to payment for costly devices implanted in ASCs at no cost or with full or partial credit are fully consistent with the OPPS policies. The proposed CY 2009 OPPS APCs and devices subject to the adjustment policy are discussed in section IV.B.2. of this proposed rule. The ASC policies include adoption of the OPPS policy for reduced payment to providers when a device is furnished without cost or with full credit for the cost of the device for those ASC covered surgical procedures that are assigned to APCs under the OPPS to which this policy applies. According to that policy, payment to the ASC is reduced by the device offset amount that we estimate represents the cost of the device when the necessary device is furnished without cost to the ASC or with a full credit for the cost of the new device (72 FR 42504). We provide the same amount of payment reduction based on the device offset amount in ASCs that would apply under the OPPS under the same circumstances. Specifically, when a procedure that is listed in Table 42 of this proposed rule is performed in an ASC and the case involves implantation of a no cost or full credit device listed in Table 43, the ASC must report the HCPCS ''FB'' modifier on the line with the covered surgical procedure code to indicate that an implantable device in Table 43 was furnished without cost.

When the ''FB'' modifier is reported with a procedure code that is listed in Table 42, the contractor reduces the ASC payment by the amount of payment that is attributed to the device when the ASC payment rate is calculated. The reduction of ASC payment in this circumstance is necessary to pay appropriately for the covered surgical procedure being furnished by the ASC.

Consistent with the OPPS policy, we also adopted an ASC payment policy for certain procedures involving partial credit for a specified device. Specifically, we reduce the payment for implantation procedures listed in Table 42 by one-half of the device offset amount that would be applied if a device were provided at no cost or with full credit, if the credit to the ASC is 50 percent or more of the device cost (72 FR 66846). ASCs must append the modifier ''FC'' to the code for the surgical procedure when the facility receives a partial credit of 50 percent or more of the cost of a device listed in Table 43 when used in a surgical procedure listed in Table 42. In order to report that they received a partial credit of 50 percent or more of the cost of a device, ASCs have the option of either: (1) Submitting the claim for the device implantation procedure to their Medicare contractor after the procedure's performance but prior to manufacturer acknowledgment of credit for the device, and subsequently contacting the contractor regarding a claims adjustment once the credit determination is made; or (2) holding the claim for the device implantation procedure until a determination is made by the manufacturer on the partial credit and submitting the claim with the ''FC'' modifier appended to the implantation procedure HCPCS code if the partial credit is 50 percent or more of the cost of the device. Beneficiary coinsurance is based on the reduced payment amount.

Consistent with the OPPS, we are proposing to update the list of device-intensive procedures that would be subject to the full and partial credit payment reduction policies for CY 2009. Table 42 displays the ASC covered implantation procedures and their payment indicators that we are proposing would be subject to the full and partial device credit policies for CY 2009.

Specifically, when a procedure that is listed in Table 42 below is performed in an ASC and the case involves implantation of a no cost or full credit device or a device for which the ASC received at least a 50 percent partial credit that is listed in Table 43, the ASC must report the HCPCS ''FB'' or ''FC'' modifier, as appropriate, on the line with the covered surgical procedure code. The procedures listed in Table 42 are those ASC covered device-intensive procedures assigned to APCs under the OPPS to which the policy applies. We are not proposing to apply this policy to the procedures and devices associated with APCs 0425 (Level II Arthroplasty or Implantation with Prosthesis) and 0648 (Level IV Breast Surgery), which are proposed for inclusion in the OPPS full and partial credit payment reduction policy for CY 2009, because ASC covered procedures assigned to these two APCs under the OPPS do not qualify for payment as ASC covered device-intensive surgical procedures (that is, their estimated device offset percentages are less than 50 percent).

TABLE 42.—PROPOSED CY 2009 ADJUSTMENTS TO PAYMENTS FOR ASC COVERED SURGICAL PROCEDURES IN CASES OF DEVICES REPORTED AT NO COST OR WITH FULL OR PARTIAL CREDIT

HCPCS code	Short descriptor	Proposed CY 2009 ASC payment indicator	Proposed CY 2009 OPPS APC	OPPS APC title	Proposed CY 2009 OPPS full offset percentage	Proposed CY 2009 OPPS partial offset percentage
27446 ..	Revision of knee joint	J8	0681	Knee Arthroplasty	74	37
33206 ..	Insertion of heart pacemaker	J8	0089	Insertion/Replacement of Permanent Pacemaker and Electrodes.	72	36
33207 ..	Insertion of heart pacemaker	J8	0089	Insertion/Replacement of Permanent Pacemaker and Electrodes.	72	36
33208 ..	Insertion of heart pacemaker	J8	0655	Insertion/Replacement/Conversion of a permanent dual chamber pacemaker.	75	37
33212 ..	Insertion of pulse generator	H8	0090	Insertion/Replacement of Pacemaker Pulse Generator.	73	36
33213 ..	Insertion of pulse generator	H8	0654	Insertion/Replacement of a permanent dual chamber pacemaker.	77	38

TABLE 42.—PROPOSED CY 2009 ADJUSTMENTS TO PAYMENTS FOR ASC COVERED SURGICAL PROCEDURES IN CASES OF DEVICES REPORTED AT NO COST OR WITH FULL OR PARTIAL CREDIT—Continued

HCPCS code	Short descriptor	Proposed CY 2009 ASC payment indicator	Proposed CY 2009 OPPS APC	OPPS APC title	Proposed CY 2009 OPPS full offset percentage	Proposed CY 2009 OPPS artial offset percentage
33214 ..	Upgrade of pacemaker system	J8	0655	Insertion/Replacement/Conversion of a permanent dual chamber pacemaker.	75	37
33224 ..	Insert pacing lead & connect	J8	0418	Insertion of Left Ventricular Pacing Elect.	70	35
33225 ..	Lventric pacing lead add-on	J8	0418	Insertion of Left Ventricular Pacing Elect.	70	35
33240 ..	Insert pulse generator	J8	0107	Insertion of Cardioverter-Defibrillator	89	44
33249 ..	Eltrd/insert pace-defib	J8	0108	Insertion/Replacement/Repair of Cardioverter-Defibrillator Leads.	88	44
33282 ..	Implant pat-active ht record	J8	0680	Insertion of Patient Activated Event Recorders.	71	35
53440 ..	Male sling procedure	H8	0385	Level I Prosthetic Urological Procedures.	57	29
53444 ..	Insert tandem cuff	H8	0385	Level I Prosthetic Urological Procedures.	57	29
53445 ..	Insert uro/ves nck sphincter	H8	0386	Level II Prosthetic Urological Procedures.	64	32
53447 ..	Remove/replace ur sphincter	H8	0386	Level II Prosthetic Urological Procedures.	64	32
54400 ..	Insert semi-rigid prosthesis	H8	0385	Level I Prosthetic Urological Procedures.	57	29
54401 ..	Insert self-contd prosthesis	H8	0386	Level II Prosthetic Urological Procedures.	64	32
54405 ..	Insert multi-comp penis pros	H8	0386	Level II Prosthetic Urological Procedures.	64	32
54410 ..	Remove/replace penis prosth	H8	0386	Level II Prosthetic Urological Procedures.	64	32
54416 ..	Remv/repl penis contain pros	H8	0386	Level II Prosthetic Urological Procedures.	64	32
61885 ..	Insrt/redo neurostim 1 array	H8	0039	Level I Implantation of Neurostimulator.	83	42
61886 ..	Implant neurostim arrays	H8	0315	Level III Implantation of Neurostimulator.	88	44
62361 ..	Implant spine infusion pump	H8	0227	Implantation of Drug Infusion Device.	81	40
62362 ..	Implant spine infusion pump	H8	0227	Implantation of Drug Infusion Device.	81	40
63650 ..	Implant neuroelectrodes	H8	0040	Percutaneous Implantation of Neurostimulator Electrodes, Excluding Cranial Nerve.	56	28
63655 ..	Implant neuroelectrodes	J8	0061	Laminectomy, Laparoscopy, or Incision for Implantation of Neurostimulator Electr.	61	30
63685 ..	Insrt/redo spine n generator	H8	0222	Level II Implantation of Neurostimulator.	84	42
64553 ..	Implant neuroelectrodes	H8	0225	Implantation of Neurostimulator Electrodes, Cranial Nerve.	61	30
64555 ..	Implant neuroelectrodes	J8	0040	Percutaneous Implantation of Neurostimulator Electrodes, Excluding Cranial Nerve.	56	28
64560 ..	Implant neuroelectrodes	J8	0040	Percutaneous Implantation of Neurostimulator Electrodes, Excluding Cranial Nerve.	56	28
64561 ..	Implant neuroelectrodes	H8	0040	Percutaneous Implantation of Neurostimulator Electrodes, Excluding Cranial Nerve.	56	28
64565 ..	Implant neuroelectrodes	J8	0040	Percutaneous Implantation of Neurostimulator Electrodes, Excluding Cranial Nerve.	56	28
64573 ..	Implant neuroelectrodes	H8	0225	Implantation of Neurostimulator Electrodes, Cranial Nerve.	61	30
64575 ..	Implant neuroelectrodes	H8	0061	Laminectomy, Laparoscopy, or Incision for Implantation of Neurostimulator Electr.	61	30

TABLE 42.—PROPOSED CY 2009 ADJUSTMENTS TO PAYMENTS FOR ASC COVERED SURGICAL PROCEDURES IN CASES OF DEVICES REPORTED AT NO COST OR WITH FULL OR PARTIAL CREDIT—Continued

HCPCS code	Short descriptor	Proposed CY 2009 ASC payment indicator	Proposed CY 2009 OPPS APC	OPPS APC title	Proposed CY 2009 OPPS full offset percentage	Proposed CY 2009 OPPS artial offset percentage
64577 ..	Implant neuroelectrodes	H8	0061	Laminectomy, Laparoscopy, or Incision for Implantation of Neurostimulator Electr.	61	30
64580 ..	Implant neuroelectrodes	H8	0061	Laminectomy, Laparoscopy, or Incision for Implantation of Neurostimulator Electr.	61	30
64581 ..	Implant neuroelectrodes	H8	0061	Laminectomy, Laparoscopy, or Incision for Implantation of Neurostimulator Electr.	61	30
64590 ..	Insrt/redo pn/gastr stimul	H8	0039	Level I Implantation of Neurostimulator.	83	42
69930 ..	Implant cochlear device	H8	0259	Level VII ENT Procedures	83	42

TABLE 43.—PROPOSED DEVICES FOR WHICH THE ''FB'' OR ''FC'' MODIFIER MUST BE REPORTED WITH THE PROCEDURE CODE WHEN FURNISHED AT NO COST OR WITH FULL OR PARTIAL CREDIT

Device HCPCS code	Short descriptor
C1721	AICD, dual chamber.
C1722	AICD, single chamber.
C1764	Event recorder, cardiac.
C1767	Generator, neurostim, imp.
C1771	Rep dev, urinary, w/sling.
C1772	Infusion pump, programmable.
C1776	Joint device (implantable).
C1778	Lead, neurostimulator.
C1779	Lead, pmkr, transvenous VDD.
C1785	Pmkr, dual, rate-resp.
C1786	Pmkr, single, rate-resp.
C1813	Prosthesis, penile, inflatab.
C1815	Pros, urinary sph, imp.
C1820	Generator, neuro rechg bat sys.
C1881	Dialysis access system.
C1882	AICD, other than sing/dual.
C1891	Infusion pump, non-prog, perm.
C1897	Lead, neurostim, test kit.
C1898	Lead, pmkr, other than trans.
C1900	Lead coronary venous.
C2619	Pmkr, dual, non rate-resp.
C2620	Pmkr, single, non rate-resp.
C2621	Pmkr, other than sing/dual.
C2622	Prosthesis, penile, non-inf.
C2626	Infusion pump, non-prog, temp.
C2631	Rep dev, urinary, w/o sling.
L8614	Cochlear device/system.

2. Proposed Payment for Covered Ancillary Services

a. Background

Our final CY 2008 payment policies under the revised ASC payment system for covered ancillary services vary according to the particular type of service and its payment policy under the OPPS. Our overall policy provides separate ASC payment for certain ancillary services integrally related to the provision of ASC covered surgical procedures that are paid separately under the OPPS and provides packaged ASC payment for other ancillary services that are packaged under the OPPS. Thus, we established a final policy to align ASC payment bundles with those under the OPPS (72 FR 42495).

Our ASC payment policies provide separate payment for drugs and biologicals that are separately paid under the OPPS at the OPPS rates, while we pay for separately payable radiology services at the lower of the MPFS nonfacility PE RVU (or technical component) amount or the rate calculated according to the standard ASC payment methodology (72 FR 42497). In all cases, these services must be provided integral to the performance of ASC covered surgical procedures for which the ASC bills Medicare. As noted in section XV.D.1.a. of this proposed rule, changes were made to the MPFS payment rates for the period of January 1, 2008 through June 30, 2008 as a result of the enactment of the Medicare, Medicaid, and SCHIP Extension Act of 2007. In addition to changing the ASC payment rates for some office-based procedures, those changes also affected the ASC rates for some covered ancillary radiology services for the first 6 months of CY 2008.

ASC payment policy for brachytherapy sources generally mirrors the payment policy under the OPPS. We finalized our policy to pay for brachytherapy sources applied in ASCs at the same prospective rates that were adopted under the OPPS or, if the OPPS rates were unavailable, at contractor-priced rates in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66832). Subsequent to publication of that rule, section 106 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 mandated that, for the period January 1, 2008 through June 30, 2008, brachytherapy sources be paid under the OPPS at charges adjusted to cost. Therefore, because our final overall ASC payment policy requires payment for brachytherapy sources at contractor-priced rates if prospective OPPS rates are not available (72 FR 42499), we paid ASCs at contractor-priced rates for brachytherapy sources provided in ASCs for this period of time. Beginning July 1, 2008, brachytherapy sources applied in ASCs are paid at the same prospectively set rates that were finalized in the CY 2008 OPPS/ASC final rule with comment period, unless Congress specifies another payment methodology.

Other separately paid covered ancillary services in ASCs, specifically corneal tissue acquisition and device categories with OPPS pass-through status, do not have prospectively established ASC payment rates according to the final policies of the revised ASC payment system (72 FR 42502 and 42509). Under the revised ASC payment system, corneal tissue acquisition is paid based on the invoiced costs for acquiring the corneal tissue for transplantation. As discussed in section IV.A.1. of this proposed rule, new pass-through device categories may be established on a quarterly basis, but currently there are no OPPS device pass-through categories that would continue for OPPS pass-through payment (and, correspondingly, separate ASC payment) in CY 2009.

b. Proposed Payment for Covered Ancillary Services for CY 2009

For CY 2009, we are proposing to update the ASC payment rates and make

changes to payment indicators as necessary in order to maintain alignment between the OPPS and ASC payment systems regarding the packaged or separately payable status of services and the proposed CY 2009 OPPS and ASC payment rates. The proposed CY 2009 OPPS payment methodologies for separately payable drugs and biologicals and brachytherapy sources are discussed in sections V. and VII. of this proposed rule, respectively, and the CY 2009 ASC payment rates for those services are proposed to equal the proposed CY 2009 OPPS rates. In Addendum BB, we indicate whether the proposed CY 2009 payment rate for radiology services is based on the MPFS PE RVU amount or the standard ASC payment calculation. Thus, the proposed CY 2009 payment indicator for a covered radiology service may differ from its CY 2008 payment indicator based on packaging changes under the OPPS or the comparison of the CY 2009 proposed MPFS nonfacility PE RVU amount to the CY 2009 ASC payment rate calculated according to the standard methodology. Services that we are proposing to pay based on the standard ASC rate methodology are assigned payment indicator ''Z2'' (Radiology service paid separately when provided integral to a surgical procedure on ASC list; payment based on OPPS relative payment weight) and those for which payment is based on the MPFS PE RVU amount are assigned payment indicator ''Z3'' (Radiology service paid separately when provided integral to a surgical procedure on ASC list; payment based on MPFS nonfacility PE RVUs).

Covered ancillary services and their proposed payment indicators are listed in Addendum BB to this proposed rule.

E. New Technology Intraocular Lenses

1. Background

In the CY 2007 OPPS/ASC final rule with comment period, we finalized our proposal to update and streamline the process for reviewing applications to establish new active classes of new technology intraocular lenses (NTIOLs) and for recognizing new candidate intraocular lenses (IOLs) inserted during or subsequent to cataract extraction as belonging to a new technology intraocular lens (NTIOL) class that is qualified for a payment adjustment (71 FR 68176) Specifically, we established the following process:

- We will announce annually in the **Federal Register** document that proposes the update of ASC payment rates for the following calendar year, a list of all requests to establish new NTIOL classes accepted for review during the calendar year in which the proposal is published and the deadline for submission of public comments regarding those requests. The deadline for receipt of public comments will be 30 days following publication of the list of requests.
- In the **Federal Register** document that finalizes the update of ASC payment rates for the following calendar year, we will—

+ Provide a list of determinations made as a result of our review of all new class requests and public comments; and

+ Publish the deadline for submitting requests for review of an application for a new NTIOL class in the following calendar year.

In determining whether a lens belongs to a new class of NTIOLs and whether the ASC payment amount for insertion of that lens in conjunction with cataract surgery is appropriate, we expect that the insertion of the candidate IOL would result in significantly improved clinical outcomes compared to currently available IOLs. In addition, to establish a new NTIOL class, the candidate lens must be distinguishable from lenses already approved as members of active or expired classes of NTIOLs that share a predominant characteristic associated with improved clinical outcomes that was identified for each class. Furthermore, in the CY OPPS/ASC 2007 final rule with comment period, we finalized our proposal to base our determinations on consideration of the following factors (71 FR 68177):

- The IOL must have been approved by the FDA and claims of specific clinical benefits and/or lens characteristics with established clinical relevance in comparison with currently available IOLs must have been approved by the FDA for use in labeling and advertising.
- The IOL is not described by an active or expired NTIOL class; that is, it does not share the predominant, class-defining characteristic associated with improved clinical outcomes with designated members of an active or expired NTIOL class.
- Evidence demonstrates that use of the IOL results in measurable, clinically meaningful, improved outcomes in comparison with use of currently available IOLs. According to the statute, and consistent with previous examples provided by CMS, superior outcomes that would be considered include the following:

+ Reduced risk of intraoperative or postoperative complication or trauma;

+ Accelerated postoperative recovery;

+ Reduced induced astigmatism;

+ Improved postoperative visual acuity;

+ More stable postoperative vision;

+ Other comparable clinical advantages, such as—

++ Reduced dependence on other eyewear (for example, spectacles, contact lenses, and reading glasses);

++ Decreased rate of subsequent diagnostic or therapeutic interventions, such as the need for YAG laser treatment;

++ Decreased incidence of subsequent IOL exchange;

++ Decreased blurred vision, glare, other quantifiable symptom or vision deficiency.

For a request to be considered complete, we require submission of the information that is found in the guidance document entitled ''Application Process and Information Requirements for Requests for a New Class of New Technology Intraocular Lens (NTIOL)'' posted on the CMS Web site at: *http://www.cms.hhs.gov/ASCPayment/05_NTIOLs.asp*.

As stated in the CY 2007 OPPS/ASC final rule with comment period (71 FR 68180), there are three possible outcomes from our review of a request for establishment of a new NTIOL class. As appropriate, for each completed request for consideration of a candidate IOL into a new class that is received by the established deadline, one of the following determinations would be announced annually in the final rule updating the ASC payment rates for the next calendar year:

- The request for a payment adjustment is approved for the candidate IOL for 5 full years as a member of a new NTIOL class described by a new HCPCS code.
- The request for a payment adjustment is approved for the candidate IOL for the balance of time remaining as a member of an active NTIOL class.
- The request for a payment adjustment is not approved.

We also discussed our plan to summarize briefly in the final rule the evidence that was reviewed, the public comments, and the basis for our determinations in consideration of applications for establishment of a new NTIOL class. We established that when a new NTIOL class is created, we would identify the predominant characteristic of NTIOLs in that class that sets them apart from other IOLs (including those previously approved as members of other expired or active NTIOL classes) and that is associated with improved clinical outcomes. The date of implementation of a payment adjustment in the case of approval of an

IOL as a member of a new NTIOL class would be set prospectively as of 30 days after publication of the ASC payment update final rule, consistent with the statutory requirement.

2. NTIOL Application Process for Payment Adjustment

In CY 2007, we posted an updated guidance document to the CMS Web site to provide process and information requirements for applications requesting a review of the appropriateness of the payment amount for insertion of an IOL to ensure that the ASC payment for covered surgical procedures includes payment that is reasonable and related to the cost of acquiring a lens that is approved as belonging to a new class of NTIOLs. This guidance document can be accessed on the CMS Web site at: *http://www.cms.hhs.gov/ASCPayment/downloads/NTIOLprocess*.

We note that we have also issued a guidance document entitled ''Revised Process for Recognizing Intraocular Lenses Furnished by Ambulatory Surgery Centers (ASCs) as Belonging to an Active Subset of New Technology Intraocular Lenses (NTIOLs).'' This guidance document can be accessed on the CMS Web site at: *http://www.cms.hhs.gov/ASCPayment/Downloads/Request_for_inclusion_in_current_NTIOL_subset.pdf*.

This second guidance document provides specific details regarding requests for recognition of IOLs as belonging to an existing, active NTIOL class, the review process, and information required for a request to review. Currently, there is one active NTIOL class whose defining characteristic is the reduction of spherical aberration. CMS accepts requests throughout the year to review the appropriateness of recognizing an IOL as a member of an active class of NTIOLs. That is, review of candidate lenses for membership in an existing, active NTIOL class is ongoing and not limited to the annual review process that applies to the establishment of new NTIOL classes. We ordinarily complete the review of such a request within 90 days of receipt, and upon completion of our review, we notify the requestor of our determination and post on the CMS Web site notification of a lens newly approved for a payment adjustment as an NTIOL belonging to an active NTIOL class when furnished in an ASC.

3. Classes of NTIOLs Approved and New Requests for Payment Adjustment

a. Background

Since implementation of the process for adjustment of payment amounts for NTIOLs that was established in the June 16, 1999 **Federal Register**, we have approved three classes of NTIOLs, as shown in the following table, with the associated qualifying IOLs to date:

NTIOL class	HCPCS code	$50 approved for services furnished on or after	NTIOL characteristic	IOLs eligible for adjustment
1	Q1001	May 18, 2000, through May 18, 2005.	Multifocal	Allergan AMO Array Multifocal lens, model SA40N.
2	Q1002	May 18, 2000, through May 18, 2005.	Reduction in Preexisting Astigmatism.	STAAR Surgical Elastic Ultraviolet-Absorbing Silicone Posterior Chamber IOL with Toric Optic, models AA4203T, AA4203TF, and AA4203TL.
3	Q1003	February 27, 2006, through February 26, 2011.	Reduced Spherical Aberration.	Advanced Medical Optics (AMO) Tecnis® IOL models Z9000, Z9001, Z9002, ZA9003, AR40xEM and Tecnis® 1–Piece model ZCB00; Alcon Acrysof® IQ Model SN60WF and Acrysert Delivery System model SN60WS; Bausch & Lomb Sofport AO models LI61AOV, and LI61AOV; STAAR Affinity Collamer model CQ2015A.

b. Request To Establish New NTIOL Class for CY 2009 and Deadline for Public Comment

As discussed below and explained in the guidance document on the CMS Web site, a request for review for a new class of NTIOLs for CY 2009 must have been submitted to CMS by March 14, 2008, the due date published in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66855). We received one request for review of the appropriateness of the ASC payment amount for insertion of a candidate IOL as a member of a new class of NTIOLs for CY 2009 by the March 14, 2008 due date. A summary of this request follows.

Requestor: Rayner Surgical, Inc.

Manufacturer: Rayner Intraocular Lenses Limited.

Lens Model Number: C-flex IOL, Model Number 570C.

Summary of the Request: Rayner Surgical, Inc. (Rayner) submitted a request for CMS to determine that its C-flex Model 570C intraocular lens meets the criteria for recognition as an NTIOL and to concurrently establish a new class of NTIOLs, with this lens as a member. As part of its request, Rayner submitted descriptive information about the candidate IOL as outlined in the guidance document that we make available on the CMS Web site for the establishment of a new class of NTIOLs, as well as information regarding approval of the candidate IOL by the U.S. Food and Drug Administration (FDA). This information included the approved labeling for the candidate lens, a summary of the IOL's safety and effectiveness, a copy of the FDA's approval notification, and instructions for its use. In addition, Rayner also submitted several peer-reviewed articles in support of its claim that the design features and hydrophilic properties of the candidate lens would reduce silicone oil adhesion and silicone oil-induced opacification. We note that we have previously considered other candidate IOLs for which ASC payment review was requested on the basis of their hydrophilic characteristics or their associated reduction in cellular deposits. We discussed these lenses in the December 20, 1999 and May 3, 2000 NTIOL proposed and final rules published in the **Federal Register** (FR 64 71148 through 71149 and 65 FR 25738 through 25740, respectively).

In its CY 2009 request, Rayner asserts that the design features and hydrophilic properties of the candidate lens would reduce silicone oil adhesion and silicone oil-induced opacification problems associated with FDA-approved IOL materials currently marketed in the United States. Rayner states that silicone oil is widely used as a tamponade in vitreoretinal surgery, and that silicone oil-induced opacification of an IOL, through adherence of the oil to the IOL surface, is a well-known surgical complication. Rayner also states that at present, there are no active or expired NTIOL classes that describe IOLs similar to its IOL.

We established in the CY 2007 OPPS/ASC final rule with comment period that when reviewing a request for recognition of an IOL as an NTIOL and a concurrent request to establish a new class of NTIOLs, we would base our

determination on consideration of the three major criteria that are outlined in the discussion above. We have begun our review of Rayner's request to recognize its C-flex IOL as an NTIOL and concurrently establish a new class of NTIOLs. We are soliciting comments on this candidate IOL with respect to the established NTIOL criteria as discussed above.

First, for an IOL to be recognized as an NTIOL we require that the IOL must have been approved by the FDA and claims of specific clinical benefits and/or lens characteristics with established clinical relevance in comparison with currently available IOLs must have been approved by the FDA for use in labeling and advertising. We note that FDA approval for the candidate lens was granted in May of 2007 and in its request, Rayner provided FDA approval documentation, including a copy of the FDA's approval notification, the FDA's summary of the IOL's safety and effectiveness, and the labeling approved by the FDA. The approved label for the Rayner C-flex states, ''The hydrophilic nature of the Rayacryl material and the design features of the Rayner C-Flex lens reduce the problems of silicone oil adhesion and silicone oil opacification.'' The FDA label does not otherwise reference specific clinical benefits or lens characteristics with established clinical relevance in comparison with currently available IOLs. Although the labeling reference to reduced ''problems'' could imply clinical relevance and clinical benefits of the lens, the label does not indicate the specific clinical benefits associated with the lens. We are interested in public comments on the specific clinical benefits and/or lens characteristics with established clinical relevance in comparison with currently available IOLs that may be associated with the silicone adherence and silicone oil-induced opacification reducing characteristics of this candidate lens.

Second, we also require that the candidate IOL not be described by an active or expired NTIOL class, that is, it does not share the predominant, class-defining characteristic associated with improved clinical outcomes with designated members of an active or expired NTIOL class. As noted in the table above regarding active and expired NTIOL classes, since implementation of the NTIOL review process that was established in the June 16, 1999 **Federal Register**, we have approved three classes of NTIOLs: Multifocal and Reduction in Preexisting Astigmatism classes, both of which were created in 2000 and expired in 2005, and the currently active Reduced Spherical Aberration class, which was created in 2006 and will expire in 2011. The class-defining characteristic specific to IOLs that are members of these classes is evident in the name assigned to the class. For example, IOLs recognized as members of the reduced spherical aberration class are characterized by their aspheric design that results in reduced spherical aberration. Please refer to the table above for information about the NTIOL classes that have been created since the implementation of the review process. Based on this information, the candidate lens may not be described by an active or expired NTIOL class. Its proposed class-defining characteristic and associated clinical benefits that were described in the submitted request, specifically the hydrophilic nature of the Rayacryl material and the design features of the C-flex lens to reduce problems with silicone oil adhesion and silicone oil-induced opacification, may not be similar to the class-defining characteristics and associated benefits of the two expired NTIOL classes, the Multifocal and Reduction in Preexisting Astigmatism classes, or to the class-defining characteristic and associated benefits of the currently active Reduced Spherical Aberration class. We welcome public comments that address whether the proposed class-defining characteristic and associated clinical benefits of the candidate Rayner IOL are described by the expired or currently active NTIOL classes.

Third, our NTIOL evaluation criteria also require that an applicant submit evidence that demonstrates use of the IOL results in measurable, clinically meaningful, improved outcomes in comparison with use of currently available IOLs. We note that in the CY 2007 OPPS/ASC final rule with comment period, we sought comments as to what constitutes currently available IOLs for purposes of such comparisons, and we received several comments in response to our solicitation (71 FR 68178). We agreed with commenters that we should remain flexible with respect to our view of ''currently available lenses'' for purposes of reviewing NTIOL requests, in order to allow for consideration of technological advances in lenses over time. For purposes of reviewing this request to establish a new NTIOL class for CY 2009, we believe that foldable, spherical, monofocal IOLs made of acrylic, silicone, or polymethylmethacrylate materials represent the currently available lenses against which the candidate NTIOL to establish a new class should be compared. The Rayner request asserts that the hydrophilic material of the candidate lens with respect to silicone oil adhesion makes the lens a novel IOL in the U.S. market. We are seeking public comment on our view of ''currently available lenses'' for the purposes of this CY 2009 review.

We reviewed the four peer-reviewed articles submitted by Rayner with the request, specifically three bench studies of silicone oil coverage of various IOL materials and a single series of three clinical case histories where silicone oil adhesion was documented. The literature did not clearly provide information regarding the clinical benefit to patients who received the candidate lens in conjunction with cataract removal surgery compared to patients receiving currently available IOLs. As stated in the Rayner request, the potential benefits of the candidate lens would apply only to individuals undergoing vitreoretinal surgery, in which silicone oil was used as a tamponade at some time after insertion of the intraocular lens. The size and composition of this population that could potentially benefit is unclear, and it is also unclear how often and what other alternative tamponade materials may be employed in the U.S. relative to silicone oil. We welcome public comments and relevant data specifically addressing whether use of the Rayner C-flex IOL results in measurable, clinically meaningful, improved outcomes in comparison with use of currently available IOLs.

In accordance with our established NTIOL review process, we are seeking public comments on all of the review criteria for establishing a new NTIOL class with the characteristic of reduced silicone oil-induced opacification based on the request for the Rayner C-flex IOL Model 570C lens. All comments on this request must be received by August 18, 2008. The announcement of CMS' determination regarding this request will appear in the CY 2009 OPPS/ASC final rule with comment period. If a determination of membership of the candidate lens in a new or currently active NTIOL class is made, this determination will be effective 30 days following the date that the final rule is published in the **Federal Register**.

4. Proposed Payment Adjustment

The current payment adjustment for a 5-year period from the implementation date of a new NTIOL class is $50. In the CY 2007 OPPS/ASC final rule with comment period, we revised § 416.200(a) through (c) to clarify how the IOL payment adjustment will be made and how an NTIOL will be paid

after expiration of the payment adjustment, as well as made minor editorial changes to § 416.200(d). For CY 2008, we did not revise the current payment adjustment amount, and we are not proposing to revise the payment adjustment amount for CY 2009 in light of our very short experience with the revised ASC payment system, implemented initially on January 1, 2008.

5. Proposed ASC Payment for Insertion of IOLs

In accordance with the final policies of the revised ASC payment system, for CY 2009 payment for IOL insertion procedures will be established according to the standard payment methodology of the revised payment system, which multiples the ASC conversion factor by the ASC payment weight for the surgical procedure to implant the IOL. CY 2009 ASC payment for the cost of a conventional lens will be packaged into the payment for the associated covered surgical procedures performed by the ASC. The proposed CY 2009 ASC payment rates for IOL insertion procedures are included in Table 44.

TABLE 44.—INSERTION OF IOL PROCEDURES AND THEIR PROPOSED CY 2009 ASC PAYMENT RATES

HCPCS code	Long descriptor	Proposed CY 2009 ASC payment
66983 ...	Intracapsular cataract extraction with insertion of intraocular lens prosthesis (one stage procedure)	$961.91
66984 ...	Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure), manual or mechanical technique (e.g., irrigation and aspiration or phacoemulsification).	961.91
66985 ...	Insertion of intraocular lens prosthesis (secondary implant), not associated with concurrent cataract removal	890.22
66986 ...	Exchange of intraocular lens	890.22

F. Proposed ASC Payment and Comment Indicators

1. Background

In addition to the payment indicators that we introduced in the August 2, 2007 final rule, we also created final comment indicators for the ASC payment system in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66855). We created Addendum DD1 to define ASC payment indicators that we use in Addenda AA and BB to provide payment information regarding covered surgical procedures and covered ancillary services, respectively, under the revised ASC payment system. The ASC payment indicators in Addendum DD1 are intended to capture policy-relevant characteristics of HCPCS codes that may receive packaged or separate payment in ASCs, including: Their ASC payment status prior to CY 2008; their designation as device-intensive or office-based and the corresponding ASC payment methodology; and their classification as separately payable radiology services, brachytherapy sources, OPPS pass-through devices, corneal tissue acquisition services, drugs or biologicals, or NTIOLs.

We also created Addendum DD2 that lists the ASC comment indicators. The ASC comment indicators used in Addenda AA and BB to the final rule with comment period will serve to identify, for the revised ASC payment system, the status of a specific HCPCS code and its payment indicator with respect to the timeframe when comments will be accepted. The comment indicator ''NI'' will be used in the final rule to indicate new HCPCS codes for which the interim payment indicator assigned is subject to comment.

The ''CH'' comment indicator is used in Addenda AA and BB to this CY 2009 proposed rule to indicate that: A new payment indicator (in comparison with the indicator for the CY 2008 ASC April quarterly update) is proposed for assignment to an active HCPCS code for the next calendar year; an active HCPCS code is proposed for addition to the list of procedures or services payable in ASCs; or an active HCPCS code is proposed for deletion at the end of the current calendar year. The ''CH'' comment indicators that are published in the final rule with comment period are provided to alert readers that a change has been made from one calendar year to the next, but do not indicate that the change is subject to comment. The full definitions of the comment indicators are provided in Addendum DD2 to this proposed rule.

2. Proposed ASC Payment and Comment Indicators

We are proposing to revise the definition of one ASC payment indicator for CY 2009. We are proposing that the definition of payment indicator ''F4'' would be changed from ''Corneal tissue acquisition; paid at reasonable cost'' to ''Corneal tissue acquisition, hepatitis B vaccine; paid at reasonable cost'' for CY 2009 as displayed in Addendum DD1 to this proposed rule. While we did not include hepatitis B vaccine HCPCS codes in Addendum BB to the CY 2008 OPPS/ASC final rule with comment period, we consider these vaccines to be separately payable drugs under the OPPS, and the revised ASC payment system policy provides the same payment for covered ancillary drugs and biologicals as would be made under the OPPS (72 FR 42501). Under the OPPS, these hepatitis B vaccines are proposed for CY 2009 payment at reasonable cost and, therefore, for the ASC payment system, we are proposing to include hepatitis B vaccines in the payment indicator definition of ''F4'' for CY 2009.

G. Calculation of the ASC Conversion Factor and ASC Payment Rates

1. Background

In the August 2, 2007 final rule, we made final our proposal to base ASC relative payment weights and payment rates under the revised ASC payment system on APC groups and relative payment weights (72 FR 42493). Consistent with that policy and the requirement at section 1833(i)(2)(D)(ii) of the Act that the revised payment system be implemented so that it would be budget neutral, the initial ASC conversion factor (CY 2008) was calculated so that estimated total Medicare payments under the revised ASC payment system in the first year would be budget neutral to estimated total Medicare payments under the existing (CY 2007) ASC payment system. That is, application of the ASC conversion factor was designed to result in aggregate expenditures under the revised ASC payment system in CY 2008 equal to aggregate expenditures that would have occurred in CY 2008 in the absence of the revised system, taking into consideration the cap on payments in CY 2007 as required under section

1833(i)(2)(E) of the Act (72 FR 42521 through 42522).

We note that we consider the term ''expenditures'' in the context of the budget neutrality requirement under section 1833(i)(2)(D)(ii) of the Act to mean expenditures from the Medicare Part B Trust Fund. We do not consider expenditures to include beneficiary coinsurance and copayments. This distinction was important for the CY 2008 ASC budget neutrality model that considered payments across hospital outpatient, ASC, and MPFS payment systems. However, because coinsurance is almost always 20 percent for ASC services, this interpretation of expenditures has minimal impact for subsequent budget neutrality adjustments calculated within the revised ASC payment system.

In the CY 2008 OPPS/ASC final rule with comment period (72 FR 66857 through 66858), we set out a step-by-step illustration of the final budget neutrality adjustment calculation based on the methodology finalized in the August 2, 2007 final rule (72 FR 42521 through 42531) and as applied to updated data available for the CY 2008 OPPS/ASC final rule with comment period. The application of that methodology to the data available for the CY 2008 OPPS/ASC final rule with comment period resulted in a budget neutrality adjustment of 0.65.

For CY 2008, we adopted the OPPS relative payment weights for most services as the ASC relative payment weights and, consistent with the final policy, we calculated the CY 2008 ASC payment rates by multiplying the ASC relative payment weights by the CY 2008 ASC conversion factor of $41.401. For covered office-based surgical procedures and covered ancillary radiology services, the final policy is to set the relative payment weights so that the national unadjusted ASC payment rate does not exceed the MPFS unadjusted nonfacility PE RVU amount. Further, as discussed in section XV.F. of this proposed rule, in addition to the standard payment methodology, we also adopted several other alternative payment methods for specific types of services (for example, device-intensive procedures).

Beginning in CY 2008, Medicare accounts for geographic wage variation in labor cost when calculating individual ASC payments by applying the pre-floor and pre-reclassified hospital wage index values that CMS calculates for payment and updated Core Based Statistical Areas (CBSAs) issued by the Office of Management and Budget in June 2003. This is the same wage index that is used to adjust for geographic differences in labor costs in all Medicare payment systems except the IPPS and the OPPS. As discussed in the August 2, 2007 final rule (72 FR 42518), the revised ASC payment system accounts for geographic wage variation when calculating individual ASC payments by applying the pre-floor and pre-reclassified hospital wage index to the labor-related portion, which is 50 percent of the ASC payment amount.

We note that as part of our review of the hospital wage index, in accordance with section 106(b)(1) of the MIEA–TRHCA, CMS has initiated a research contract that will evaluate the application of the hospital wage index in non-inpatient settings (73 FR 23618). For further information, see the discussion in the FY 2009 IPPS proposed rule.

2. Proposed Policy Regarding Calculation of the ASC Payment Rates

a. Updating the ASC Relative Payment Weights for CY 2009 and Future Years

We update the ASC relative payment weights in the revised ASC payment system each year using the national OPPS relative payment weights (and MPFS nonfacility PE RVU amounts, as applicable) for that same calendar year and uniformly scale the ASC relative payment weights for each update year to make them budget neutral (72 FR 42531 through 42532). Consistent with our established policy, we are proposing to scale the CY 2009 relative payment weights for ASCs according to the following method. Holding ASC utilization and the mix of services constant from CY 2007, for CY 2009, we would compare the total payment weight using the CY 2008 ASC relative payment weights under the 75/25 blend (of the CY 2007 payment rate and the revised ASC payment rate) with the total payment weight using the CY 2009 ASC relative payment weights under the 50/50 blend (of the CY 2007 ASC payment rate and the revised ASC payment rate) to take into account the changes in the OPPS relative payment weights between CY 2008 and CY 2009. We would use the ratio of CY 2008 to CY 2009 total payment weight (the weight scaler) to scale the ASC relative payment weights for CY 2009. The proposed ASC scaler is 0.9753 and scaling of ASC relative payment weights would apply to covered surgical procedures and covered ancillary radiology services whose ASC payment rates are based on OPPS relative payment weights. Scaling would not apply in the case of ASC payment for separately payable covered ancillary services that have a predetermined national payment amount (that is, their national ASC payment amounts are not based on OPPS relative payment weights), such as drugs and biologicals or brachytherapy sources that are separately paid under the OPPS or services that are contractor-priced or paid at reasonable cost in ASCs. Any service with a predetermined national payment amount would be included in the ASC budget neutrality comparison, but scaling of the ASC relative payment weights would not apply to those services. The ASC payment weights for those services without predetermined national payment amounts (that is, those services with national payment amounts that would be based on OPPS relative payment weights if a payment limitation did not apply) would be scaled to eliminate any difference in the total payment weight between the current year and the update year.

The proposed weight scaler used to model ASC fully implemented rates in order to reflect our estimate of rates if there was no transition for CY 2009 is equal to 0.9412. This scaler was applied to all payment weights subject to scaling, in order to estimate the fully implemented payment rates for CY 2009 without the transition, for purposes of the ASC impact analysis discussed in section XXI.D. of this proposed rule.

For any given year's ratesetting, we typically use the most recent full calendar year of claims data to model budget neutrality adjustments. We currently have 95 percent of CY 2007 ASC claims data available for this proposed rule. These claims do not include new covered surgical procedures and covered ancillary services under the revised ASC payment system that were first payable in ASCs in CY 2008 and only contain data for ASC services billed in CY 2007 that were eligible to receive payment under the previous ASC payment system. We do not have sufficiently robust CY 2008 ASC claims data upon which to base the CY 2009 ASC payment system update. Therefore, for CY 2009 budget neutrality adjustments, we assume that there would be no significant change in the weight scaler or wage adjustment attributable to new covered surgical and covered ancillary services.

To create an analytic file to support calculation of the weight scaler and budget neutrality adjustment for the wage index (discussed below), we summarized available CY 2007 ASC claims by provider and by HCPCS code. We defined a unique supplier identifier solely for the purpose of identifying unique providers within the CY 2007 claims data. We used the provider zip code reported on the claim to associate

state, county, and CBSA with each ASC. This file, available to the public as a supporting data file for this proposed rule, is posted on the CMS Web site at: *http://www.cms.hhs.gov/ASCPayment/01_Overview.asp#TopOfPage.*

b. Updating the ASC Conversion Factor

Under the OPPS, we typically apply a budget neutrality adjustment for provider-level changes, most notably a change in the wage index for the upcoming year, to the conversion factor. For the CY 2009 ASC payment system, we are proposing to calculate and apply the pre-floor and pre-reclassified hospital wage index that is used for ASC payment adjustment to the ASC conversion factor, just as the OPPS wage index adjustment is calculated and applied to the OPPS conversion factor. For CY 2009, we calculated this proposed adjustment for the revised ASC payment system by using the most recent CY 2007 claims data available and estimating the difference in total payment that would be created by introducing the CY 2009 pre-floor and pre-reclassified hospital wage index. Specifically, holding CY 2007 ASC utilization and service-mix and CY 2009 national payment rates after application of the weight scaler constant, we calculated the total adjusted payment using the CY 2008 pre-floor and pre-reclassified hospital wage index and a total adjusted payment using the proposed CY 2009 pre-floor and pre-reclassified hospital wage index. We used the 50-percent labor that we finalized for the revised ASC payment system in CY 2008 for both total adjusted payment calculations. We then compared the total adjusted payment calculated with the CY 2008 pre-floor and pre-reclassified hospital wage index to the total adjusted payment calculated with the proposed CY 2009 pre-floor and pre-reclassified hospital wage index and applied the resulting ratio of 0.9996 (the ASC wage index budget neutrality adjustment) to the CY 2008 ASC conversion factor to calculate the CY 2009 ASC conversion factor.

Section 1833(i)(2)(C) of the Act requires that, if the Secretary has not updated the ASC payment amounts in a calendar year after CY 2009, the payment amounts shall be increased by the percentage increase in the Consumer Price Index for All Urban Consumer (CPI–U) as estimated by the Secretary for the 12-month period ending with the midpoint of the year involved. Therefore, as discussed in the August 2, 2007 final rule, we adopted a final policy to update the ASC conversion factor using the CPI–U in order to adjust ASC payment rates for inflation (72 FR 42518 through 42519). We will implement the annual updates through an adjustment to the conversion factor under the revised ASC payment system beginning in CY 2010 when the statutory requirement for a zero update no longer applies. Therefore, for CY 2009, we are only proposing to update the ASC conversion factor with the budget neutrality adjustment due to the revised CY 2009 pre-floor and pre-reclassified hospital wage index, resulting in a proposed CY 2009 ASC conversion factor of $41.384, which is the product of $41.401 multiplied by 0.9996.

3. Display of Proposed ASC Payment Rates

Addenda AA and BB to this proposed rule display the proposed updated ASC payment rates for CY 2009 for covered surgical procedures and covered ancillary services, respectively. These addenda contain several types of information related to the proposed CY 2009 payment rates. Specifically, in Addendum AA, the column titled ''Subject to Multiple Procedure Discounting'' indicates whether a surgical procedure would be subject to the multiple procedure payment reduction policy. As discussed in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66829 through 66830), most covered surgical procedures are subject to a 50-percent reduction in the ASC payment for the lower-paying procedure when more than one procedure is performed in a single operative session. Display of the comment indicator ''CH'' in the column titled ''Comment Indicator'' indicates a proposed change in payment policy for the item or service, including identifying new or discontinued HCPCS codes, designating items or services newly proposed for payment under the ASC payment system, and identifying items or services with a proposed change in the ASC payment indicator for CY 2009. The column titled ''CY 2009 Second Year Transition Payment Weight'' is the relative transition payment weight for the service. CY 2009 is the second year of a 4-year transition to ASC payment rates calculated according to the standard methodology of the revised ASC payment system. As proposed, the CY 2009 ASC payment rates for the covered surgical procedures subject to transitional payment (payment indicators ''A2'' and ''H8'' in Addendum AA) are based on a blend of 50 percent of the CY 2007 ASC payment weight for the procedure and 50 percent of the proposed CY 2009 fully implemented ASC weight before scaling for budget neutrality, calculated according to the standard methodology. The payment weights for all covered surgical procedures and covered ancillary radiology services whose ASC payment rates are based on OPPS relative payment weights are scaled for budget neutrality. Thus, scaling was not applied for the device portion of the device-intensive procedures, services that are paid at the MPFS nonfacility PE RVU amount, separately payable covered ancillary services that have a predetermined national payment amount, such as drugs, biologicals, and brachytherapy sources that are separately paid under the OPPS or services that are contractor-priced or paid at reasonable cost in ASCs.

To derive the proposed CY 2009 payment rate displayed in the ''CY 2009 Second Year Transition Payment'' column, each ASC payment weight in the ''CY 2009 Second Year Transition Payment Weight'' column is multiplied by the proposed CY 2009 ASC conversion factor of $41.384, that includes a budget neutrality adjustment for changes in the wage index. Items and services with a predetermined national payment amount, such as separately payable drugs and biologicals displayed in Addendum BB to this proposed rule, may not show a relative payment weight. The ''CY 2009 Second Year Transition Payment'' column displays the proposed CY 2009 national unadjusted ASC payment rates for all items and services. The proposed CY 2009 ASC payment rates for separately payable drugs and biologicals are based on ASP data used for payment in physicians' offices in April 2008.

XVI. Reporting Quality Data for Annual Payment Rate Updates

A. Background

1. Reporting Hospital Outpatient Quality Data for Annual Payment Update

Section 109(a) of the MIEA–TRHCA (Pub. L. 109–432) amended section 1833(t) of the Act by adding a new subsection (17) that affects the payment rate update applicable to OPPS payments for services furnished by hospitals in outpatient settings on or after January 1, 2009. Section 1833(t)(17)(A) of the Act, which applies to hospitals as defined under section 1886(d)(1)(B) of the Act, requires that hospitals that fail to report data required for the quality measures selected by the Secretary in the form and manner required by the Secretary under section 1833(t)(17)(B) of the Act will incur a reduction in their annual payment update factor by 2.0 percentage points. Section 1833(t)(17)(B) of the Act

requires that hospitals submit quality data in a form and manner, and at a time that the Secretary specifies. Sections 1833(t)(17)(C)(i) and (ii) of the Act require the Secretary to develop measures appropriate for the measurement of the quality of care (including medication errors) furnished by hospitals in outpatient settings and that these measures reflect consensus among affected parties and, to the extent feasible and practicable, include measures set forth by one or more national consensus building entities. The Secretary is not prevented from selecting measures that are the same as (or a subset of) the measures for which data are required to be submitted under section 1886(b)(3)(B)(viii) of the Act for the IPPS Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) program. Section 1833(t)(17)(D) of the Act gives the Secretary the authority to replace measures or indicators as appropriate, such as when all hospitals are effectively in compliance or when the measures or indicators have been subsequently shown not to represent the best clinical practice. Section 1833(t)(17)(E) of the Act requires the Secretary to establish procedures for making data submitted available to the public. Such procedures must give hospitals the opportunity to review data before these data are released.

In the CY 2007 OPPS/ASC final rule with comment period (71 FR 68189), we indicated our intent to establish an OPPS payment program modeled after the current IPPS RHQDAPU program. We stated our belief that the quality of hospital outpatient services would be most appropriately and fairly rewarded through the reporting of quality measures developed specifically for application in the hospital outpatient setting. We agreed that assessment of hospital outpatient performance would ultimately be most appropriately based on reporting of hospital outpatient measures developed specifically for this purpose. We stated our intent to implement the full OPPS payment rate update beginning in CY 2009 based upon hospital reporting of quality data beginning in CY 2008, using effective measures of the quality of hospital outpatient care that have been carefully developed and evaluated, and endorsed as appropriate, with significant input from stakeholders.

The amendments to the Act made by section 109(a) of the MIEA–TRHCA are consistent with our intent and direction outlined in the CY 2007 OPPS/ASC final rule with comment period. Under these amendments, we were statutorily required to establish a program under which hospitals would report data on the quality of hospital outpatient care using standardized measures of care in order to receive the full annual update to the OPPS payment rate, effective for payments beginning in CY 2009. We refer to the program established under these amendments as the Hospital Outpatient Quality Data Reporting Program (HOP QDRP).

In reviewing the measures currently available for care in the hospital outpatient settings, we continue to believe that it would be most appropriate and desirable to use measures that specifically apply to the hospital outpatient setting. In other words, we do not believe that we should simply, without further analysis, adopt the IPPS RHQDAPU program measures as the measures for the HOP QDRP. Nonetheless, we note that section 1833(t)(17)(C)(ii) of the Act allows the Secretary to ''[select] measures that are the same as (or a subset of) the measures for which data are required to be submitted'' under the IPPS RHQDAPU program. We invite comment on whether we should select for the HOP QDRP some or all measures from the current RHQDAPU program measure set that apply to the outpatient setting. In the CY 2008 OPPS/ASC final rule with comment period (72 FR 66860), we established a separate reporting program, and adopted quality measures that were deemed appropriate for measuring hospital outpatient quality of care that reflected consensus among affected parties, and were set forth by one or more national consensus building entities.

2. Reporting ASC Quality Data for Annual Payment Update

Section 109(b) of the MIEA–TRHCA amended section 1833(i) of the Act by adding new sections 1833(i)(2)(D)(iv) and 1833(i)(7) to the Act. These amendments may affect ASC payments for services furnished in ASC settings on or after January 1, 2009. Section 1833(i)(2)(D)(iv) of the Act authorizes the Secretary to implement the revised payment system for services furnished in ASCs (established under section 1833(i)(2)(D) of the Act), ''so as to provide for a reduction in any annual payment increase for failure to report on quality measures * * *.''

Section 1833(i)(7)(A) of the Act authorizes the Secretary to provide that any ASC that fails to report data required for the quality measures selected by the Secretary in the form and manner required by the Secretary under section 1833(i)(7) of the Act will incur a reduction in any annual payment update of 2.0 percentage points. Section 1833(i)(7)(A) of the Act also specifies that a reduction for one year cannot be taken into account in computing the ASC update for a subsequent calendar year.

Section 1833(i)(7)(B) of the Act provides that, ''except as the Secretary may otherwise provide,'' the hospital outpatient quality data provisions of section 1833(t)(17)(B) through (E) of the Act, summarized above, shall apply to ASCs. We did not implement an ASC quality reporting program for CY 2008 (72 FR 66875).

We refer readers to section XVI.H. of this proposed rule for a discussion of our proposal to implement ASC quality data reporting in a later rulemaking.

B. Hospital Outpatient Quality Measures for CY 2009

For the CY 2009 annual payment update, we required HOP QDRP reporting using 7 quality measures—5 Emergency Department measures plus 2 Perioperative Care measures. These measures address care provided to a large number of adult patients in hospital outpatient settings, across a diverse set of conditions, and were selected for the initial set of HOP QDRP measures based on their relevance as a set to all hospital outpatient departments.

The five Emergency Department measures capture the quality of outpatient care in hospital emergency departments (EDs), specifically for those adult patients with acute myocardial infarction (AMI) who are treated and then transferred to another facility for further care. These patients receive many of the same interventions as patients who are evaluated and admitted at the same facility. Three of these five measures are currently reported under the IPPS RHQDAPU program, and are published on the Hospital Compare Web site at: *http://www.HospitalCompare.hhs.gov*. Transferred AMI patients are currently not included in the calculation of the inpatient AMI measures because of differences in data collection and reporting for this patient group. The processes of care encompassed by these measures address care on arrival, the promptness of interventions, and discharge care for patients presenting to a hospital with an AMI.

In addition to the five ED-AMI measures, we required reporting of two measures related to surgical care improvement. These two surgical care improvement measures derived from the Physician Quality Reporting Initiative (PQRI) are directly related to interventions provided in the outpatient setting.

Specifically, in order for hospitals to receive the full OPPS payment update for services furnished in CY 2009, in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66860) we required that subsection (d) hospitals paid under the OPPS submit data on the following 7 measures as designated below, effective with hospital outpatient services furnished on or after April 1, 2008:

QUALITY MEASURE
ED–AMI–1—Aspirin at Arrival.
ED–AMI–2—Median Time to Fibrinolysis.
ED–AMI–3—Fibrinolytic Therapy Received within 30 Minutes of Arrival.
ED–AMI–4—Median Time to Electrocardiogram (ECG).
ED–AMI–5: Median Time to Transfer for Primary PCI.
PQRI #20: Perioperative Care: Timing of Antibiotic Prophylaxis.
PQRI #21: Perioperative Care: Selection of Perioperative Antibiotic.

C. Proposed Quality Measures for CY 2010 and Subsequent Calendar Years and Proposed Process to Update Measures

1. Proposed Quality Measures for CY 2010 Payment Determinations

For CY 2010, we are proposing to require continued submission of data on the existing 7 measures discussed above and to adopt 4 imaging measures. We propose to designate the existing 7 measures as follows:

CY 2009 QUALITY MEASURES WITH PROPOSED CY 2010 DESIGNATIONS

Current designation	Proposed quality measure designation
ED–AMI–2	OP–1: Median Time to Fibrinolysis.
ED–AMI–3	OP–2: Fibrinolytic Therapy Received Within 30 Minutes.
ED–AMI–5	OP–3: Median Time to Transfer to Another Facility for Acute Coronary Intervention.
ED–AMI–1	OP–4: Aspirin at Arrival.
ED–AMI–4	OP–5: Median Time to ECG.
PQRI #20	OP–6: Timing of Antibiotic Prophylaxis.
PQRI #21	OP–7: Prophylactic Antibiotic Selection for Surgical Patients.

The 4 imaging measures that we are proposing to adopt beginning with the CY 2010 payment determination are claims-based measures that CMS can calculate using Medicare Part B claims data without imposing on hospitals the burden of additional chart abstraction. For purposes of the CY 2010 payment determination, CMS will calculate these measures using CY 2008 Medicare administrative claims data.

The proposed imaging measures are based on clinical evidence that, we believe, promote efficient and high quality patient care. MedPAC has expressed concern about potential overuse of imaging services based upon the rapid growth in the volume of usage over the last 5 years. Because of growing concerns regarding overuse of imaging services, CMS has developed and is now proposing 4 imaging measures which measure high quality, efficient use of services for the outpatient setting. Efficiency has been identified as an important area of development by the Institute of Medicine (IOM).

PROPOSED ADDITIONAL QUALITY MEASURES FOR CY 2010

Topic	Measure
Imaging Efficiency	OP–8: MRI Lumbar Spine for Low Back Pain. OP–9: Mammography Follow-up Rates. OP–10: Abdomen CT—Use of Contrast Material: • OP–10: CT Abdomen—Use of Contrast Material. • OP–10a: CT Abdomen—Use of Contrast Material excluding calculi of the kidneys, ureter, and/or urinary tract. • OP–10b: CT Abdomen—Use of Contrast Material for diagnosis of calculi in the kidneys, ureter, and/or urinary tract. OP–11: Thorax CT—Use of Contrast Material.

We invite public comment on these 4 proposed imaging measures which have been submitted to the NQF for consideration. The NQF is one example of a voluntary consensus building entity, thus, meeting the requirement to include measures set forth by one or more such entities for use in HOP QDRP reporting as stipulated in section 1833(t)(17)(C)(i) of the Act.

While we are required under section 1833(t)(17)(C)(i) of the Act to develop measures appropriate for the measurement of the quality of care furnished by hospitals in hospital outpatient settings, it is also our intent to consider, when developing these measures, whether they can be ''harmonized'' with measures that can be or are already adopted in the context of comparable inpatient and ambulatory care. In other words, it is CMS' intent to harmonize measures that assess the care that is given across settings and providers and to use the same measure specifications based on clinical evidence and guidelines for the care being assessed regardless of provider and setting. The goal of harmonization is to assure that comparable care in different settings can be evaluated in similar ways, which further assures that quality measurement can focus more on the needs of a patient with a particular condition than on the specific program or policy attributes of the setting in which the care is provided.

2. Proposed Process for Updating Measures

Although we adopt measures through the rulemaking process, we are proposing to establish a sub-regulatory process that will allow us to update the technical specifications that we use to calculate those measures when we believe such updates are warranted based on scientific evidence and guidance from a consensus building entity such as the NQF. We believe that the establishment of such a sub-regulatory process is necessary so that the HOP QDRP measures are calculated based on the most up-to-date scientific and consensus standards. We also recognize that neither scientific advances nor updates to measure

specifications made by a consensus building entity are linked to the timing of regulatory actions. An example of changes that would prompt us to update a measure would be a change in antibiotic selection and/or timing (see measures with proposed designations of OP–6 and OP–7) based on updated clinical guidelines or best practices.

Therefore, we are proposing that when a consensus building entity such as the NQF updates the measure specifications for a measure that we have adopted for the HOP QDRP program, we will update our measure specifications for that measure accordingly. We will provide notification of the measure specification updates on the QualityNet Web site, *http://www.qualitynet.org,* and in the CMS Hospital Outpatient Quality Measures Specifications Manual (Specifications Manual) no less than three months before any changes become effective for purposes of reporting under the HOP QDRP. We are inviting public comments on this proposal.

3. Possible New Quality Measures for CY 2011 and Subsequent Calendar Years

We are seeking comment on possible new quality measures for CY 2011 and subsequent calendar years. The following table contains a list of 18 measures included within 9 measure sets from which additional quality measures could be selected for inclusion in the HOP QDRP. This table includes measures and measure sets that are part of clinical topics for which we currently do not require quality measure data reporting, such as cancer. We note that we sought comment on some of these measures in the CY 2008 OPPS/ASC proposed rule. We are seeking public comment on the measures and measure sets that are listed below as well as on any possible critical gaps or missing measures or measure sets. We specifically request input concerning the following:

- Which of the measures or measure sets should be included in the HOP QDRP for CY 2011 or subsequent calendar years?
- What challenges for data collection and reporting are posed by the identified measures and measure sets?
- What improvements could be made to data collection or reporting that might offset or otherwise address those challenges?

We are soliciting public comment on the following measure sets and measures for consideration in CY 2011 and subsequent calendar years.

MEASURES UNDER CONSIDERATION FOR CY 2011 AND SUBSEQUENT CALENDAR YEARS

Topic	Measure
Cancer	1. Radiation Therapy is Administered within 1 Year of Diagnosis for Women Under Age 70 Receiving Breast Conserving Surgery for Breast Cancer.*
	2. Adjuvant Chemotherapy is Considered or Administered within 4 Months of Surgery to Patients Under Age 80 with AJCC III Colon Cancer.*
	3. Adjuvant Hormonal Therapy for Patients with Breast Cancer.*
	4. Needle Biopsy to Establish Diagnosis of Cancer Precedes Surgical Excision/Resection.*
ED Throughput	5. Median Time from ED Arrival to ED Departure for Discharged ED Patients.
Diabetes	6. Low Density Lipoprotein Control in Type 1 or 2 Diabetes Mellitus.*
	7. High Blood Pressure Control in Type 1 or 2 Diabetes Mellitus.*
Falls	8. Screening for Fall Risk.*
Depression	9. Antidepressant Medication During Acute Phase for Patients with New Episode of Major Depression.*
Stroke & Rehabilitation	10. Computed Tomography (CT) or Magnetic Resonance Imaging (MRI) Reports.*
	11. Carotid Imaging Reports.*
Osteo	12. Communication with the Physician Managing Ongoing Care Post Fracture.*
	13. Screening or Therapy for Women Aged 65 Years and Older.*
	14. Pharmacologic Therapy.*
	15. Management Following a Fracture.*
Medication Reconciliation	16. Medication Reconciliation.*
Respiratory	17. Asthma Pharmacological Therapy.*
	18. Assessment of Mental Status for Community Acquired Pneumonia.*

*One of the 30 measures included as ''under consideration'' in the CY 2008 OPPS/ASC proposed rule.

We welcome suggestions regarding other additional measures and topics relevant to the hospital outpatient setting that we could use to further develop the measure set, and are particularly interested in receiving comments on potential HOP QDRP measures that could be used to measure the quality of care in other settings (such as hospital inpatient, physician office, and emergency care settings) and, thus, contribute to improved coordination and harmonization of high quality patient care.

D. Proposed Payment Reduction for Hospitals That Fail To Meet the HOP QDRP Requirements for the CY 2009 Payment Update

1. Background

Section 1833(t)(17)(A) of the Act, which applies to hospitals as defined under section 1886(d)(1)(B) of the Act, requires that hospitals that fail to report data required for the quality measures selected by the Secretary, in the form and manner required by the Secretary under section 1833(t)(17)(B) of the Act, incur a 2.0 percentage point reduction to their OPD fee schedule increase factor, that is, the annual payment update factor. Section 1833(t)(17)(A)(ii) of the Act specifies that any reduction would apply only to the payment year involved and would not be taken into account in computing the applicable OPD fee schedule increase factor for a subsequent payment year.

This section discusses how the proposed payment reduction for failure to meet the administrative, data collection and submission requirements of the HOP QDRP will affect the CY 2009 payment update applicable to OPPS payments for HOPD services furnished by the hospitals defined under section 1886(d)(1)(B) of the Act to which the program applies. The application of a reduced OPD fee schedule increase factor results in reduced national unadjusted payment rates that will apply to certain outpatient items and services provided

by hospitals that are required to report outpatient quality data and that fail to meet the HOP QDRP requirements. All other hospitals paid under the CY 2009 OPPS will receive the full OPPS payment update without the reduction.

2. Proposed Reduction of OPPS Payments for Hospitals That Fail To Meet the HOP QDRP CY 2009 Payment Update Requirements

a. Calculation of Reduced National Unadjusted Payment Rates

The national unadjusted payment rates for many services paid under the OPPS equal the product of the OPPS conversion factor and the scaled relative weight for the APC to which the service is assigned. The OPPS conversion factor is updated annually by the OPD fee schedule increase factor. The conversion factor is used to calculate the OPPS payment rate for services with the following status indicators (listed in Addendum B to this proposed rule): ''P,'' ''Q1,'' ''Q2,'' ''Q3,'' ''R,'' ''S,'' ''T,'' ''U,'' ''V,'' or ''X.'' We are proposing that payment for all services assigned the status indicators listed above would be subject to the reduction of the national unadjusted payment rates for applicable hospitals, with the exception of services assigned to New Technology APCs. While services assigned to New Technology APCs, specifically APCs 1491 (New Technology-Level IA ($0–$10)) through 1574 (New Technology-Level XXXVII ($9,500–$10,000)), are assigned status indicator ''S'' or ''T,'' the payment rates for New Technology APCs are set at the mid-point of a cost band increment, rather than based on the product of the OPPS conversion factor and relative payment weight. Therefore, we are proposing to exclude services assigned to New Technology APCs from the list of services that are subject to the reduced national unadjusted payment rates because the OPD fee schedule increase factor is not used to update the payment rates for these APCs.

The conversion factor is also not used to calculate the OPPS payment rates for separately payable services that are assigned status indicators other than status indicators ''P,'' ''Q1,'' ''Q2,'' ''Q3,'' ''R,'' ''S,'' ''T,'' ''U,'' ''V,'' or ''X.'' These services include separately payable drugs and biologicals, separately payable therapeutic radiopharmaceuticals, pass-through drugs and devices that are paid at charges adjusted to cost, and a few other specific services that receive cost-based payment. As a result, we are also proposing that the OPPS payment rates for these services would not be reduced because the payment rates for these services are not calculated using the conversion factor and, therefore, the payment rates for these services are not updated by the OPD fee schedule increase factor.

The OPD fee schedule increase factor, or market basket update, is an input into the OPPS conversion factor, which is used to calculate OPPS payment rates. To implement the requirement to reduce the market basket update for hospitals that fail to meet reporting requirements, we are proposing that, effective for services paid under the CY 2009 OPPS, CMS would calculate two conversion factors: A full market basket conversion factor (that is, the full conversion factor) and a reduced market basket conversion factor (that is, the reduced conversion factor). It is necessary to calculate a reduced market basket conversion factor for hospitals that fail to meet reporting requirements as section 1833(t)(17)(A)(i) of the Act requires a reduction of 2.0 percentage points from the market basket update for those hospitals. (We implemented this statutory requirement in regulations at 42 CFR 419.43(h).) For a complete discussion of the calculation of the OPPS conversion factor, we refer readers to section II.B. of this proposed rule. Therefore, we are proposing to calculate a reduction ratio by dividing the reduced conversion factor by the full conversion factor. We refer to this reduction ratio as the ''reporting ratio'' to indicate that it applies to payment for hospitals that fail to meet their reporting requirements. Beginning January 1, 2009, the PRICER will calculate reduced national unadjusted payment rates that will be used as a basis for paying hospitals that fail to meet the requirements of the HOP QDRP by multiplying the national unadjusted payment rates by the reporting ratio. This will result in reduced national unadjusted payment rates that are mathematically equivalent to the reduced national unadjusted payment rates that would result if we multiplied the scaled OPPS relative weights by the reduced conversion factor. For CY 2009, we are proposing a reporting ratio of 0.981, calculated by dividing the reduced conversion factor of $64.409 by the full conversion factor of $65.684. As stated above, the use of the reporting ratio is mathematically equivalent to the creation and application of a reduced conversion factor to the OPPS payment weights.

To determine the proposed reduced national unadjusted payment rates that would apply to hospitals that fail to meet their quality reporting requirements for the CY 2009 OPPS, we would multiply the proposed full national unadjusted payment rate in Addendum B to this proposed rule by the proposed reporting ratio of 0.981. For example, CPT code 11401 (Excision, benign lesion including margins, except skin tag (unless listed elsewhere) trunk, arms or legs; excised diameter 0.6 to 1.0 cm), is assigned to APC 0019, with a proposed national unadjusted payment rate of $288.20. Where a hospital fails to meet the requirements of the HOP QDRP for the CY 2009 payment update, the reduced national unadjusted payment rate for that hospital would be $282.72 (the reporting ratio of 0.981 multiplied by the full national unadjusted payment rate for CPT code 11401).

b. Calculation of Reduced Minimum Unadjusted and National Unadjusted Beneficiary Copayments

Under the OPPS, we have two levels of Medicare beneficiary copayment for many services: the minimum unadjusted copayment and the national unadjusted copayment. The minimum unadjusted copayment is always 20 percent of the national unadjusted payment rate for each separately payable service. The national unadjusted copayment is determined based on the historic coinsurance rate for the services assigned to the APC. Where the national unadjusted copayment is blank for an item or service listed in Addendum B to this proposed rule, the national unadjusted copayment is equal to the minimum unadjusted copayment. In general, under our longstanding copayment policy, the coinsurance percentage (the ratio of the copayment to the service payment) for a particular service may decline over time to a minimum of 20 percent but will never increase. This is consistent with the statute's intent that eventually all services paid under the OPPS would be subject to a 20 percent coinsurance percentage. We refer readers to section 1833(t)(3)(B)(ii) of the Act for the specific statutory language. For additional background on the standard OPPS copayment calculation, we refer readers to the CY 2004 OPPS final rule with comment period (68 FR 63458 through 63459).

For hospitals that receive the reduced OPPS payment for failure to meet the HOP QDRP requirements, we believe that it is both equitable and appropriate that a reduction in the payment for a service should result in proportionately reduced copayment liability for beneficiaries. Similarly, we believe that it would be inequitable to the beneficiary and in conflict with the intent of the law (section 1833(t)(3)(B)(ii) of the Act) and our longstanding policy (68 FR 63458

through 63459) if the coinsurance percentage of the total payment for certain OPPS services to which reduced national unadjusted payment rates apply was to increase as a result of using the reduced conversion factor to calculate these reduced national unadjusted payment rates. Therefore, we are proposing that the Medicare beneficiary's minimum unadjusted copayment and national unadjusted copayment for a service to which a reduced national unadjusted payment rate applies would each equal the product of the reporting ratio and the national unadjusted copayment or the minimum unadjusted copayment, as applicable, for the service, under the authority of section 1833(t)(2)(E) of the Act, which authorizes the Secretary to ''establish, in a budget neutral manner, * * * adjustments as determined to be necessary to ensure equitable payments'' under the OPPS.

We considered calculating the national unadjusted copayments and the minimum unadjusted copayments based on the reduced national unadjusted payment rates, using our standard copayment methodology. We found that in many cases the beneficiary's copayment amount would remain the same as calculated based on the full national unadjusted payment rate, although the total reduced national unadjusted payment rate would decline because of the reduction to the conversion factor. Therefore, in these cases, the ratio of the copayment to the total payment (the coinsurance percentage) would increase rather than decrease if we were to calculate copayments based on the reduced national unadjusted payment rates. For example, in the case of APC 0019 (Level I Excision/Biopsy), the full national unadjusted payment rate for CY 2008 is $274.13 and the national unadjusted copayment is $71.87 or 26 percent of the full national unadjusted payment rate for the APC. If the reduction were in effect for CY 2008, the reduced national unadjusted payment rate would be $268.65, but the national unadjusted copayment, if calculated under the standard rules, would continue to be $71.87, which represents 27 percent of the reduced national unadjusted payment rate. We believe that the increased coinsurance percentage that results from this methodology is contradictory to the intent of the statute that the coinsurance percentage would never increase and is also contradictory to our copayment rules that are intended to gradually reduce the percentage of the payment attributed to copayments until the national unadjusted copayment is equal to the minimum unadjusted copayment for all services.

To avoid this inconsistent result, we are proposing to apply the reporting ratio to the national unadjusted copayment and the minimum unadjusted copayment to calculate the national unadjusted copayments that would apply to each APC for hospitals that receive the reduced CY 2009 OPPS payment update. This application of the reporting ratio would be to the national unadjusted and minimum unadjusted copayments as calculated according to § 419.41, prior to any adjustment for hospitals' failure to meet the quality reporting standards according to § 419.43(h). Beneficiaries and secondary payers would thereby share in the reduction of payments to these hospitals. We believe that applying this copayment calculation methodology for those hospitals that fail to meet the HOP QDRP requirements allows us to appropriately set the national unadjusted copayments for the reduced OPPS national unadjusted payment rates and is most consistent with the eventual establishment of 20 percent of the payment rate as the uniform coinsurance percentage for all services under the OPPS. We are proposing to make changes to §§ 419.41, 419.42, and 419.43 in this proposed rule to reflect this policy.

c. Treatment of Other Payment Adjustments

We are proposing that all other applicable adjustments to the OPPS national unadjusted payment rates would apply in those cases when the OPD fee schedule increase factor is reduced for hospitals that fail to meet the requirements of the HOP QDRP. For example, the following standard adjustments would apply to the reduced national unadjusted payment rates: The wage index adjustment, the multiple procedure adjustment, the interrupted procedure adjustment, the rural sole community hospital adjustment, and the adjustment for devices furnished with full or partial credit or without cost. We believe that these adjustments continue to be equally applicable to payments for hospitals that do not meet the HOP QDRP requirements.

Similarly, we are proposing that outlier payments would continue to be made when the criteria are met. For hospitals that fail to meet the quality data reporting requirements, we are proposing that the hospitals' costs would be compared to the reduced payments for purposes of outlier eligibility and payment calculation. We believe no changes in the regulation text would be necessary to implement this policy because using the reduced payment for these outlier eligibility and payment calculations is contemplated in the current regulations at § 419.43(d). This proposal conforms to current practice under the IPPS in this regard. Specifically, under the IPPS, for purposes of determining the hospital's eligibility for outlier payments, the hospital's estimated operating costs for a discharge are compared to the outlier cost threshold based on the hospital's actual DRG payment for the case. For a complete discussion of the OPPS outlier calculation and eligibility criteria, we refer readers to section II.F. of this proposed rule.

E. Requirements for HOP Quality Data Reporting for CY 2010 and Subsequent Calendar Years

In the CY 2008 OPPS/ASC final rule with comment period (72 FR 66869), we stated that in order to participate in the HOP QDRP for CY 2009 and subsequent calendar years, hospitals must meet administrative, data collection and submission, and data validation requirements. Hospitals that do not meet the requirements of the HOP QDRP, as well as hospitals not participating in the program and hospitals that withdraw from the program, will not receive the full OPPS payment rate update. Instead, in accordance with section 1833(t)(17)(A) of the Act, those hospitals would receive a reduction of 2.0 percentage points in their updates for the affected payment year.

For payment determinations affecting the CY 2010 payment update, we are proposing to implement the requirements listed below. Most of these requirements are the same as the requirements we implemented for the CY 2009 payment determination.

1. Administrative Requirements

To participate in the HOP QDRP, several administrative steps must be completed. These steps require the hospital to:

- Identify a QualityNet administrator who follows the registration process and submits the information to the appropriate CMS designated contractor. All CMS designated contractors will be identified on the QualityNet Web site. The same person may be the QualityNet administrator for both the IPPS RHQDAPU program and the OPPS HOP QDRP. This designation must be kept current and must be done, regardless of whether the hospital submits data directly to the CMS designated contractor or uses a vendor for transmission of data.

• Register with QualityNet regardless of the method used for data submission.

• Complete the Notice of Participation form if one has not been completed or if a hospital has previously submitted a withdrawal form. We remind hospitals that they do not need to submit another Notice of Participation form if they have already done so and they have not withdrawn from participation. At this time, the participation form for the HOP QDRP is separate from the IPPS RHQDAPU program and completing a Notice of Participation form for each program is required. Agreeing to participate includes acknowledging that the data submitted to the CMS designated contractor will be submitted to CMS and may also be shared with a different CMS contractor or contractors supporting the implementation of the HOP QDRP program. For HOP QDRP decisions affecting CY 2010 payment determinations, hospitals that share the same Medicare Provider Number (MPN), now known as the CMS Certification Number (CCN) must complete a single Notice of Participation form.

Hospitals with a newly acquired CCN and hospitals that are not participating in the CY 2009 HOP QDRP must send a completed paper copy of the Notice of Participation form to the appropriate CMS designated contractor in order to participate in the CY 2010 HOP QDRP. Hospitals with a newly acquired CCN must submit a Notice of Participation form no later than 30 days after receiving their new provider CCN. Hospitals that did not participate or withdrew from participation in the CY 2009 HOP QDRP must submit a Notice of Participation form by January 31, 2009 in order to participate in the CY 2010 HOP QDRP. We are proposing for CY 2011 to implement an on-line registration form and eliminate the paper form. We invite public comment on this proposed change.

Hospitals with newly acquired CCNs, as well as hospitals that are not participating in the CY 2009 HOP QDRP, that do not properly submit a Notice of Participation form for CY 2010 as described above will be deemed as non-participatory, will not be able to submit data to the OPPS Clinical Warehouse, and will be deemed as not meeting reporting requirements under the HOP QDRP for CY 2010. Hospitals that have previously completed a Notice of Participation form and subsequently wish to terminate participation in the HOP QDRP must submit a withdrawal form.

2. Data Collection and Submission Requirements

We are proposing that, to be eligible for the full OPPS payment update in CY 2010, hospitals must:

• Collect data required for the CY 2010 measure set that will be finalized in the CY 2009 OPPS/ASC final rule and that will be published and maintained in the Specifications Manual that can be found at: *http://www.qualitynet.org.* It will not be necessary to submit data for all eligible cases for some measures if sufficient eligible case thresholds are met. Instead, for those measures where a hospital has a sufficiently large number of cases, the hospital will be allowed to sample cases and submit data for these sampled cases rather than submitting data from all eligible cases. This sampling scheme will be set out in the Specifications Manual at least 4 months in advance of required data collection.

In addition, in order to reduce the burden on hospitals that treat a low number of patients who meet the submission requirements for a particular quality measure, we are proposing that beginning with services furnished on or after January 1, 2009, hospitals that have five or fewer claims (both Medicare and non-Medicare) for any measure included in a measure topic in a quarter will not be required to submit patient level data for the entire measure topic for that quarter. However, the hospital would still be required to submit its aggregate measure population and sample size counts for the applicable measure topic as part of its quarterly data submission.

• Submit the data according to the data submission schedule that will be available on the QualityNet Web site. HOP QDRP data will continue to be submitted through the QualityNet secure Web site (*https://www.qualitynet.org*). This Web site meets or exceeds all current Health Insurance Portability and Accountability Act requirements. Submission deadlines will be four months after the last day of each calendar quarter for measures finalized in the CY 2009 OPPS/ASC final rule. Thus, for example, the submission deadline for data for services occurring during the first calendar quarter of 2009 (January–March 2009) will be August 1, 2009, and the submission deadline for the second calendar quarter of 2009 (April–June 2009) will be November 1, 2009.

• Submit data to the OPPS Clinical Warehouse using either the CMS Abstraction and Reporting Tool for Outpatient Department measures (CART–OPD) or the tool of a third-party vendor that meets the measure specification requirements for data transmission to QualityNet.

Hospitals must submit quality data through the QualityNet Web site to the OPPS Clinical Warehouse; a CMS-designated contractor will submit OPPS Clinical Warehouse data to CMS. Under current implementation, OPPS Clinical Warehouse data are not considered QIO data. However, it is possible that the information in the OPPS Clinical Warehouse may at some point be considered QIO information. If this occurs, OPPS Clinical Warehouse data may become subject to the stringent QIO confidentiality regulations in 42 CFR part 480.

Hospitals are to submit data under the HOP QDRP on outpatient episodes of care to which the required measures apply. For the purposes of the HOP QDRP, an outpatient episode of care is defined as care provided to a patient who has not been admitted as an inpatient but who is registered on the hospital's medical records as an outpatient and receives services (rather than supplies alone) directly from the hospital. Every effort will be made to assure that data elements common to both inpatient and outpatient settings are defined consistently (such as ''time of arrival'').

To be accepted by the CMS designated contractor, submissions would, at a minimum, need to be timely, complete, and accurate. Data are considered to have been ''timely'' when data are submitted prior to the reporting deadline and have passed all CMS designated contractor edits. A ''complete'' submission is determined based on sampling criteria that will be published and maintained in the Specifications Manual to be found on the Web site at *http://www.qualitynet.org*, and must correspond to both the aggregate number of cases submitted by a hospital and the number of Medicare claims it submits for payment. To be considered ''accurate,'' submissions must pass validation, if applicable.

• Submit the aggregate numbers of outpatient episodes of care which are eligible for submission under the HOP QDRP. These aggregated numbers of outpatient episodes would represent the number of outpatient episodes of care in the universe eligible for data reporting under the HOP QDRP. We plan to use the aggregate population and sample size data to assess data submission completeness and adherence to sampling requirements for Medicare and non-Medicare patients.

3. HOP QDRP Validation Requirements

a. Proposed Data Validation Requirements for CY 2010

Validation, as discussed in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66871), is intended to provide assurance of the accuracy of the hospital abstracted data. A data validation requirement was not implemented for purposes of the CY 2009 annual payment update. We are now proposing to implement validation requirements that will apply beginning with the CY 2010 payment determinations.

Specifically, we propose to randomly select per year, 50 patient episodes of care that a hospital successfully submitted to the OPPS Clinical Warehouse for the relevant time period and validate those data by requesting that the hospital send the supporting medical record documentation that corresponds to each selected episode to a CMS contractor within 30 calendar days of the date of the request. The CMS contractor will then independently reabstract quality measure data elements from those records, compare the reabstracted data to the data originally submitted by the hospital, and provide feedback to each hospital on the results of the reabstraction.

We propose to validate data reported beginning with January 2009 episodes of care to be used toward CY 2010 payment determinations.

Unlike the IPPS RHQDAPU program, where we validate data for each participating hospital each quarter (for a total of 20 cases per year), we are proposing not to validate data submitted by every hospital participating in the HOP QDRP every year. Instead, we are proposing to validate data from 800 randomly selected hospitals (approximately 20 percent of all participating HOP QDRP hospitals) each year. In other words, only 800 participating HOP QDRP hospitals will have their data validated each year. However, we note that because the 800 hospitals will be selected randomly, every HOP QDRP participating hospital will be eligible each year for validation selection. We believe that the approach of validating a larger number of cases per hospital will produce a more reliable estimate of whether that hospital's data has been submitted accurately and will provide more reliable estimates of measure level data.

For calculation of a hospital's validation score, we propose that percent agreement for each calculated clinical measure rather than for the individual data elements would be calculated. Due to the contingent nature of data elements comprising quality measures, a mismatch of a few data elements can result in the elimination of subsequent data elements from the data abstraction process. Thus, while the quality measure calculation can match, a low validation score based upon level of data element match can occur. Calculating match rates at the quality measure level obviates the issue of low validation scores at the data element level and also validates the data as they are publicly reported, that is, at the measure level.

To receive the full OPPS payment rate update, the hospital must pass our validation requirement of a minimum of 80 percent reliability, based upon our validation process, for the designated time periods. In addition, an upper bound of 95 percent confidence interval to measure accuracy will be used.

The methodology to be used for calculating the confidence intervals under the HOP QDRP will be the methodology currently utilized for the IPPS RHQDAPU program. We anticipate estimating the percent reliability based upon a review of submitted documentation and then calculating the upper 95 percent confidence limit for that estimate. If that upper limit is above the required 80 percent reliability threshold, we will consider the hospital's data ''validated'' for payment update purposes for CY 2010. We intend to use the design specific estimate of the variance for the confidence interval calculation, which, in this case, is a single stage cluster sample, with unequal cluster sizes. (For reference, see Cochran, William G. (1977) Sampling Techniques, John Wiley & Sons, New York, chapter 3, section 3.12.) Each sampled medical record is considered as a cluster for variance estimation purposes, as documentation and abstraction errors are believed to be clustered within specific medical records.

We solicit comment on this validation methodology, and believe that this approach is a reliable process that is suitable for the HOP QDRP. We also note that we are considering whether to propose a similar approach for the RHQDAPU program in future years. CMS continues to study approaches to improve its quality data reporting program, and aligning the RHQDAPU program and HOP QDRP validation approaches in the future is one possible area of improvement.

b. Alternative Data Validation Approaches for CY 2011

We are also soliciting comments on three alternative validation methodologies. We are considering whether we could apply one of these methodologies to validate data as part of our CY 2011 payment determination. The first alternative approach would be to validate data from all participating HOP QDRP hospitals, as is currently done under the RHQDAPU program. Under this approach, data validation would be done on a random sample of 5 records per quarter (20 records per year) per hospital.

A second alternative approach would be to select targeted hospitals based on criteria designed to measure whether the data being reported by them raises a concern regarding their accuracy. We welcome suggestions for criteria to be used for targeting hospitals for validation. Either percent agreement at the clinical measure level or the data element level (currently used for the RHQDAPU program) could be calculated for the validation score. Because few data have been collected under the HOP QDRP at this point, we are considering this approach for possible use in future years.

A third alternative approach would involve some combination of the two approaches discussed above.

F. Publication of HOP QDRP Data

Section 1833(t)(17)(E) of the Act requires that the Secretary establish procedures to make data collected under this program available to the public and to report quality measures of process, structure, outcome, patients' perspectives of care, efficiency, and costs of care that relate to services furnished in outpatient settings in hospitals on the CMS Web site. We intend to make the information collected under the HOP QDRP public in CY 2010 by posting it on the CMS Web site. Participating hospitals will be granted the opportunity to review this information as we have recorded it before the information is published.

CMS requires hospitals to sign and submit a Notice of Participation form in order to participate in the HOP QDRP. Hospitals signing this form agree that they will allow CMS to publicly report the quality measures as required by the HOP QDRP.

All hospitals have a unique CCN, whereas a single hospital may have multiple National Provider Identifiers (NPI), another CMS identifier. We propose for CY 2010 that hospitals sharing the same CCN must combine data collection and submission across their multiple campuses for all clinical measures for public reporting purposes. We also propose to publish quality data by CCN under the HOP QDRP; however, we will note on our Web site where the publicly reported measures combine

results from two or more hospitals. This approach is consistent with the approach taken under the IPPS RHQDAPU program.

G. Proposed HOP QDRP Reconsideration and Appeals Procedures

When the IPPS RHQDAPU program was initially implemented, it did not include a reconsideration submission process for hospitals. Subsequently, we received many requests for reconsideration of those payment decisions, and as a result established a process by which participating hospitals would submit requests for reconsideration. We anticipate similar concerns with the HOP QDRP and in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66875), we stated our intent to implement for the HOP QDRP a reconsideration process modeled after the reconsideration process we implemented for the IPPS RHQDAPU program. We are therefore proposing a mandatory reconsideration and appeals process that will apply to the CY 2010 payment decisions. In order to receive reconsideration of a CY 2010 payment decision, the hospitals must—

- Submit to CMS, via QualityNet, a Reconsideration Request form that will be made available on the QualityNet Web site. This form shall contain the following information:
  - Hospital Medicare ID number known as the CCN.
  - Hospital Name.
  - CMS-identified reason for failure (as provided in any CMS notification of failure to the hospital).
  - Hospital basis for requesting reconsideration. This must identify the hospital's specific reason(s) for believing it met the HOP QDRP program requirements and should receive a full annual payment update.
  - CEO contact information, including name, e-mail address, telephone number, and mailing address (must include physical address, not just a post office box).
  - A copy of all material that the hospital submitted to CMS in order to receive the full payment update for the year that is the subject of the reconsideration request. Such material would include, but not be limited to, the applicable Notice of Participation form, quality measure data that the hospital submitted, and data that the hospital submitted in response to a validation request.
  - QualityNet System Administrator contact information, including name, e-mail address, telephone number, and mailing address (must include physical address, not just the post office box).
  - The request must be signed by the hospital's CEO.
- Following receipt of a request for reconsideration, CMS will—
  - Provide an e-mail acknowledgement, using the contact information provided in the reconsideration request, to the CEO and the QualityNet Administrator notifying them that the hospital's request has been received.
  - Provide a formal response to the hospital CEO, using the contact information provided in the reconsideration request, notifying the hospital of the outcome of the reconsideration process.

If a hospital is dissatisfied with the result of a HOP QDRP reconsideration decision, the hospital may file a claim under 42 CFR part 405, subpart R (PRRB) appeal.

H. Reporting of ASC Quality Data

As discussed above, section 109(b) of the MIEA–TRHCA amended section 1833(i) of the Act by redesignating clause (iv) as clause (v), adding section 1833(i)(2)(D)(iv) to the Act, and adding section 1833(i)(7) to the Act. These amendments authorize the Secretary to require ASCs to submit data on quality measures and to reduce the annual payment update in a year by 2.0 percentage points for ASCs that fail to do so. These provisions permit, but do not require, the Secretary to require ASCs to submit such data and to reduce any annual increase for non-compliant ASCs.

In the CY 2008 OPPS/ASC final rule with comment period, we indicated that we intended to implement the provisions of section 109(b) of the MIEA–TRHCA in a future rulemaking (72 FR 66875). While we believe that promoting high quality care in the ASC setting through quality reporting is highly desirable and fully in line with our efforts under other payment systems, we believed that the transition to the revised payment system in CY 2008 posed such a significant challenge to ASCs that it would be most appropriate to allow some experience with the revised payment system before introducing other new requirements. We believed that implementation of quality reporting in CY 2008 would require systems changes and other accommodations by ASCs, facilities which do not have prior experience with quality reporting as hospitals already have for inpatient quality measures, at a time when they are implementing a significantly revised payment system. We believed that our CY 2008 decision to implement quality reporting for HOPDs prior to establishing quality reporting for ASCs would allow time for ASCs to adjust to the changes in payment and case-mix that are anticipated under the revised payment system. We would also gain experience with quality measurement in the ambulatory setting in order to identify the most appropriate measures for quality reporting in ASCs prior to the introduction of the requirement in ASCs.

We continue to believe that promoting high quality care in the ASC setting through quality reporting is highly desirable and fully in line with our efforts under other payment systems. However, we continue to have the concerns outlined above for CY 2009 and, therefore, we intend to implement the provisions of section 109(b) of the MIEA–TRHCA in a future rulemaking. We invite public comment on this deferral of quality data reporting for ASCs and invite suggestions for quality measures geared toward the services provided by ASCs. We also seek comment on potential reporting mechanisms for ASC quality data, including electronic submission of these data.

XVII. Healthcare-Associated Conditions

A. Background

In its landmark 1999 report ''To Err is Human: Building a Safer Health System,'' the Institute of Medicine found that medical errors, particularly hospital-acquired conditions (referred to as HACs in the FY 2008 IPPS proposed and final rules and the FY 2009 IPPS proposed rule) caused by medical errors, are a leading cause of morbidity and mortality in the United States. The report noted that the number of Americans who die each year as a result of medical errors that occur in hospitals may be as high as 98,000. The cost burden of hospital-acquired conditions is also high. Total national costs of these errors due to lost productivity, disability, and health care costs were estimated at $17 billion to $29 billion.[1] In 2000, the CDC estimated that hospital-acquired infections added nearly $5 billion to U.S. health care costs every year.[2] A 2007 study found that, in 2002, 1.7 million hospital-acquired infections were associated

[1] Institute of Medicine: To Err Is Human: Building a Safer Health System, November 1999. Available at: *http://www.iom.edu/Object.File/Master/4/117/ToErr-8pager.pdf.*

[2] Centers for Disease Control and Prevention: Press Release, March 2000. Available at: *http://www.cdc.gov/od/oc/media/pressrel/r2k0306b.htm.*

with 99,000 deaths.[3] Research has also shown that hospitals are not following recommended guidelines to avoid preventable hospital-acquired infections. A 2007 Leapfrog Group survey of 1,256 hospitals found that 87 percent of those hospitals do not follow recommendations to prevent many of the most common hospital-acquired infections.[4]

As one approach to combating hospital-acquired conditions in 2005 Congress authorized CMS to adjust Medicare IPPS hospital payments to encourage the prevention of these conditions. Section 1886(d)(4)(D) of the Act (as added by section 5001(c) of the Deficit Reduction Act (DRA) of 2005, Pub. L. 109–171) required the Secretary to select by October 1, 2007, at least two conditions that are: (1) High cost, high volume, or both; (2) assigned to a higher paying DRG when present as a secondary diagnosis; and (3) could reasonably have been prevented through the application of evidence-based guidelines. Beginning October 1, 2008, Medicare cannot assign an inpatient discharge that includes the selected conditions to a higher-paying MS–DRG unless these conditions were present on admission. Beginning October 1, 2007, CMS required hospitals to begin submitting information on Medicare hospital claims specifying whether diagnoses were present on admission (POA). In the FY 2008 IPPS final rule with comment (72 FR 47202 through 47218), eight conditions were selected for the hospital-acquired conditions payment provision. In the FY 2009 IPPS proposed rule (73 FR 23547 through 23562), 10 additional conditions are proposed for the hospital-acquired conditions payment provision.

The preventable hospital-acquired conditions payment provision at section 1886(d)(4)(D) of the Act is part of an array of Medicare value-based purchasing (VBP) tools that CMS is using to promote increased quality and efficiency of care. Those tools include measuring performance, using payment incentives, publicly reporting performance results, applying national and local coverage policy decisions, enforcing conditions of participation, and providing direct support for providers through QIO activities. CMS' application of VBP tools through various initiatives is transforming Medicare from a passive payer to an active purchaser of higher-value health care services. CMS is applying these strategies across the continuum of care for Medicare beneficiaries.

B. Broadening the Concept of the IPPS Hospital-Acquired Conditions Payment Provision to the OPPS

The principle of Medicare not paying more for the preventable hospital-acquired conditions during inpatient stays paid under the IPPS could be applied more broadly to other Medicare payment systems for conditions that occur or result from care in other settings. Other potential settings of care include HOPDs, ASCs, SNFs, home health care, end-stage renal disease (ESRD) facilities, and physicians' practices; therefore, we will refer to conditions that occur in settings other than the inpatient hospital setting as ''healthcare-associated conditions.'' The implementation would be different for each setting, as each Medicare payment system is different, and the reasonable preventability through the application of evidence-based guidelines would vary for candidate conditions across the various care settings. However, alignment of incentives across settings of care is an important goal for all of CMS' VBP initiatives, including the hospital-acquired conditions payment provision.

The risks of preventable medical errors leading to the occurrence of healthcare-associated conditions is likely high in the outpatient setting, given the substantially larger number of encounters and exposures that occur in those settings. For example, studies indicate that 400,000 preventable drug-related injuries occur each year in hospitals. Roughly 530,000 preventable drug-related injuries occur each year among Medicare beneficiaries in outpatient clinics.[5] These statistics clearly point to the significant magnitude of the problem of healthcare-associated conditions in outpatient settings. Indeed, we would have no reason to believe that medical errors would be less common in the outpatient setting than the hospital inpatient setting and, as increasingly more health care services are delivered in outpatient settings, we would expect the occurrence of healthcare-associated conditions stemming from outpatient care to grow directly as a result of this shift in sites of service.

The HOPD, where a broad array of services covered and paid under the OPPS are provided, could be another setting for Medicare to extend the concept of not paying more for preventable healthcare-associated conditions that occur as a result of care provided during an encounter. Hospitals provide a range of services under the OPPS that may overlap or precede the inpatient activities of the hospital, including many surgical procedures and diagnostic tests that are commonly performed on both hospital inpatients and outpatients. Similarly, individuals who are eventually admitted as hospital inpatients often initiate their hospital encounter in the HOPD, where they receive clinic or emergency department visits or observation care that precede their ultimate hospital admission. In addition, like the IPPS, under the authority of section 1833(t)(17) of the Act (as amended by section 109(a) of the MIEA–TRHCA), the OPPS is also subject to the ''pay-for-reporting'' provision that affects the hospital annual payment update. Under this authority, hospitals report quality data for specified performance measures related to hospital outpatient services under the HOP QDRP. Hospitals that fail to meet the reporting requirements established by CMS for the payment update year receive a reduced payment update that is applicable to OPPS payments for most services furnished by hospitals in outpatient settings in the succeeding year. The HOP QDRP is further discussed in section XVI. of this proposed rule.

We note that we are not proposing new Medicare policy in this discussion of healthcare-associated conditions as they relate to the OPPS. Instead, we are seeking public comments on options and considerations, including statutory authority, related to extending the IPPS hospital-acquired conditions payment provision for hospitals to the OPPS. We understand that there would be challenges in expanding the IPPS provision to other settings paid under different Medicare payment systems, and we are seeking public comments that present ideas and models for extending the principle behind the IPPS provision to the OPPS. To stimulate reflection and creativity, we present discussion in the following areas:

- Criteria for possible candidate OPPS conditions
- Collaboration process
- Potential OPPS healthcare-associated conditions
- OPPS infrastructure and payment for encounters resulting in healthcare-associated conditions

[3] Klevens et al. Estimating Health Care-Associated Infections and Deaths in U.S. Hospitals, 2002. Public Health Reports. March–April 2007. Volume 122.

[4] 2007 Leapfrog Group Hospital Survey. The Leapfrog Group 2007. Available at: *http://www.leapfroggroup.org/media/file/Leapfrog_hospital_acquired_infections_release.pdf.*

[5] Asplen, P., Wolcott, J., Bootman, J.L., Cronenwett, L.R. (editors): Preventing Medication Errors: Quality Chasm Series, The National Academy Press, 2007. Available at: *http://www.nap.edu/catalog.php?record_id=11623.*

1. Criteria for Possible Candidate OPPS Conditions

We have applied the following statutory criteria to the analysis of candidate inpatient conditions for the IPPS hospital-acquired conditions payment provision:

- Cost or Volume—Medicare data must support that the selected inpatient conditions are high cost, high volume, or both.
- Complicating Conditions (CC) or Major Complication Conditions (MCC)—Selected inpatient conditions must be represented by ICD–9–CM diagnosis codes that clearly identify the condition, are designated as a CC or an MCC, and result in the assignment of the case to an MS–DRG that has a higher payment when the code is reported as a secondary diagnosis. That is, selected inpatient conditions must be a CC or an MCC that would, in the absence of this provision, result in assignment to a higher paying MS–DRG.
- Evidence-Based Guidelines—Selected inpatient conditions must be reasonably presentable through the application of evidence-based guidelines. By reviewing guidelines developed by professional organizations, academic institutions, and other entities such as the Healthcare Infection Control Practices Advisory Committee (HICPAC), we evaluated whether guidelines are available that hospitals should follow to prevent the condition from occurring in the hospital.
- Reasonably Preventable—Selected inpatient conditions must be reasonably preventable through the application of evidence-based guidelines.

We are seeking public comment on the applicability of these criteria to the selection of candidate healthcare-associated conditions for the OPPS. Specifically, we are interested in comments on the definition of reasonably preventable in the HOPD setting. Additionally, there are significant infrastructure differences between the IPPS and the OPPS (discussed further in section XVII.V.4. below). OPPS payment is determined by assignment of HCPCS codes for items and services to APCs that represent groups of services that share clinical and resource characteristics. APC assignments for related services are determined by the similarities between the clinical aspects of services and their hospital costs from claims data, rather than by patient-specific clinical parameters such as level of severity or comorbidities. In some cases, there are multiple related levels of APCs for specific types of services defined by distinct HCPCS codes (for examples, APCs 0203 through 0207 for Levels I, II, III, and IV Nerve Injections) based on increasing hospital resource requirements, but, in other cases, there is only a single level APC to which all related HCPCS codes are assigned (for example, APC 0283 for Computed Tomography with Contrast). As explained below in more detail, under the OPPS—unlike the IPPS—payment generally depends on the package of services provided rather than severity of illness. Thus, as higher severity of illness does not directly affect payment under the OPPS as it does under the IPPS, it is not as straightforward as not recognizing the healthcare-associated condition when determining how not to pay a hospital for its higher costs in the OPPS when a preventable adverse event occurs as a result of treatment. We are interested in public comments generally and specifically those that would help answer the following questions:

- Are there examples within the context of the reporting of ICD–9–CM codes for diagnoses and HCPCS codes for services on OPPS claims that could be used to identify where a higher payment for a hospital outpatient encounter would result from a medical error?
- Are there examples of evidence-based guidelines related to the prevention of high volume or high cost conditions, or both, that are sufficiently rigorous to permit selection of healthcare-associated conditions that could reasonably have been prevented in the HOPD setting?
- What other criteria should be considered in the selection of healthcare-associated conditions for the OPPS?

2. Collaboration Process

CMS has worked with public health and infectious disease experts from the Centers for Disease Control and Prevention (CDC) to select hospital-acquired conditions, including infections, that meet the statutory criteria under section 1886(d)(4)(D) of the Act for application in the hospital inpatient setting. CMS and CDC have also collaborated to develop the process for submission of a present on admission (POA) indicator on the inpatient claim for each diagnosis. We would expect to continue our collaboration with CDC to examine the relevance and applicability of a POA indicator in the HOPD setting, and also to utilize their expertise in chronic diseases in the selection of candidate healthcare-associated conditions for the OPPS. In addition, we would expect to seek collaboration with the Agency for Healthcare Research and Quality (AHRQ) to utilize its expertise in patient safety. We would also expect to seek collaboration with other Federal agencies and with medical specialty societies. We are soliciting public comment regarding a collaborative process for the identification of candidate healthcare-associated conditions for hospital outpatient services and a mechanism for public input from stakeholders.

3. Potential OPPS Healthcare-Associated Conditions

The FY 2008 IPPS final rule with comment period (72 FR 47202 through 47218) provides a detailed analysis supporting the hospital-acquired conditions selected for application under the IPPS for FY 2008. We believe that only a small number of the hospital-acquired conditions adopted in the FY 2008 IPPS final rule with comment period could potentially be applicable to the OPPS. These include:

- Object left in during surgery;
- Air embolism;
- Blood incompatibility; and
- Falls and trauma fractures, dislocations, intracranial injuries, crushing injuries, and burns.

The characteristics of these conditions are such that they would be relatively straightforward to incorporate in an OPPS healthcare-associated conditions payment provision. For example, these events would likely occur and be coded in the timeframe of an OPPS encounter reported on a single claim and determination of the occurrence of these events would probably not require sequential evaluation of claims over time. We are seeking public comment on the potential for considering these conditions as healthcare-associated conditions for the HOPD. Also, we are soliciting public comment on which of the hospital-acquired conditions proposed in the FY 2009 IPPS proposed rule (73 FR 23554 through 23555) might be considered for the OPPS. For reasons cited above, we believe only a small number of the proposed conditions (for example, iatrogenic pneumothorax) might be considered for the OPPS.

We understand that this short list of possible candidate conditions for the OPPS is weighted toward surgical procedures. However, surgical procedures account for a large proportion (about 33 percent) of total OPPS spending. Overall, surgical procedures, together with imaging, separately payable drugs, and clinic visits, account for approximately 80 percent of OPPS spending.

We acknowledge that reporting even this short list of healthcare-associated

conditions as a secondary diagnosis on a claim in order to attribute their occurrence to the HOPD encounter might present problems for hospitals, particularly for the conditions resulting from trauma or falls. Consequently, we are also seeking comment on whether or not we could assume that these conditions reported as secondary diagnoses on OPPS claims would have developed during the encounter or whether the reporting of POA indicator information should be required under the OPPS (and perhaps under every Medicare payment system) because POA data increase the utility of claims for analyzing the characteristics of a clinical encounter. More generally, we recognize that patients may be cared for by different providers across settings and that the provider caring for certain types of complicating conditions may not have provided the health care services that led to the healthcare-associated condition. Therefore, we welcome broad public comment on the approaches and challenges related to the appropriate attribution of different types of healthcare-associated conditions encountered in the HOPD. Ultimately, payment policy for healthcare-associated conditions under the OPPS should fully address the broad range of clinical services in the HOPD where preventable healthcare-associated conditions may harm Medicare beneficiaries. Therefore, we are seeking public comment on additional candidate conditions that could have applicability to the OPPS, beyond those mentioned above that would be extensions from the IPPS final or proposed hospital-acquired conditions. We are particularly interested in recommendations of preventable healthcare-associated conditions that are likely to occur with frequency in the HOPD (and other outpatient settings) and that may be associated with significant harm, such as adverse drug events related to medication errors or other complications of care for which we either currently have no diagnosis codes or where correct coding for such occurrences has not been clearly defined.

The CDC has been interested in further developing and expanding strategies to improve the External Cause-of-Injury coding (E-codes). A recent CDC Workgroup report discussed the importance and value of using high-quality E-coding.[6] Workgroup recommendations included enhancing the completeness and accuracy of E-coding and making E-coded data more useful for injury surveillance and prevention activities (including medical errors) at the local, State, and Federal levels. E-coding may represent a mechanism for coding clarity for preventable healthcare-associated conditions such as adverse drug events related to medication errors. In addition, we are seeking public comment on how to account for patient-specific risk factors that increase the likelihood of the occurrence of healthcare-associated conditions.

4. OPPS Infrastructure and Payment for Encounters Resulting in Healthcare-Associated Conditions

The OPPS infrastructure is a prospective payment system based on relative costs from hospital claims for services assigned to APC groups, where there is an individual payment rate that is specific to each APC. Each APC contains HCPCS codes for items or services that are clinically similar and that have comparable resource costs. In most cases, an APC payment is made for each unit of each separately payable HCPCS code through the code's assigned APC. For a single hospital outpatient clinical encounter in which a patient receives services described by several HCPCS codes with individual APC assignments (for example, emergency department visit, first hour of therapeutic intravenous infusion, chest x-ray, and electrocardiogram), the hospital would receive multiple APC payments for that encounter. This payment approach is altogether different from the MS–DRG-based IPPS, which groups the services provided to an inpatient into an assigned MS–DRG for which a single payment for the inpatient case is made. Under the MS–DRGs that took effect in FY 2008, there are currently 258 sets of MS–DRGs that are split into 2 or 3 subgroups based on the presence or absence of a CC or an MCC. (We refer readers to the FY 2008 IPPS final rule with comment period for a discussion of DRG reforms (72 FR 47141).) Prior to the October 1, 2008, effective date of the IPPS hospital-acquired conditions payment provision, if a condition acquired during a hospital stay was one of the conditions on the CC or MCC list, the hospital received a higher payment under the MS–DRGs. Beginning October 1, 2008, Medicare can no longer assign an inpatient hospital discharge to a higher paying MS–DRG if a selected hospital-acquired condition was not present on admission and no other CC or MCC that is not on the list of hospital-acquired conditions is present. That is, the case will be paid as though the secondary diagnosis (selected hospital-acquired condition) was not present, unless a nonselected secondary diagnosis that is a CC or an MCC is also present. Medicare will continue to assign a discharge to a higher paying MS–DRG if the selected condition was present on admission.

As discussed previously, the OPPS currently has neither the infrastructure to identify POA indicator data nor the ability to stratify by CC or MCC for differential payment under the present APC payment methodology. OPPS claims report an ''admitting diagnosis'' which identifies the reason for the encounter prior to the establishment of the principal diagnosis, but the admitting diagnosis cannot be presumed to be equivalent to a diagnosis that is present on admission as reported on an inpatient claim. As a consequence, initial application of a healthcare-associated conditions payment policy under the OPPS might be limited in its scope of conditions as discussed above and in its options for payment adjustment. We welcome public comment on how necessary a POA indicator would be for the candidate conditions we have identified for potential use in the OPPS setting, and on how the OPPS infrastructure could be modified to allow for the incorporation of any POA information.

We also seek recommendations regarding how hospital payment for a clinical encounter (which could include multiple individual APC payments) could be adjusted to reflect a derivative payment reduction similar to the CC/MCC MS–DRG adjustment for hospital-acquired conditions under the IPPS. Without a POA and risk stratification infrastructure for the OPPS, one approach to limiting OPPS payment for healthcare-associated conditions in the short term could be to pay for all services provided in the encounter that led to the healthcare-associated condition at the same reduced rate that would be paid to a hospital that failed to meet the quality reporting requirements. Currently, this would mean that the hospital payment for an encounter where a healthcare-associated condition resulted would be based on the OPPS conversion factor reduced by a 2 percentage point reduction to the market basket increase for the year. Alternatively, a flat case rate reduction percentage could be considered for all, or a subset, of services provided in the clinical encounter. This reduction could potentially be empirically derived from analyzing the costs of subsets of OPPS claims for Medicare beneficiaries with and without healthcare-associated conditions, or could possibly be

[6] Centers for Disease Control and Prevention: Morbidity and Mortality Weekly Report, March 28, 2008, Vol. 57, No. RR–1. Available at: *http://cdc.gov/mmwr/mmwr_rr.html.*

developed through analysis of the IPPS payment relationship between MS–DRGs with the presence or absence of a CC or an MCC. Any reduction in OPPS payment should also be applied to the 20-percent beneficiary copayment requirement for the OPPS so that the beneficiary's cost sharing (which is paid for each service furnished) would not rise as a proportion of the total Medicare payment when the payment would be reduced. In contrast to the payment limitation approach used for the IPPS, we recognize that neither of the possible payment limitation approaches discussed above would specifically target the separate OPPS payment for those additional hospital services provided as a result of the healthcare-associated condition (as opposed to the payment for the services that initially brought the beneficiary to the HOPD). We note that the current OPPS payment structure sets a single payment rate for a service based on the APC median cost from all claims for services assigned to the APC, including cases with healthcare-associated conditions as well as cases without healthcare-associated conditions. Therefore, we believe it could be appropriate to reduce the single OPPS payment through one of the general payment limitation approaches described above for the OPPS because any additional costs of encounters resulting in healthcare-associated conditions would already be included in the base OPPS payment rates for most OPPS services. We are seeking public comment on these possibilities or other ways to use or adapt the current OPPS infrastructure for purposes of implementing a healthcare-associated conditions payment provision.

A related application of the broad principle behind the IPPS hospital-acquired conditions payment provision could be accomplished through Medicare secondary payer policy by requiring the provider that failed to prevent the occurrence of a healthcare-associated condition in one setting to pay for all or part of the necessary followup care in a second setting. This would shield the Medicare program from paying for the downstream effects of a condition acquired in the first setting but treated in the second setting. This type of scenario would likely be common for certain healthcare-associated conditions related to HOPD care, given the relatively short lengths of stay for HOPD services. We are interested in public comments regarding this more general approach to extending beyond the inpatient setting the concept of not providing Medicare payment for healthcare-associated conditions, including the advantages and disadvantages of taking a payment system by payment system approach or of adopting the general principle of holding the provider that failed to prevent the occurrence of a condition in one setting responsible for payment of the followup care in any other setting.

We emphasize that we are not proposing new Medicare policy in this discussion of extending the principle behind the IPPS hospital-acquired conditions payment provision to the OPPS. Rather, we are seeking public comment on this discussion of possible healthcare-associated conditions and the challenges associated with OPPS implementation of related payment policies. We look forward to continuing to work with stakeholders to improve the quality, safety, and value of health care. We view addressing the ongoing problem of preventable healthcare-associated conditions in outpatient settings, including the HOPD, as a key VBP strategy to sharpen the focus on such improvements beyond hospital inpatient care to those settings where the majority of Medicare beneficiaries receive most of their health care services.

XVIII. Files Available to the Public Via the Internet

A. Information in Addenda Related to the Proposed CY 2009 Hospital OPPS

Addenda A and B to this proposed rule provide various data pertaining to the proposed CY 2009 payment for items and services under the OPPS. Addendum A, which includes a list of all APCs proposed to be payable under the OPPS, and Addendum B, which includes a list of all active HCPCS codes and their proposed CY 2009 OPPS payment status, are available to the public by clicking ''Hospital Outpatient Regulations and Notices'' on the CMS Web site at: *http://www.cms.hhs.gov/HospitalOutpatientPPS/*.

For the convenience of the public, we are also including on the CMS Web site a table that displays the HCPCS data in Addendum B sorted by proposed APC assignment, identified as Addendum C.

Addendum D1 defines the proposed payment status indicators that are used in Addenda A and B. Addendum D2 defines the proposed comment indicators that are used in Addendum B. Addendum E lists the proposed HCPCS codes that would only be payable as inpatient procedures and would not be payable under the OPPS. Addendum L contains the proposed out-migration wage adjustment for CY 2009. Addendum M lists the proposed HCPCS codes that would be members of a composite APC and identifies the composite APC to which they would be assigned. This addendum also identifies the status indicator for the code and a comment indicator if there is a proposed change in the code's status with regard to its membership in the composite APC. Each of the proposed HCPCS codes included in Addendum M has a single procedure payment APC, listed in Addendum B, to which it would be assigned when the criteria for assignment to the composite APC are not met. When the criteria for payment of the code through the composite APC are met, one unit of the composite APC payment is paid, thereby providing packaged payment for all services that are assigned to the composite APC according to the specific I/OCE logic that applies to the APC. We refer readers to the discussion of composite APCs in section II.A.2.e. of this proposed rule for a complete description of the composite APCs.

These addenda and other supporting OPPS data files are available on the CMS Web site at: *http://www.cms.hhs.gov/HospitalOutpatientPPS/*.

B. Information in Addenda Related to the Proposed CY 2009 ASC Payment System

Addenda AA and BB to this proposed rule provide various data pertaining to the proposed CY 2009 payment for ASC covered surgical procedures and covered ancillary services for which ASCs may receive separate payment. Addendum AA lists the proposed ASC covered surgical procedures and the proposed CY 2009 ASC payment indicators and payment rates for each procedure. Addendum BB displays the proposed ASC covered ancillary services and their proposed CY 2009 payment indicators and payment rates. All proposed relative payment weights and payment rates for CY 2009 are a result of applying the revised ASC payment system methodology established in the final rule for the revised ASC payment system published in the **Federal Register** on August 2, 2007 (72 FR 42470 through 42548) to the proposed CY 2009 OPPS and MPFS ratesetting information.

Addendum DD1 defines the proposed payment indicators that are used in Addenda AA and BB. Addendum DD2 defines the proposed comment indicators that are used in Addenda AA and BB.

Addendum EE (available only on the Internet) lists the surgical procedures that we are proposing to exclude from Medicare payment if furnished in ASCs. The excluded procedures listed in

Addendum EE are surgical procedures that would either be assigned to the OPPS inpatient list, would not be covered by Medicare, would be reported using a CPT unlisted code, or have been determined to pose a significant safety risk or are expected to require an overnight stay when performed in ASCs.

These addenda and other supporting ASC data files are included on the CMS Web site at: *http://www.cms.hhs.gov/ASCPayment/*. The MPFS data files are located at: *http://www.cms.hhs.gov/PhysicianFeeSched/*.

The links to all of the FY 2009 IPPS wage index related tables (that are proposed to be used for the CY 2009 OPPS) from the FY 2009 IPPS proposed rule (73 FR 23723 through 23886) are accessible on the CMS Web site at: *http://www.cms.hhs.gov/AcuteInpatientPPS/WIFN/list.asp#TopofPage*.

XIX. Collection of Information Requirements

A. Legislative Requirement for Solicitation of Comments

Under the Paperwork Reduction Act of 1995, we are required to provide 60-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. In order to fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 (PRA) requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

B. Associated Information Collections Not Specified in Regulatory Text

This proposed rule makes reference to one associated information collection, HOP QDRP, that is not presented in the regulatory text. The following is a discussion of this collection:

Section 419.43(h) requires hospitals, in order to qualify for the full annual update, to submit quality data to CMS, as specified by CMS. In this proposed rule, we are proposing the specific requirements related to the data that must be submitted for the update for CY 2010. The burden associated with this section is the time and effort associated with collecting and submitting the data, completing participating forms and submitting charts for chart audit validation. We estimate that there will be approximately 3,500 respondents per year.

For hospitals to collect and submit the information on the required measures, we estimate it will take 30 minutes per sampled case. Further, based on an estimated 10 percent sample size and estimated populations of 2.5 to 5 million outpatient visits per measure, we estimate a total of 1,800,000 cases per year. In addition, we estimate that completing participation forms will require approximately 4 hours per hospital per year. We expect the burden for all of these hospitals to total 914,000 hours per year.

For CY 2010, our proposed validation process requires a random sample of 800 participating hospitals to submit 50 charts on an annual basis. The burden associated with this requirement is the time and effort associated with collecting, copying, and submitting these charts. It will take approximately 20 hours per hospital to submit the 50 charts. There will be a total of approximately 40,000 charts (800 hospitals $\times$ 50 charts per hospital) submitted by the hospitals to CMS for a total burden of 16,000 hours. Therefore, the total burden for all hospitals would be 930,000 hours per year.

We have submitted a copy of this proposed rule to OMB for its review of the information collection requirements described above. These requirements are not effective until they have been approved by OMB.

C. Addresses for Submittal of Comments on ICRs

If you comment on these information collection and recordkeeping requirements, please do either of the following:

1. Submit your comments electronically as specified in the **ADDRESSES** section of this proposed rule; or

2. Mail copies to the address specified in the **ADDRESSES** section of this proposed rule and to—Office of Information and Regulatory Affairs, Office of Management and Budget, Room 10235, New Executive Office Building, Washington, DC 20503, *Attn:* Carolyn L. Raffaelli, CMS Desk Officer, CMS–1390–P, *e-mail: Carolyn_L._Raffaelli@omb.eop.gov,* Fax (202) 395–6974.

XX. Response to Comments

Because of the large number of public comments we normally receive on **Federal Register** documents, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the **DATES** section of this proposed rule, and, when we proceed with a subsequent document(s), we will respond to those comments in the preamble to that document(s).

XXI. Regulatory Impact Analysis

A. Overall Impact

We have examined the impacts of this proposed rule as required by Executive Order 12866 (September 1993, Regulatory Planning and Review), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96–354), section 1102(b) of the Social Security Act, the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4), Executive Order 13132 on Federalism, and the Congressional Review Act (5 U.S.C. 804(2)).

1. Executive Order 12866

Executive Order 12866 (as amended by Executive Order 13258) directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in any 1 year).

We estimate that the effects of the OPPS provisions that would be implemented by this proposed rule would result in expenditures exceeding $100 million in any 1 year. We estimate the total increase (from proposed changes in this proposed rule as well as enrollment, utilization, and case-mix changes) in expenditures under the OPPS for CY 2009 compared to CY 2008 to be approximately $1.8 billion.

We estimate that the proposed update to the ASC payment system for CY 2009 (such as adding nine procedures to the ASC list of covered surgical procedures and designating five additional procedures as office-based) would have no net effect on Medicare expenditures in CY 2009 compared to the level of expenditures in CY 2008. A more detailed discussion of the effects of the proposed changes to the ASC payment system for CY 2009 is provided in section XXI.C. of this proposed rule.

We estimate that this proposed rulemaking is ''economically significant'' as measured by the $100 million threshold, and hence also a major rule under the Congressional Review Act. Accordingly, we have prepared an initial Regulatory Impact Analysis that, to the best of our ability, presents the costs and benefits of the rulemaking.

2. Regulatory Flexibility Act (RFA)

The RFA requires agencies to analyze options for regulatory relief of small businesses if a rule has a significant impact on a substantial number of small entities. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small governmental jurisdictions. Most hospitals, other providers, ASCs, and other suppliers are considered to be small entities, either by being nonprofit organizations or by meeting the Small Business Administration (SBA) definition of a small business (having revenues of $31.5 million or less in any 1 year). (For details on the latest standards for health care providers, we refer readers the SBA's Web site at: *http://sba.gov/idc/groups/public/documents/sba_homepage/serv_sstd_tablepdf.pdf* (refer to the 620000 series).

For purposes of the RFA, we have determined that most hospitals and most ASCs would be considered small entities according to the SBA size standards. Individuals and States are not included in the definition of a small entity. Therefore, the Secretary has determined that this proposed rule would have a significant impact on a substantial number of small entities.

3. Small Rural Hospitals

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule 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 603 of the RFA. With the exception of hospitals located in certain New England counties, for purposes of section 1102(b) of the Act, we now define a small rural hospital as a hospital that is located outside of an urban area and has fewer than 100 beds. Section 601(g) of the Social Security Amendments of 1983 (Pub. L. 98–21) designated hospitals in certain New England counties as belonging to the adjacent urban areas. Thus, for OPPS purposes of this proposed rule, we continue to classify these hospitals as urban hospitals. We believe that the proposed changes to the OPPS in this proposed rule would affect both a substantial number of rural hospitals as well as other classes of hospitals and that the effects on some may be significant. The proposed changes to the ASC payment system for CY 2009 would have no effect on small rural hospitals.

Therefore, the Secretary has determined that this proposed rule would have a significant impact on the operations of a substantial number of small rural hospitals.

4. Unfunded Mandates

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. That threshold level is currently approximately $130 million. This proposed rule will not mandate any requirements for State, local, or tribal government, nor will it affect private sector costs.

5. Federalism

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct costs on State and local governments, preempts State law, or otherwise has Federalism implications.

We have examined the OPPS and ASC proposed provisions included in this proposed rule in accordance with Executive Order 13132, Federalism, and have determined that they would not have a substantial direct effect on State, local or tribal governments, preempt State law, or otherwise have a Federalism implication. As reflected in Table 45 below, we estimate that OPPS payments to governmental hospitals (including State and local governmental hospitals) would increase by 3.9 percent under this proposed rule. The proposed provisions related to payments to ASCs in CY 2009 would not affect payments to governmental hospitals.

B. Effects of OPPS Changes in This Proposed Rule

We are proposing to make several changes to the OPPS that are required by the statute. We are required under section 1833(t)(3)(C)(ii) of the Act to update annually the conversion factor used to determine the APC payment rates. We are also required under section 1833(t)(9)(A) of the Act to revise, not less often than annually, the wage index and other adjustments. In addition, we must review the clinical integrity of payment groups and weights at least annually. Accordingly, in this proposed rule, we are proposing to update the conversion factor and the wage index adjustment for hospital outpatient services furnished beginning January 1, 2009, as we discuss in sections II.B. and II.C., respectively, of this proposed rule. We also are proposing to revise the relative APC payment weights using claims data from January 1, 2007 through December 31, 2007 and updated cost report information. We are proposing to continue the payment adjustment for rural SCHs, including EACHs. We are proposing to remove two device categories, HCPCS code C1821 (Interspinous process distraction device (implantable)) and HCPCS code L8690 (Auditory osseointegrated device, includes all internal and external components), from pass-through payment status in CY 2009. Finally, we list the 15 drugs and biologicals in Table 20 of this proposed rule that we are proposing to remove from pass-through payment status for CY 2009.

Under this proposed rule, the proposed update change to the conversion factor as provided by statute would increase total OPPS payments by 3.0 percent in CY 2009. The proposed changes to the APC weights, the proposed changes to the wage indices, and the proposed continuation of a payment adjustment for rural SCHs, including EACHs, would not increase OPPS payments because these proposed changes to the OPPS are budget neutral. However, these proposed updates do change the distribution of payments within the budget neutral system as shown in Table 45 below and described in more detail in this section.

1. Alternatives Considered

Alternatives to the changes we are proposing to make and the reasons that we have chosen the options are discussed throughout this proposed rule. Some of the major issues discussed in this proposed rule and the options considered are discussed below.

a. Alternatives Considered for Payment of Multiple Imaging Procedures

We are proposing to revise our payment methodology for multiple imaging procedures performed during a single session using the same imaging modality by applying a composite APC payment methodology in CY 2009. We would provide one composite APC payment each time a hospital bills for second and subsequent procedures described by the HCPCS codes in one imaging family on a single date of service. As discussed in detail in section II.A.2.e.(5) of this proposed rule, we are

proposing to utilize three imaging families of HCPCS codes based on imaging modality for purposes of this methodology (that is, Ultrasound, CT and CTA, and MRI and MRA). The proposed composite APC methodology for multiple imaging services would result in the creation of the following five new APCs due to the statutory requirement that we differentiate payment for OPPS imaging services provided with and without contrast: APC 8004 (Ultrasound Composite); APC 8005 (CT and CTA without Contrast Composite); APC 8006 (CT and CTA with Contrast Composite); APC 8007 (MRI and MRA without Contrast Composite); and APC 8008 (MRI and MRA with Contrast Composite).

We considered three alternative CY 2009 payment options for imaging services under the OPPS. The first alternative we considered was to make no change to the current payment policy of providing hospitals a full APC payment for each imaging service on a claim, regardless of how many procedures are performed during a single session using the same imaging modality or whether the procedures are performed on contiguous body areas. We did not choose this alternative because we believe that continuing the current payment methodology would neither reflect nor promote the efficiencies hospitals can achieve when they perform multiple imaging procedures during a single session, as demonstrated in CY 2007 claims data and discussed in section II.A.2.e.(5) of this proposed rule.

The second alternative we considered was to utilize the 11 families of imaging HCPCS codes applicable under the MPFS multiple imaging discount policy, distinct groups of codes which are based on imaging modality and contiguous body area, in the development of the multiple imaging composite APCs. We did not choose this alternative because, as we discuss in section II.A.2.e.(5) of this proposed rule, we believe that the large number of smaller MPFS families are neither appropriate nor necessary for the OPPS. These groups do not correspond to the larger APC groups of services paid under the OPPS in contrast to the service-specific payment under the MPFS, and would not reflect all efficiencies that may typically be gained in a single imaging session in the hospital outpatient setting of care.

The third alternative we considered and are proposing for CY 2009 is to develop the multiple imaging composite APCs by collapsing the 11 MPFS imaging families into 3 imaging families based solely on imaging modality. We chose this alternative because we believe that the contiguous body area concept that is central to the MPFS imaging families is not necessary to capture potential efficiencies in a hospital outpatient imaging session. As discussed in section II.A.2.e.(5) of this proposed rule, we would not expect second and subsequent imaging services of the same modality involving noncontiguous body areas to require certain duplicate facility services. We believe that collapsing the 11 MPFS imaging families into 3 groups for purposes of the OPPS multiple imaging composite payment methodology most accurately reflects how these services are provided in the hospital outpatient setting of care and would most effectively encourage hospital efficiencies that could be achieved when multiple imaging procedures are performed during a single session. We also believe that deriving the proposed multiple imaging composite APCs from 3 collapsed imaging families, rather than the 11 MPFS imaging families, would enable us to maximize the use of multiple imaging claims for ratesetting.

b. Alternatives Considered for the Proposed HOP QDRP Requirements for the CY 2009 Payment Update

As discussed in section XVI.D.2. of this proposed rule, we are proposing to implement the payment provisions of section 109 of the MIEA–TRHCA, which amended section 1833(t) of the Act by adding a new subsection (17). In summary, new section 1833(t)(17)(A) of the Act requires that certain hospitals that fail to meet the HOP QDRP reporting requirements incur a 2.0 percentage point reduction to their OPD fee schedule increase factor, that is, the market basket update. The application of a reduced OPD fee schedule increase factor results in reduced national unadjusted payment rates that will apply to certain outpatient items and services performed by hospitals that are required to report outpatient quality data and that fail to meet the HOP QDRP requirements.

As described in detail in section XVI.D.2. of this proposed rule, we are proposing that, effective for services paid under the CY 2009 OPPS, we would calculate two conversion factors: A full market basket conversion factor (that is, the full CF) and a reduced market basket conversion factor (that is, the reduced CF). Therefore, we are proposing to calculate a ''reporting ratio'' which would apply to payment for hospitals that fail to meet their reporting requirements, by dividing the reduced CF by the full CF.

Under the OPPS, we have two levels of Medicare beneficiary copayment for many separately paid services: The minimum unadjusted copayment and the national unadjusted copayment. The minimum unadjusted copayment is always 20 percent of the unadjusted national payment rate for each separately payable service. The national unadjusted copayment is determined based on the historic coinsurance rate for the services assigned to the APC. We considered two alternative policy options for the copayment calculation methodology for those hospitals that fail to meet the HOP QDRP requirements.

The first alternative we considered was to calculate the national unadjusted copayments and the minimum unadjusted copayments based on the reduced national unadjusted payment amounts, using our standard copayment methodology. We found that in many cases the beneficiary copayment amount would remain the same as calculated based on the full national unadjusted payment rates, although the total reduced national unadjusted payment rate would decline because of the reduction to the conversion factor. Therefore, in these cases, the ratio of the copayment to the total payment (the coinsurance percentage) would increase rather than decrease if we were to calculate copayments based on the reduced national unadjusted payment rates. We did not choose this option because we believe that the increased coinsurance percentage that results from this methodology is contradictory to the intent of the statute that the coinsurance percentage should never increase and is also contradictory to our copayment rules that are intended to gradually reduce the percentage of the payment attributed to copayments until the copayment is equal to the minimum unadjusted copayment for all services.

The second alternative we considered and are proposing is to apply the reporting ratio noted above to both the national unadjusted copayment and the minimum unadjusted copayment that would apply to each APC for hospitals that receive the reduced CY 2009 OPPS payment update. Beneficiaries and secondary payers would thereby not pay a higher coinsurance rate and would share in the reduction of payments to these hospitals. We believe that this alternative would allow us to appropriately set the national unadjusted copayments for the reduced OPPS national unadjusted payment rates and is most consistent with the eventual establishment of 20 percent of the payment rate as the uniform coinsurance percentage for all services under the OPPS.

c. Alternatives Considered Regarding OPPS Cost Estimation for Relative Payment Weights

Since the implementation of the OPPS, some commenters have raised concerns about potential bias in the OPPS cost-based weights due to ''charge compression,'' which is the practice of applying a lower charge markup to higher-cost services and a higher charge markup to lower-cost services. To explore this issue, in August 2006 we awarded a contract to RTI to study the effects of charge compression in calculating the IPPS relative weights, particularly with regard to the impact on inpatient DRG payments, and to consider methods to reduce the variation in the CCRs used to calculate costs for the IPPS relative weights across services within cost centers. Of specific note was analysis of a regression-based methodology estimating an average adjustment for CCRs by type of revenue code from an observed relationship between provider cost center CCRs and proportional billing of high and low cost services in the cost center. In August 2007, we expanded the RTI contract to determine whether the findings of the report were also applicable to the payment weights established under the OPPS and to more systematically explore cost estimation issues specific to the OPPS, including the revenue code-to-cost center crosswalk. We refer readers to section II.A.1.c. of this proposed rule for discussion of the issues and *http://www.rti.org* for the RTI findings and recommendations. The final RTI report describing its research findings was made available at about the time of the release of this proposed rule in July 2008. In this report, RTI made a number of recommendations for achieving more accurate estimates of cost for services paid under both the IPPS and the OPPS. This report also distinguished between two types of research findings and recommendations, that is, those pertaining to the accounting or cost report data itself and those related to statistical regression analysis. RTI made 11 recommendations to improve IPPS and OPPS cost estimation, including both short- and long-term accounting changes, and short-term regression-based and other statistical adjustments. For a detailed discussion of the RTI recommendations from the July 2008 report, we refer readers to section II.A.1.c. of this proposed rule.

With respect to adopting the RTI recommendations, we considered three alternatives. The first alternative we considered was to propose no changes in response to the RTI findings and to accept none of the recommendations regarding cost estimation. We did not choose this alternative because we agree with RTI's findings that there are likely misassigned costs in the cost reports that could adversely affect the OPPS relative weights and that charge compression influences the OPPS payment weights.

The second alternative we considered was to accept all of the RTI recommendations. We did not choose this alternative because of the magnitude and scope of impact on APC relative weights that would result from adopting all accounting and statistical changes in cost estimation that were recommended. Further, the numerous and substantial changes that RTI recommended have significantly complex interactions with one another and we believe that we should proceed cautiously in considering their adoption. In a budget neutral payment system, increases in payment for some services always result in reductions to payment for other services. We believe that any potential accounting and statistical changes in cost estimation are likely to result in significant shifts in payment within hospital departments and between hospitals and should be thoroughly assessed before we decide whether to propose changes beyond those we are proposing for CY 2009 as discussed below.

The third alternative we considered and the one we are proposing in this OPPS rule is to break the single standard cost center 5600 into two proposed new standard cost centers: Drugs with High Overhead Cost Charged to Patients and Drugs with Low Overhead Cost Charged to Patients, to reduce the reallocation of pharmacy overhead cost from expensive to inexpensive drugs and biologicals when setting an equivalent average ASP-based payment amount in the future. This proposal is consistent with RTI's recommendation for creating a new cost center whose CCR would be used to adjust charges to costs for drugs requiring detail coding. We refer readers to section V.B.3. of this proposed rule for the discussion of the creation of the two proposed new cost centers and the potential approaches to distinguishing between the two groups of drugs and biologicals. We note that we made a similar proposal for the Medical Supplies Charged to Patients cost center in the FY 2009 IPPS proposed rule (73 FR 23546). We are proposing this alternative because we believe that it would lead to more accurate cost estimation for drugs and biologicals and their associated pharmacy overhead costs in a manner that is consistent with our current methodology for estimating costs under both the IPPS and the OPPS. The nature of cost report timing and changes in reporting charges would phase in the resulting changes to payment rates in such a way that the impact would be moderated compared to the effect of applying the regression adjustments to the current claims data. Therefore, this approach would ultimately provide more accurate payment for drugs and biologicals based on the costs of hospitals as reported to us and would also not introduce a high level of instability in the OPPS payment rates. Moreover, we would be able to complete a full assessment of the potential impact of all of the cost estimation changes recommended by RTI and to consider and analyze public comments on the numerous other recommendations before deciding whether or not to propose any of the other recommendations of the RTI study.

2. Limitations of Our Analysis

The distributional impacts presented here are the projected effects of the proposed CY 2009 policy changes on various hospital groups. We post our hospital-specific estimated payments for CY 2009 with the other supporting documentation for this proposed rule. To view the hospital-specific estimates, we refer readers to the CMS Web site at: *http://www.cms.hhs.gov/HospitalOutpatientPPS/*. Select ''regulations and notices'' from the left side of the page and then select ''CMS–1404–P'' from the list of regulations and notices. The hospital-specific file layout and the hospital-specific file are listed with the other supporting documentation for this proposed rule. We show hospital-specific data only for hospitals whose claims were used for modeling the impacts shown in Table 45 below. We do not show proposed hospital-specific impacts for hospitals whose claims we were unable to use. We refer readers to section II.A.2. of this proposed rule for a discussion of the hospitals whose claims we do not use for ratesetting and impact purposes.

We estimate the effects of the proposed individual policy changes by estimating payments per service, while holding all other payment policies constant. We use the best data available but do not attempt to predict behavioral responses to our proposed policy changes. In addition, we do not make adjustments for future changes in variables such as service volume, service-mix, or number of encounters. As we have done in previous rules, we are soliciting public comment and information about the anticipated effect

of the proposed changes on hospitals and our methodology for estimating them.

3. Estimated Effects of This Proposed Rule on Hospitals

Table 45 below shows the estimated impact of this proposed rule on hospitals. Historically, the first line of the impact table, which estimates the proposed change in payments to all hospitals, has always included cancer and children's hospitals, which are held harmless to their pre-BBA payment to cost ratio. We are also including CMHCs in the first line that includes all providers because we included CMHCs in our weight scaler estimate. We typically do not report a separate impact for CMHCs because they are paid for only one service, PHP, under the OPPS, and each CMHC can typically easily estimate the impact of the proposed changes by referencing payment for PHP services in Addendum A. Because we are proposing a CY 2009 policy change to PHP payment that is more complicated than a simple change in the payment rate, this year we present separate impacts for CMHCs in Table 45 and discuss the impact on CMHCs in section XXI.B.4. below.

The estimated increase in the total payments made under the OPPS is limited by the increase to the conversion factor set under the methodology in the statute. The distributional impacts presented do not include assumptions about changes in volume and service-mix. The enactment of Pub. L. 108–173 on December 8, 2003 provided for the additional payment outside of the budget neutrality requirement for wage indices for specific hospitals reclassified under section 508. The MMSEA extended section 508 reclassifications through September 30, 2008. The amounts attributable to this reclassification are incorporated into the CY 2008 estimates but because section 508 expires in 2008, no additional payments under section 508 are considered for CY 2009 in this impact analysis.

Table 45 shows the estimated redistribution of hospital and CMHC payments among providers as a result of proposed APC reconfiguration and recalibration; wage indices; the combined impact of the APC recalibration, wage effects, and the market basket update to the conversion factor; and, finally, estimated redistribution considering all proposed payments for CY 2009 relative to all payments for CY 2008, including the impact of changes in the outlier threshold and changes to the pass-through estimate. We did not model a budget neutrality adjustment for the rural adjustment for SCHs, including EACHs, because we are not proposing any changes to the policy for CY 2009. Because updates to the conversion factor, including the update of the market basket and the addition of money not dedicated to pass-through payment for CY 2009, are applied uniformly across services, observed redistributions of payments in the impact table for hospitals largely depend on the mix of services furnished by a hospital (for example, how the APCs for the hospital's most frequently furnished services would change), and the impact of the wage index changes on the hospital. However, total payments made under this system and the extent to which this proposed rule would redistribute money during implementation also would depend on changes in volume, practice patterns, and the mix of services billed between CY 2008 and CY 2009, which CMS cannot forecast.

Overall, the proposed OPPS rates for CY 2009 would have a positive effect for providers paid under the OPPS, resulting in a 3.2 percent increase in Medicare payments. Removing cancer and children's hospitals because their payments are held harmless to the pre-BBA ratio between payment and cost, and CMHCs, suggests that proposed changes would result in a 3.6 percent increase in Medicare payments to all other hospitals, exclusive of transitional pass-through payments.

To illustrate the impact of the proposed CY 2009 changes, our analysis begins with a baseline simulation model that uses the final CY 2008 weights, the FY 2008 final post-reclassification IPPS wage indices, and the final CY 2008 conversion factor. Column 2 in Table 45 shows the independent effect of proposed changes resulting from the reclassification of services among APC groups and the proposed recalibration of APC weights, based on 12 months of CY 2007 hospital OPPS claims data and more recent cost report data. We modeled the effect of proposed APC recalibration changes for CY 2009 by varying only the weights (the final CY 2008 weights versus the estimated proposed CY 2009 weights) and calculating the percent difference in payments. Column 2 also reflects the effect of proposed changes resulting from the APC reclassification and recalibration changes and any changes in multiple procedure discount patterns that occur as a result of the changes in the relative magnitude of proposed payment weights.

Column 3 reflects the independent effects of updated wage indices, including proposed application of budget neutrality for the rural floor policy on a statewide basis. While we have included changes to the rural adjustment in this column in the past, we did not model a budget neutrality adjustment for the rural adjustment for SCHs, including EACHs, because we are proposing no changes to the policy for CY 2009. We modeled the independent effect of updating the wage index and the rural adjustment by varying only the wage index, using the proposed CY 2009 scaled weights and a CY 2008 conversion factor that included a budget neutrality adjustment for changes in wage effects and the rural adjustment between CY 2008 and CY 2009.

Column 4 demonstrates the combined ''budget neutral'' impact of APC recalibration (that is, Column 2), the wage index update (that is, Column 3), as well as the impact of updating the conversion factor with the market basket update. We modeled the independent effect of the budget neutrality adjustments and the market basket update by using the weights and wage indices for each year, and using a CY 2008 conversion factor that included the market basket update and budget neutrality adjustments for differences in wages.

Finally, Column 5 depicts the full impact of the CY 2009 proposed policies on each hospital group by including the effect of all the proposed changes for CY 2009 (including the APC reconfiguration and recalibration shown in Column 2) and comparing them to all estimated payments in CY 2008, including changes to the wage index under section 508 of Pub. L. 108–173 as extended by the MMSEA. Column 5 shows the combined budget neutral effects of Columns 2 through 4, plus the impact of the proposed change to the fixed outlier threshold from $1,575 to $1,800; the impact of expiring section 508 reclassification wage index increases; and the impact of reducing the estimate of the percentage of total OPPS payments dedicated to transitional pass-through payments. We estimate that these proposed cumulative changes would increase payments to all providers by 3.2 percent for CY 2009. We modeled the independent effect of all proposed changes in Column 5 using the final weights for CY 2008 and the proposed weights for CY 2009. We used the final conversion factor for CY 2008 of $63.694 and the proposed CY 2009 conversion factor of $65.684. Column 5 also contains simulated outlier payments for each year. We used the charge inflation factor used in the FY 2009 IPPS proposed rule of 5.84 percent (1.0585) to increase individual costs on

the CY 2007 claims to reflect CY 2008 dollars, and we used the most recent overall CCR in the April 2008 Outpatient Provider-Specific File. Using the CY 2007 claims and a 5.84 percent charge inflation factor, we currently estimate that outlier payments for CY 2008, using a multiple threshold of 1.75 and a fixed-dollar threshold of $1,575, would be approximately 0.76 percent of total payments. Outlier payments of 0.76 percent appear in the CY 2008 comparison in Column 5. We used the same set of claims and a charge inflation factor of 12.04 percent (1.1204) and the CCRs in the April 2008 Outpatient Provider-Specific File, with an adjustment of 0.9920 to reflect relative changes in cost and charge inflation between CY 2007 and CY 2009, to model the proposed CY 2009 outliers at 1.0 percent of total payments using a multiple threshold of 1.75 and a fixed-dollar threshold of $1,800.

Column 1: Total Number of Hospitals

The first line in Column 1 in Table 45 shows the total number of providers (4,181), including cancer and children's hospitals and CMHCs for which we were able to use CY 2007 hospital outpatient claims to model CY 2008 and CY 2009 payments by classes of hospitals. We excluded all hospitals for which we could not accurately estimate CY 2008 or CY 2009 payment and entities that are not paid under the OPPS. The latter entities include CAHs, all-inclusive hospitals, and hospitals located in Guam, the U.S. Virgin Islands, Northern Mariana Islands, American Samoa, and the State of Maryland. This process is discussed in greater detail in section II.A. of this proposed rule. At this time, we are unable to calculate a disproportionate share (DSH) variable for hospitals not participating in the IPPS. Hospitals for which we do not have a DSH variable are grouped separately and generally include psychiatric hospitals, rehabilitation hospitals, and LTCHs. We show the total number (3,902) of OPPS hospitals, excluding the hold-harmless cancer and children's hospitals, and CMHCs, on the second line of the table. We excluded cancer and children's hospitals because section 1833(t)(7)(D) of the Act permanently holds harmless cancer hospitals and children's hospitals to a proportion of their pre-BBA payment relative to their pre-BBA costs and, therefore, we removed them from our impact analyses. We show the isolated impact on 218 CMHCs in the last row of the impact table and discuss that impact separately below.

Column 2: APC Changes Due to Reassignment and Recalibration

This column shows the combined effects of proposed reconfiguration, recalibration, and other policies (such as composite payment for multiple imaging procedures performed on the same day, payment for drugs at ASP+4 percent, and changes in payment for PHP services). In many cases, the redistribution created by the reduction in the PHP payment offsets other recalibration losses. Specifically, the reduction in PHP payment is redistributed to hospitals and reflected in the 0.4 percent increase for the 3,902 hospitals that remain after excluding hospitals held harmless and CMHCs. Overall, these proposed changes would increase payments to urban hospitals by 0.4 percent. We estimate that large urban hospitals would see an increase of 0.4 percent and other urban hospitals would see a 0.5 percent increase in payments, all attributable to recalibration.

Overall, rural hospitals would show a 0.5 percent increase as a result of proposed changes to the APC structure. With the money redistributed from PHP services, rural hospitals of all bed sizes would experience no change or would experience increases ranging from 0.4 to 0.7 percent.

Among teaching hospitals, the largest observed impacts resulting from APC recalibration include an increase of 0.6 percent for major teaching hospitals and an increase of 0.4 percent for minor teaching hospitals.

Classifying hospitals by type of ownership suggests that proprietary hospitals would see an increase of 0.3 percent, governmental hospitals would see an increase of 0.4 percent, and voluntary hospitals would see an increase of 0.5 percent.

We note also that both low volume urban and rural hospitals with less than 5,000 lines and hospitals for which DSH payments are not available would experience decreases of 0.2 to 6.2 percent as a result of the decline in payment for PHP services and the proposed change in payment policy for PHP services from one per diem rate in CY 2008 to two per diem rates in CY 2009.

Column 3: New Wage Indices and the Effect of the Rural Adjustment

This column estimates the impact of applying the proposed FY 2009 IPPS wage indices for the CY 2009 OPPS. Overall, these proposed changes would not change the payments to urban or rural hospitals.

Among teaching hospitals, the largest observed impact resulting from proposed changes to the wage indices is a decrease of 0.1 percent for major teaching hospitals in contrast to no change for minor teaching hospitals. Classifying hospitals by type of ownership suggests that proprietary hospitals would gain 0.1 percent, governmental hospitals would see an increase of 0.2 percent, and voluntary hospitals would experience no change.

We estimate that the combination of updated wage data from FY 2005 cost reports and statewide application of rural floor budget neutrality redistributes payment among regions. Both rural and urban areas in New England and the Middle Atlantic states experience declines up to 2.0 percent. The Central regions (excluding the East North Central regions) and the Pacific regions of the country experience increases up to 0.5 percent. Change in Puerto Rico's wage data contributes to the decrease of 0.8 percent.

Column 4: All Proposed Budget Neutrality Changes and Market Basket Update

With the exception of urban hospitals with the lowest volume of services and hospitals not paid under the IPPS, including psychiatric hospitals, rehabilitation hospitals, and long term care hospitals (DSH not available), the addition of the proposed market basket update of 3.0 percent mitigates any negative impacts on proposed payments for CY 2009 created by the budget neutrality adjustments made in Columns 2 and 3. In general, all hospitals would see an increase of 3.4 percent, attributable to the proposed 3.0 percent market basket increase and the 0.4 percent increase in payment weight created by the reduction in payment for PHP services that is then redistributed to other services.

Overall, these proposed changes would increase payments to urban hospitals by 3.4 percent. We estimate that large urban hospitals would see an increase of 3.3 percent and other urban hospitals would see a 3.6 percent increase. In contrast, small urban hospitals that bill fewer than 5,000 lines per year would experience a decrease in payment of 1.0 percent, largely as a result of the decrease in payment for PHP and mental health services appearing in Column 2.

Overall, rural hospitals would show a 3.5 percent increase as a result of the proposed market basket update. Rural hospitals that bill less than 5,000 lines would see a 3.5 percent increase. Increases in payment due to the proposed wage index modestly offset the reduction in payment for PHP services in low volume rural hospitals.

Rural hospitals that bill more than 5,000 lines would experience increases of 2.7 to 3.6 percent.

Among teaching hospitals, the observed impacts resulting from the proposed market basket update include an increase of 3.4 percent for both major and minor teaching hospitals.

Classifying hospitals by type of ownership suggests that proprietary hospitals would increase 3.3 percent, governmental hospitals would increase 3.6 percent, and voluntary hospitals would experience an increase of 3.4 percent.

Column 5: All Proposed Changes for CY 2009

Column 5 compares all proposed changes for CY 2009 to final payment for CY 2008 and includes the expiring section 508 reclassification wage indices, the change in the outlier threshold, and the difference in pass-through estimates which are not included in the combined percentages shown in Column 4. Overall, we estimate that providers would see an increase of 3.2 percent under this proposed rule in CY 2009 relative to total spending in CY 2008. The projected 3.2 percent increase for all providers in Column 5 reflects the proposed 3.0 percent market basket increase, plus 0.02 percent for the proposed change in the pass-through estimate between CY 2008 and CY 2009, plus 0.24 percent for the difference in estimated outlier payments between CY 2008 (0.76 percent) and CY 2009 (1.0 percent), less 0.09 percent for the expired section 508 wage payments. When we exclude cancer and children's hospitals (which are held harmless to their pre-OPPS costs) and CMHCs, the gain would be 3.6 percent.

The combined effect of all proposed changes for CY 2009 would increase payments to urban hospitals by 3.6 percent. We estimate that large urban hospitals would see a 3.5 percent increase, while ''other'' urban hospitals would experience an increase of 3.6 percent. Urban hospitals that bill less than 5,000 lines would experience a decrease of 1.0 percent.

Overall, rural hospitals would show a 3.6 percent increase as a result of the combined effects of all proposed changes for CY 2009. Rural hospitals that bill less than 5,000 lines would experience an increase of 4.0 percent, which is greater than the 3.5 percent increase in Column 4. All rural hospitals that bill greater than 5,000 lines would experience increases ranging from 2.9 percent to 3.7 percent.

Among teaching hospitals, the largest observed impacts resulting from the combined effects of all proposed changes include an increase of 3.9 percent for major teaching hospitals and an increase of 3.5 percent for minor teaching hospitals.

Classifying hospitals by type of ownership suggests that proprietary hospitals would gain 3.4 percent, governmental hospitals would experience an increase of 3.9 percent, and voluntary hospitals would experience an increase of 3.5 percent.

4. Estimated Effects of This Proposed Rule on CMHCs

The last row of the impact analysis in Table 45 demonstrates the impact on CMHCs. We modeled this impact assuming that CMHCs would continue to provide the same number of days of PHP care, with each day having either three services or four or more services, as seen in the CY 2007 claims data. Using these assumptions, there would be a 33.2 percent decrease in payments to CMHCs due to these proposed APC policy changes (shown in Column 2). Column 3 shows that the CY 2009 proposed wage index updates account for a small decrease in payments to CMHCs (0.2 percent). We note that all providers paid under the OPPS, including CMHCs, receive a 3.0 percent market basket increase (shown in Column 4). Combining this market basket increase, along with proposed changes in APC policy for CY 2009 and the CY 2009 wage index updates, the combined impact on CMHCs for CY 2009 is a 30.3 percent decrease.

We anticipate that CMHCs would change their behavior in response to the CY 2009 proposed payment rates for PHP services, consistent with patient need. By providing one additional qualifying partial hospitalization service, CMHCs would qualify for payment of proposed APC 0173 (Level II Partial Hospitalization payment (4 or more services)), whose proposed payment rate is approximately $174, rather than proposed APC 0172 (Level I Partial Hospitalization payment rate (3 services)), whose proposed payment rate is approximately $140. This change in behavior would lessen the impact on CMHCs in CY 2009.

Using the CY 2007 CMHC claims data, there are a large number of days provided by CMHCs with only 3 services furnished in a given day (nearly 1 million days billed by CMHCs were for 3 units of service). If CMHCs were to provide 1 additional service on 50 percent of those 1 million days with 3 services, we estimate that the impact on CY 2009 payment to CMHCs would be a 26.8 percent decrease rather than a 33.2 percent decrease (which is the decrease due to proposed APC changes, while keeping the number of days with 3 services the same as reflected in CY 2007 claims data). Continuing to use the assumption that 50 percent of CMHC days would qualify for the Level II PHP payment rate, we estimate that the combined impact including all changes (market basket increase, proposed changes in APC policy for CY 2009, and CY 2009 wage index updates), on CMHCs for CY 2009 would be approximately a 24.7 percent decrease in payment.

We believe that CMHCs may provide additional services on days in excess of the 50 percent of current 3 service days assumed in the scenario described above, behavior which would further mitigate the estimated decrease in payments to CMHCs. Furthermore, we note that there are approximately 40,000 days billed by CMHCs in CY 2007 with only 1 or 2 PHP services. The impact analysis shown in Table 45 is modeled assuming that those days would not receive any payment, in accordance with our proposed policy to deny payment for days with less than three services. However, we anticipate that CMHCs would also change their behavior in response to our proposed policy to deny payment for days with less than three services, to the extent providing additional services is consistent with the plan of care established by each patient's physician. This change in behavior would mitigate modeled payment reductions to CMHCs because additional days would qualify for proposed new APC 0172.

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Table 45. -- IMPACT OF CY 2009 PROPOSED CHANGES FOR HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM

	(1)	(2)	(3)	(4)	(5)
	Number of Hospitals	APC Changes	New Wage Index	Combined (cols 2, 3) with Market Basket Update	All Changes
ALL PROVIDERS *	4181	0.0	0.0	3.0	3.2
ALL HOSPITALS	3902	0.4	0.0	3.4	3.6
(excludes hospitals held harmless and CMHCs)					
URBAN HOSPITALS	2907	0.4	0.0	3.4	3.6
LARGE URBAN (GT 1 MILL.)	1591	0.4	-0.1	3.3	3.5
OTHER URBAN (LE 1 MILL.)	1316	0.5	0.1	3.6	3.6
RURAL HOSPITALS	995	0.5	0.0	3.5	3.6
SOLE COMMUNITY	404	0.4	0.1	3.5	3.5
OTHER RURAL	591	0.5	0.0	3.5	3.6
BEDS (URBAN)					
0 - 99 BEDS	956	0.5	0.0	3.5	3.6
100-199 BEDS	898	0.4	0.0	3.4	3.4
200-299 BEDS	474	0.6	0.0	3.6	3.6
300-499 BEDS	394	0.4	0.1	3.5	3.6
500 + BEDS	185	0.3	-0.1	3.2	3.6
BEDS (RURAL)					
0 - 49 BEDS	346	0.0	0.1	3.1	3.4
50- 100 BEDS	387	0.4	-0.1	3.3	3.4
101- 149 BEDS	154	0.4	0.1	3.5	3.6
150- 199 BEDS	63	0.6	0.3	4.0	4.0
200 + BEDS	45	0.7	0.0	3.7	3.8
VOLUME (URBAN)					
LT 5,000 Lines	578	-4.1	0.0	-1.0	-1.0
5,000 - 10,999 Lines	182	-0.2	0.1	2.8	2.9
11,000 - 20,999 Lines	294	0.5	0.1	3.7	3.8
21,000 - 42,999 Lines	541	0.5	0.0	3.5	3.5
GT 42,999 Lines	1312	0.5	0.0	3.4	3.6

	Number of Hospitals	APC Changes	New Wage Index	Combined (cols 2, 3) with Market Basket Update	All Changes
VOLUME (RURAL)					
LT 5,000 Lines	83	-0.2	0.7	3.5	4.0
5,000 - 10,999 Lines	111	-0.6	0.3	2.7	2.9
11,000 - 20,999 Lines	205	-0.1	0.1	3.0	3.0
21,000 - 42,999 Lines	311	0.4	0.0	3.4	3.5
GT 42,999 Lines	285	0.6	0.0	3.6	3.7
REGION (URBAN)					
NEW ENGLAND	151	0.5	-0.7	2.8	2.9
MIDDLE ATLANTIC	377	0.5	-0.4	3.1	2.9
SOUTH ATLANTIC	452	0.5	0.0	3.5	3.6
EAST NORTH CENT.	465	0.6	-0.3	3.3	3.6
EAST SOUTH CENT.	183	0.4	0.2	3.6	3.7
WEST NORTH CENT.	183	0.6	0.5	4.1	4.1
WEST SOUTH CENT.	469	0.2	0.3	3.5	3.8
MOUNTAIN	185	0.6	0.3	3.8	4.0
PACIFIC	393	0.2	0.5	3.7	3.9
PUERTO RICO	49	0.8	-0.8	3.0	3.2
REGION (RURAL)					
NEW ENGLAND	25	1.0	-2.0	2.0	2.3
MIDDLE ATLANTIC	67	0.8	-0.2	3.5	3.6
SOUTH ATLANTIC	169	0.3	0.2	3.5	3.6
EAST NORTH CENT.	128	0.6	-0.2	3.4	3.4
EAST SOUTH CENT.	180	0.3	0.4	3.7	3.7
WEST NORTH CENT.	113	0.6	0.3	3.9	4.0
WEST SOUTH CENT.	203	0.1	0.5	3.6	3.8
MOUNTAIN	74	0.4	0.0	3.3	3.3
PACIFIC	36	0.3	0.5	3.8	3.7
TEACHING STATUS					
NON-TEACHING	2894	0.4	0.0	3.5	3.5
MINOR	731	0.4	0.0	3.4	3.5
MAJOR	277	0.6	-0.1	3.4	3.9

	Number of Hospitals	APC Changes	New Wage Index	Combined (cols 2, 3) with Market Basket Update	All Changes

DSH PATIENT PERCENT					
0	4	3.6	-0.6	6.0	6.0
GT 0 - 0.10	390	0.6	-0.3	3.4	3.4
0.10 - 0.16	440	0.6	-0.1	3.5	3.6
0.16 - 0.23	797	0.5	-0.1	3.4	3.5
0.23 - 0.35	954	0.5	0.2	3.6	3.8
GE 0.35	747	0.3	0.0	3.4	3.7
DSH NOT AVAILABLE **	570	-6.2	0.0	-3.1	-3.0
URBAN TEACHING/DSH					
TEACHING & DSH	905	0.5	0.0	3.4	3.6
NO TEACHING/DSH	1457	0.5	0.0	3.6	3.6
NO TEACHING/NO DSH	4	3.6	-0.6	6.0	6.0
DSH NOT AVAILABLE **	541	-6.0	0.0	-3.0	-2.9
TYPE OF OWNERSHIP					
VOLUNTARY	2104	0.5	0.0	3.4	3.5
PROPRIETARY	1224	0.3	0.1	3.3	3.4
GOVERNMENT	574	0.4	0.2	3.6	3.9
CMHCs	218	-33.2	-0.2	-30.4	-30.3

Column (1) shows total hospitals.

Column (2) shows the impact of changes resulting from the reclassification of HCPCS codes among APC groups and the recalibration of APC weights based on 2007 hospital claims data.

Column (3) shows the budget neutral impact of updating the wage index by applying the FY 2009 hospital inpatient wage index. We did not propose any changes to the rural adjustment.

Column (4) shows the impact of all budget neutrality adjustments and the addition of the market basket update.

Column (5) shows the additional adjustments to the conversion factor resulting from a change in the pass-through estimate and adds outlier payments. This column also shows the impact of the expiring 508 wage reclassification, which ends September 30, 2008.

*These 4,181 providers include children and cancer hospitals, which are held harmless to pre-BBA payments, and CMHCs.

**Complete DSH numbers are not available for providers that are not paid under IPPS, including rehabilitation, psychiatric, and long-term care hospitals.

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5. Estimated Effect of This Proposed Rule on Beneficiaries

For services for which the beneficiary pays a copayment of 20 percent of the payment rate, the beneficiary share of payment would increase for services for which the OPPS payments would rise and would decrease for services for which the OPPS payments would fall. For example, for a service assigned to Level IV Needle Biopsy/Aspiration Except Bone Marrow (APC 0037) in the CY 2008 OPPS, the national unadjusted copayment was $228.76, and the minimum unadjusted copayment was $172.95. For CY 2009, the proposed national unadjusted copayment for APC 0037 is $228.76, the same national unadjusted copayment in effect for CY 2008. The proposed minimum unadjusted copayment for APC 0037 is $177.69, or 20 percent of the proposed national unadjusted payment rate for APC 0037 of $888.42 for CY 2009. The proposed minimum unadjusted copayment would rise because the proposed payment rate for APC 0037 would rise for CY 2009. In all cases, the statute limits beneficiary liability for copayment for a service to the inpatient hospital deductible for the applicable year. The CY 2009 inpatient deductible is not yet available.

In order to better understand the impact of proposed changes in copayment on beneficiaries, we modeled the percent change in total copayment liability using CY 2007 claims. We estimate, using the claims of the 4,181 hospitals and CMHCs on which our modeling is based, that total beneficiary liability for copayments would decline as an overall percentage of total payments from 24.9 percent in CY 2008 to 23.1 percent in CY 2009. This estimated decline in beneficiary liability is a consequence of the APC recalibration and reconfiguration we are proposing for CY 2009.

6. Conclusion

The proposed changes in this proposed rule would affect all classes of hospitals. Some classes of hospitals would experience significant gains and others less significant gains, but almost all classes of hospitals would experience positive updates in OPPS payments in CY 2009. Table 45 demonstrates the estimated distributional impact of the OPPS budget neutrality requirements that results in a 3.2 percent increase in payments for CY 2009, after considering all proposed changes to APC reconfiguration and recalibration, as well as the proposed market basket increase, wage index changes, estimated payment for outliers, and proposed changes to the pass-through payment estimate. The accompanying discussion, in combination with the rest of this proposed rule, constitutes a regulatory impact analysis.

7. Accounting Statement

As required by OMB Circular A–4 (available at *http://www.whitehouse.gov/omb/circulars/a004a-4.pdf*), in Table 46, we have prepared an accounting statement showing the CY 2009 estimated hospital OPPS incurred benefit impact associated with the proposed CY 2009 hospital outpatient market basket update shown in this proposed rule, based on the 2008 Trustees' Report baseline. All estimated impacts are classified as transfers.

TABLE 46.—ACCOUNTING STATEMENT: CY 2009 ESTIMATED HOSPITAL OPPS INCURRED BENEFIT IMPACT ASSOCIATED WITH THE PROPOSED CY 2009 HOSPITAL OUTPATIENT MARKET BASKET UPDATE

[In billions]

Category	Transfers
Annualized Monetized Transfers	$0.6.
From Whom to Whom	Federal Government to outpatient hospitals and other providers who received payment under the hospital OPPS.
Total	$0.6.

C. Effects of Proposed ASC Payment System Changes in This Proposed Rule

On August 2, 2007, we published in the **Federal Register** the final rule for the revised ASC payment system, effective January 1, 2008 (72 FR 42470). In that final rule, we: Adopted the methodologies to set payment rates for covered ASC services to implement the revised payment system so that it would be designed to result in budget neutrality as required by section 626 of Public Law 108–173; established that the OPPS relative payment weights would be the basis for payment and that we would update the system annually as part of the OPPS rulemaking cycle; and provided that the revised ASC payment rates would be phased in over four years. During the 4-year transition to full implementation of the revised ASC rates, payments for surgical procedures paid in ASCs in CY 2007 will be made using a blend of the CY 2007 ASC payment rate and the revised ASC payment rate for that calendar year. In CY 2009, we are proposing to pay ASCs using a 50/50 blend, in which payment would be calculated by adding 50 percent of the CY 2007 ASC rate for a surgical procedure on the CY 2007 ASC list of covered surgical procedures and 50 percent of the CY 2009 revised ASC rate for the same procedure. For CY 2010, we would transition the blend to a 25/75 blend of the CY 2007 ASC rate and the revised ASC payment rate. Beginning in CY 2011, we would pay ASCs for all covered surgical procedures, including those on the CY 2007 ASC list, at the full revised ASC payment rates. Payment for procedures that were not included on the ASC list of covered surgical procedures in CY 2007 are not subject to the transitional payment methodology.

ASC payment rates are calculated by multiplying the ASC conversion factor by the ASC relative payment weight. As discussed fully in section XV. of this proposed rule, we set the CY 2009 proposed ASC relative payment weights by scaling unadjusted CY 2009 ASC relative payment weights by the ASC scaler of 0.9753. These weights take into consideration the 50/50 blend for the second year of transitional payment for certain services. If there were no transition, the scaler for CY 2009 fully implemented payment rates would be 0.9412. The estimated effects on payment rates during this transitional period are varied and are reflected in the estimated payments displayed in Tables 47 and 48 below.

The proposed CY 2009 ASC conversion factor was calculated by adjusting the CY 2008 ASC conversion factor to account for changes in the pre-floor and pre-reclassified hospital wage indices between CY 2008 and CY 2009. Under section 1833(i)(2)(C)(iv) of the Act, there is no inflation update to the ASC conversion factor for CY 2009. The proposed CY 2009 ASC conversion factor is $41.384.

1. Alternatives Considered

Alternatives to the changes we are making and the reasons that we have chosen the options are discussed throughout this proposed rule.

a. Office-Based Procedures

According to our final policy for the revised ASC payment system, we designate as office-based those procedures that are added to the ASC list of covered surgical procedures in CY 2008 or later years and that we determine are usually performed in physicians' offices based on consideration of the most recent available volume and utilization data for each individual procedure code and/or, if appropriate, the clinical characteristics, utilization, and volume of related codes. We establish payment for procedures designated as office-based at the lesser of the MPFS nonfacility PE RVU amount or the ASC rate developed according to the standard methodology of the revised ASC payment system.

In developing this proposed rule, we reviewed the newly available CY 2007 utilization data for all surgical procedures added to the ASC list of covered surgical procedures in CY 2008 and for those procedures for which the office-based designation is temporary in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66840 through 66841). Based on that review, and as discussed in section XV.C.1.b. of this proposed rule, we are proposing to newly designate five surgical procedures as office-based, with four of those designations as permanent. We considered two alternatives in developing this policy.

The first alternative we considered was to make no change to the procedure payment designations. This would mean that we would continue to pay for the five procedures we are proposing to designate as office-based at an ASC payment rate developed according to the standard methodology of the revised ASC payment system. We did not select this alternative because our analysis of data for these services and related procedures indicated that the five procedures we are proposing to designate as office-based could be considered to be usually performed in physicians' offices. Consistent with our final policy adopted in the August 2, 2007 revised ASC payment system final rule (72 FR 42509), we were concerned that if these services were not designated as office-based, their ASC payment could create financial incentives for the procedures to shift from physicians' offices to ASCs for reasons unrelated to clinical decisions regarding the most appropriate setting for surgical care.

The second alternative we considered, and the alternative we selected, is to propose to designate five additional procedures added to the ASC list of covered surgical procedures in CY 2008 as office-based for CY 2009. We selected this alternative because our claims data indicate that these procedures could be considered to be usually performed in physicians' offices. We believe that designating these procedures as office-based, which results in the ASC payment rate for these procedures potentially being capped at the physician's office rate (that is, the MPFS nonfacility PE RVU amount), if applicable, is an appropriate step to ensure that Medicare payment policy does not create financial incentives for such procedures to shift unnecessarily from physicians' offices to ASCs, consistent with our final policy adopted in the August 2, 2007 revised ASC payment system final rule.

b. Covered Surgical Procedures

According to our final policy for the revised ASC payment system, we designate as covered surgical procedures all surgical procedures that we determine do not pose a significant risk to beneficiary safety or are not expected to require an overnight stay.

In developing this proposed rule, we reviewed the clinical characteristics and newly available CY 2007 utilization data, if applicable, for all procedures reported by Category III CPT codes implemented July 1, 2008 and surgical procedures that were excluded from ASC payment for CY 2008. Based on that review, we identified nine surgical procedures that meet the criteria for inclusion on the ASC list of covered surgical procedures and we are proposing to add those procedures to the list for CY 2009 payment. We considered two alternatives in developing this policy.

The first alternative we considered was to make no change to the ASC list of covered surgical procedures. We did not select this alternative because our analysis of data for these services and related procedures indicated that the nine procedures we are proposing to designate as covered surgical procedures for CY 2009 may be safely provided to beneficiaries in ASCs and are not expected to require an overnight stay. Consistent with our final policy, we were concerned that if these services were not designated as ASC covered surgical procedures, beneficiaries would lack access to these services in the most clinically appropriate setting.

The second alternative we considered, and the alternative we selected, is to propose to designate nine additional procedures as ASC covered surgical procedures for CY 2009. We selected this alternative because our claims data indicate that these procedures do not pose a significant risk to beneficiary safety and are not expected to require an overnight stay, and thus they meet the criteria for inclusion on the list of ASC covered surgical procedures. We believe that adding these procedures to the list of covered surgical procedures is an appropriate step to ensure that beneficiary access to services is not limited unnecessarily.

2. Limitations of Our Analysis

Presented here are the estimated effects of the proposed changes for CY 2009 on Medicare payment to ASCs. A key limitation of our analysis is our inability to predict changes in ASC service-mix between CY 2007 and CY 2009 with precision. The aggregate impacts displayed in Tables 47 and 48 below are based upon a methodology that assumes no changes in service-mix with respect to the CY 2007 ASC data used for this proposed rule. In addition, data on services that are newly payable under the revised ASC payment system are not yet reflected in the available claims data. We believe that the net effect on Medicare expenditures resulting from the CY 2009 changes will be negligible in the aggregate. However, such changes may have differential effects across surgical specialty groups as ASCs adjust to payment rates. We are unable to accurately project such changes at a disaggregated level. Clearly, individual ASCs will experience changes in payment that differ from the aggregated estimated impacts presented below.

3. Estimated Effects of This Proposed Rule on Payments to ASCs

Some ASCs are multispecialty facilities that perform the gamut of surgical procedures, from excision of lesions to hernia repair to cataract extraction; others focus on a single specialty and perform only a limited range of surgical procedures, such as eye, digestive system, or orthopedic procedures. The combined effect on an individual ASC of the update to the CY 2009 payments will depend on a number of factors including, but not limited to, the mix of services the ASC provides, the volume of specific services provided by the ASC, the percentage of its patients who are Medicare beneficiaries, and the extent to which an ASC will choose to provide different services in the coming year. The following discussion presents tables that provide estimates of the impact of the proposed CY 2009 update to the revised ASC payment system on Medicare payments to ASCs, assuming the same mix of services as reflected in our CY 2007 claims data. Table 47 depicts the estimated aggregate percent change in payment by surgical specialty group and Table 48 shows a comparison of payment for procedures that we estimate would receive the most Medicare payment in CY 2008.

Table 47 shows the expected effects on aggregate Medicare payments under the revised ASC payment system by surgical specialty group. We have aggregated the surgical HCPCS codes by specialty group and estimated the effect on aggregated payment for surgical specialty groups, considering separately the CY 2009 transitional rates and the fully implemented revised ASC payment rates that would apply in CY 2009 if there were no transition. The groups are sorted for display in descending order by estimated Medicare program payment to ASCs for CY 2008. The following is an explanation of the information presented in Table 47.

- Column 1—*Surgical Specialty Group* indicates the surgical specialties into which ASC procedures are grouped. We used the CPT code range definitions and Level II HCPCS codes and Category III CPT codes, as appropriate, to account for all surgical procedures to which the Medicare program payments are attributed.
- Column 2—*Estimated CY 2008 ASC Payments* were calculated using CY 2007 ASC utilization (the most recent full year of ASC utilization) and CY 2008 ASC payment rates. The surgical specialty groups are displayed in descending order based on estimated CY 2008 ASC payments.
- Column 3—*Estimated CY 2009 Percent Change with Transition (50/50 Blend)* is the aggregate percentage increase or decrease, compared to CY 2008, in Medicare program payment to ASCs for each surgical specialty group that is attributable to proposed updates to the ASC payment rates for CY 2009 under the scaled, 50/50 blend of the CY 2007 ASC payment rate and the proposed CY 2009 revised ASC payment rate.
- Column 4—*Estimated CY 2009 Percent Change without Transition (Fully Implemented)* is the aggregate percentage increase or decrease in Medicare program payment to ASCs for each surgical specialty group that is attributable to proposed updates to ASC payment rates for CY 2009 compared to CY 2008 if there were no transition period to the revised payment rates. We used a different relative payment weight scaler to model the estimated CY 2009 ASC payment effects as a result of ASC

rates without the transition than we did for the proposed CY 2009 ASC payment rates with the transition. The percentages appearing in Column 4 are presented only as comparisons to the percentage changes under the transition policy in column 3. We are not proposing to eliminate or modify the transition that was finalized in the August 2, 2007 revised ASC payment system final rule (72 FR 42519).

As seen in Table 47, the proposed update to ASC rates for CY 2009 is expected to result in small aggregate decreases in payment amounts for eye and ocular adnexa and nervous system procedures and somewhat greater decreases for digestive system procedures. As shown in column 4 in the table, those payment decreases would be expected to be greater in CY 2009 if there were no transitional payment for all three of those surgical specialty groups.

Generally, for the surgical specialty groups that account for less ASC utilization and spending, the expected payment effects of the CY 2009 update are positive. ASC payments for procedures in those surgical specialties are expected to increase in CY 2009 with the 50/50 transitional payment rates and, in the absence of the transition, would be expected to increase even more. For instance, in the aggregate, integumentary system procedures are expected to increase by 7 percent under the proposed CY 2009 rates and by 19 percent if there were no transition. Similar effects are observed for genitourinary, cardiovascular, musculoskeletal, respiratory, and auditory system procedures as well. An estimated increase in aggregate payment for the specialty group does not mean that all procedures in the group would experience increased payment rates. For example, the estimated increased payments at the surgical specialty group level may be due to decreased payments for some of the most frequently provided procedures in the group and the moderating effect of the sometimes substantial payment increases for the less frequently performed procedures within the surgical specialty group.

TABLE 47.—ESTIMATED CY 2009 IMPACT OF THE REVISED ASC PAYMENT SYSTEM ON ESTIMATED AGGREGATE CY 2009 MEDICARE PROGRAM PAYMENTS UNDER THE 50/50 TRANSITION BLEND AND WITHOUT A TRANSITION, BY SURGICAL SPECIALTY GROUP

Surgical specialty group	Estimated CY 2008 ASC payments (in millions)	Estimated CY 2009 percent change with transition (50/50 blend)	Estimated CY 2009 percent change without transition (fully implemented)
(1)	(2)	(3)	(4)
Eye and ocular adnexa	$1,373	−1	−2
Digestive system	742	−6	−16
Nervous system	321	−3	−8
Musculoskeletal system	217	19	54
Integumentary system	87	7	19
Genitourinary system	86	11	29
Respiratory system	22	13	38
Cardiovascular system	14	16	45
Auditory system	5	18	46

Table 48 below shows the estimated impact of the proposed updates to the revised ASC payment system on aggregate ASC payments for selected procedures during CY 2009 with and without the transitional blended rate. The table displays 30 of the procedures estimated to be responsible for the greatest estimated CY 2008 aggregate Medicare payments to ASCs. The HCPCS codes are sorted in descending order by estimated program payment.

- Column 1—*HCPCS code.*
- Column 2—*Short Descriptor* of the HCPCS code.
- Column 3—*Estimated CY 2008 ASC Payments* were calculated using CY 2007 ASC utilization (the most recent full year of ASC utilization) and the CY 2008 ASC payment rates. The estimated CY 2008 payments are expressed in millions of dollars.
- Column 4—*CY 2009 Percent Change with Transition (50/50 Blend)* reflects the percent differences between the estimated ASC payment for CY 2008 and the estimated payment for CY 2009 based on the proposed update, incorporating a 50/50 blend of the CY 2007 ASC payment rate and the proposed CY 2009 revised ASC payment rate.
- Column 5—*CY 2009 Percent Change without Transition (Fully Implemented)* reflects the percent differences between the estimated ASC payment for CY 2008 and the estimated payment for CY 2009 based on the proposed update if there were no transition period to the fully implemented revised payment rates. We used a different relative payment weight scaler to model the estimated CY 2009 ASC payment effects as a result of ASC rates without the transition than we did for the proposed CY 2009 ASC payment rates with the transition. The percentages appearing in Column 5 are presented as a comparison to the percentage changes under the transition policy in Column 4. We are not proposing to eliminate or modify the transition that was finalized in the August 2, 2007 revised ASC payment system final rule (72 FR 42519).

As displayed in Table 48, 23 of the 30 procedures with the greatest estimated aggregate CY 2008 Medicare payment are included in the three surgical specialty groups that are estimated to account for the most Medicare payment in CY 2008, specifically eye and ocular adnexa, digestive system, and nervous system groups. Consistent with the estimated payment effects on the surgical specialty groups displayed in Table 47, the estimated effects of the proposed CY 2009 update on ASC payment for individual procedures in year 2 of the transition are varied. Aggregate ASC payments for many of the most frequently furnished ASC procedures are expected to decrease as the transition causes individual procedure payments to reflect relative ASC payment weights that are more closely aligned with the relativity of payments under the OPPS.

The procedure for which the most Medicare ASC payment is estimated to

be made in CY 2008 is the cataract removal procedure reported with CPT code 66984 (Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure), manual or mechanical technique (e.g., irrigation and aspiration or phacoemulsification)). The proposed update to the ASC rates is expected to result in a 1 percent payment decrease for that procedure in CY 2009. The estimated payment effects on the four other high volume eye and ocular adnexa procedures included in that table are slightly positive and negative, but for CPT code 66821 (Discission of secondary membranous cataract (opacified posterior lens capsule and/or anterior hyaloid); laser surgery (e.g., YAG laser) (one or more stages)), the expected CY 2009 payment decrease is 10 percent, significantly greater than the decreases expected for any of the other eye and ocular adnexa procedures shown.

The proposed transitional payment rates for 8 of the 9 digestive system procedures included in Table 48 are expected to decrease by 6 to 9 percent in CY 2009. Those estimated decreases are consistent with the estimated 6 percent reduction shown in Table 47 for the digestive system surgical specialty group.

The 10 nervous system procedures for which the most Medicare payment is estimated to be made to ASCs in CY 2008 are included in Table 48. The proposed CY 2009 update is expected to result in 4 percent payment decreases for 5 of those procedures and result in even more substantial decreases, 19 percent and 22 percent respectively, for CPT code 64484 (Injection, anesthetic agent and /or steroid, transforaminal epidural; lumbar or sacral, each additional level) and CPT code 64476 (Injection, anesthetic agent and/or steroid, paravertebral facet joint or facet joint nerve; lumbar or sacral, each additional level). The other three nervous system procedures included in the table are expected to realize payment increases, especially CPT code 64721 (Neuroplasty and/or transposition; medial nerve at carpal tunnel) for which payment is estimated to increase by 13 percent in CY 2009.

The estimated payment effects for most of the remaining procedures listed in Table 48 are positive. For example, the CY 2009 proposed transitional payment rate for CPT code 29826 (Arthroscopy, shoulder, distal claviculectomy (Mumford Procedure); decompression of subacromial space with partial acromioplasty, with or without coracoacromial release) is estimated to increase 45 percent over the CY 2008 transitional payment amount.

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TABLE 48.--ESTIMATED IMPACT OF PROPOSED UPDATE TO CY 2009 ASC PAYMENT SYSTEM ON AGGREGATE PAYMENTS FOR SELECTED PROCEDURES

HCPCS Code	Short Descriptor	Estimated CY 2008 ASC Payments (in millions)	Estimated CY 2009 Percent Change (50/50 blend)	Estimated CY 2009 Percent Change without Transition (fully implemented)
66984	Cataract surg w/iol, 1 stage	1,068	-1	-2
43239	Upper gi endoscopy, biopsy	164	-7	-14
45378	Diagnostic colonoscopy	139	-6	-12
45380	Colonoscopy and biopsy	131	-6	-12
45385	Lesion removal colonoscopy	100	-6	-12
66821	After cataract laser surgery	82	-10	-20
62311	Inject spine l/s (cd)	74	-4	-8
64483	Inj foramen epidural l/s	53	-4	-8
66982	Cataract surgery, complex	51	-2	-2
G0121	Colon ca scrn not hi rsk ind	37	-9	-18
45384	Lesion remove colonoscopy	37	-6	-12
G0105	Colorectal scrn; hi risk ind	31	-9	-18
15823	Revision of upper eyelid	30	3	5
64475	Inj paravertebral l/s	27	-4	-8
43235	Uppr gi endoscopy, diagnosis	24	0	0
52000	Cystoscopy	23	-2	-9
64476	Inj paravertebral l/s add-on	21	-22	-54
29881	Knee arthroscopy/surgery	20	17	27
64721	Carpal tunnel surgery	19	13	22
63650	Implant neuroelectrodes	17	9	10
29880	Knee arthroscopy/surgery	16	17	27
62310	Inject spine c/t	14	-4	-8
67041	Vit for macular pucker	14	-1	-3
67904	Repair eyelid defect	14	4	8
43248	Uppr gi endoscopy/guide wire	13	-7	-14
64484	Inj foramen epidural add-on	13	-19	-39
28285	Repair of hammertoe	12	15	23
63685	Insrt/redo spine n generator	12	5	3
G0260	Inj for sacroiliac jt anesth	11	-4	-8
29826	Shoulder arthroscopy/surgery	11	45	54

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Over time, we believe that the ASC payment system has served as an incentive to ASCs to focus on providing procedures for which they determine Medicare payments will support ASCs' continued operation. We note that historically, the ASC payment rates for many of the most frequently performed procedures in ASCs were similar to the OPPS payment rates for the same procedures. Conversely, procedures with ASC payment rates that were substantially lower than the OPPS rates have been performed least often in ASCs. We believe the revised ASC payment system represents a major stride towards encouraging greater efficiency in ASCs and promoting a significant increase in the breadth of surgical procedures performed in ASCs because it distributes payments across the entire spectrum of covered surgical procedures based on a coherent system of relative payment weights that are related to the clinical and facility resource characteristics of those procedures.

4. Estimated Effects of This Proposed Rule on Beneficiaries

We estimate that the proposed changes to the revised ASC payment system would be generally positive for beneficiaries with respect to the procedures newly proposed for addition to the ASC list of covered surgical procedures and for those proposed as office-based for CY 2009. First, except for screening colonoscopy and flexible sigmoidoscopy procedures, the ASC coinsurance rate for all procedures is 20 percent. This contrasts with procedures performed in HOPDs, where the beneficiary is responsible for copayments that range from 20 percent to 40 percent of the procedure payment. Second, ASC payment rates under the revised payment system are lower than payment rates for the same procedures under the OPPS, so the beneficiary coinsurance amount under the ASC payment system almost always would be less than the OPPS copayment amount for the same services. (The only exceptions would be when the ASC coinsurance amount exceeds the inpatient deducible. The statute requires that copayment amounts under the OPPS not exceed the inpatient deductible.) For those procedures newly proposed for addition to the ASC list of covered surgical procedures in CY 2009

that would migrate from the HOPD to the ASC, the beneficiary coinsurance amount would be less than the OPPS copayment amount. Furthermore, these proposed additions to the list would provide beneficiaries access to more surgical procedures in ASCs. Beneficiary coinsurance for services migrating from physicians' offices to ASCs may decrease or increase under the revised ASC payment system, depending on the particular service and the relative payment amounts for that service in the physician's office compared to the ASC. However, for those procedures newly proposed for designation as office-based in CY 2009, the beneficiary coinsurance amount would be no greater than the beneficiary coinsurance in the physician's office.

In addition, as finalized in the August 2, 2007, revised ASC payment system final rule (72 FR 42520), in CY 2009, the second year of the 4 year transition to the ASC payment rates calculated according to the standard methodology of the revised ASC payment system, ASC payment rates for a number of commonly furnished ASC procedures would continue to be reduced, resulting in lower beneficiary coinsurance amounts for these ASC services in CY 2009. Continued migration of procedures currently on the list of ASC covered surgical procedures from the HOPD to the ASC would also reduce beneficiary liability for these services, for the two reasons described above with respect to the proposed new ASC covered services.

5. Conclusion

The updates to the ASC payment system for CY 2009 will affect each of the approximately 5,300 ASCs currently approved for participation in the Medicare program. The effect on an individual ASC will depend on its mix of patients, the proportion of the ASC's patients that are Medicare beneficiaries, the degree to which the payments for the procedures offered by the ASC are changed under the revised payment system, and the degree to which the ASC chooses to provide a different set of procedures.

Like the OPPS, the revised ASC payment system is designed to result in the same aggregate amount of Medicare expenditures in CY 2009 as was estimated to be made in CY 2008. We estimate that the update to the revised ASC payment system, including the addition of surgical procedures to the list of covered surgical procedures, that we are proposing for CY 2009 will have no net effect on Medicare expenditures compared to the estimated level of Medicare expenditures in CY 2008.

6. Accounting Statement

As required by OMB Circular A–4 (available at *http://www.whitehouse.gov/omb/circulars/a004/a-4.pdf*), in Table 49 below, we have prepared an accounting statement showing the classification of the expenditures associated with the update to the CY 2009 revised ASC payment system, based on the provisions of this proposed rule. We estimate that Medicare payments to ASCs for CY 2009 will be about $3.884 billion. This table provides our best estimate of Medicare payments to providers and suppliers as a result of the proposed update to the CY 2009 revised ASC payment system, as presented in this proposed rule. All expenditures are classified as transfers.

TABLE 49.—ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED EXPENDITURES FROM CY 2008 TO CY 2009 AS A RESULT OF THE CY 2009 UPDATE TO THE REVISED ASC PAYMENT SYSTEM

Category	Transfers
Annualized Monetized Transfers	$0 Million.
From Whom to Whom	Federal Government to Medicare Providers and Suppliers.
Annualized Monetized Transfer	$0 Million.
From Whom to Whom	Premium Payments from Beneficiaries to Federal Government.
Total	$0 Million

D. Effects of Proposed Requirements for Hospital Reporting of Quality Data for Annual Hospital Payment Update

In section XVII. of the CY 2008 OPPS/ASC final rule with comment period (72 FR 66871), we finalized our measures and requirements for reporting of quality data to CMS for services furnished in hospital outpatient settings under the CY 2009 HOP QDRP. The initial data submission for April to June 2008 services is due to the OPPS Clinical Warehouse by November 1, 2008 (72 FR 66871). CMS and its contractors will provide assistance to all affected hospitals that wish to submit data. In section XVI. of this proposed rule, we discuss our measures and requirements for reporting of quality data to CMS for services furnished in hospital outpatient settings under the CY 2010 HOP QDRP.

We have no previous history under the HOP QDRP to indicate the percentage of hospitals that will submit quality data. However, for the initial data submission, in CY 2008, 98 percent of affected hospitals have pledged to participate. In addition, results from the RHQDAPU program indicate that over 98 percent of IPPS hospitals submitted quality data in the initial year of the program. We expect that affected hospitals will participate at approximately the same rate under the HOP QDRP. We have continued our efforts to ensure that our CMS contractors provide assistance to all affected hospitals that wish to submit data. Therefore, for purposes of this CY 2009 impact analysis, we have assumed that the 98 percent of affected hospitals that have pledged to participate will qualify for the full payment update factor for CY 2009.

E. Executive Order 12866

In accordance with the provisions of Executive Order 12866, this proposed rule was reviewed by the OMB.

List of Subjects

42 CFR Part 410

Health facilities, Health professions, Laboratories, Medicare, Rural areas, X-rays.

42 CFR Part 419

Hospitals, Medicare, Reporting and recordkeeping requirements.

For reasons stated in the preamble of this proposed rule, the Centers for Medicare & Medicaid Services is proposing to amend 42 CFR Chapter IV as set forth below:

PART 410—SUPPLEMENTARY MEDICAL INSURANCE (SMI) BENEFITS

1. The authority citation for part 410 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

2. Section 410.43 is amended by—

a. Removing the word ''and'' at the end of paragraph (a)(2).

b. Redesignating paragraph (a)(3) as paragraph (a)(4).

c. Adding a new paragraph (a)(3).

c. Adding a new paragraph (c).

The additions read as follows:

§ 410.43 Partial hospitalization services: Conditions and exclusions.

(a) * * *

(3) Are furnished in accordance with a physician certification and plan of care as specified under § 424.24(e) of this chapter; and

* * * * *

(c) Partial hospitalization programs are intended for patients who—

(1) Require 20 hours per week of therapeutic services;

(2) Are likely to benefit from a coordinated program of services and require more than isolated sessions of outpatient treatment.

(3) Do not require 24-hour care;

(4) Have an adequate support system while not actively engaged in the program;

(5) Have a mental health diagnosis;

(6) Are not judged to be dangerous to self or others; and

(7) Have the cognitive and emotional ability to participate in the active treatment process and can tolerate the intensity of the partial hospitalization program.

PART 419—PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES

3. The authority citation for part 419 continues to read as follows:

Authority: Secs. 1102, 1833(t), and 1871 of the Social Security Act (42 U.S.C. 1302, 1395l(t), and 1395hh).

4. Section 419.41 is amended by revising paragraph (c)(4)(iv) to read as follows:

§ 419.41 Calculation of national beneficiary copayment amounts and national Medicare program payment amounts.

* * * * *

(c) * * *

(4) * * *

(iv) The copayment amount is computed as if the adjustment under §§ 419.43(d) and (e) (and any adjustments made under § 419.43(f) in relation to these adjustments) and § 419.43(h) had not been paid.

* * * * *

5. Section 419.42 is amended by revising paragraph (e) to read as follows:

§ 419.42 Hospital election to reduce insurance.

* * * * *

(e) In electing reduced coinsurance, a hospital may elect a copayment amount that is less than that year's wage-adjusted copayment amount for the group but not less than 20 percent of the APC payment rate as determined under § 419.32 or, in the case of payments calculated under § 419.43(h), not less than 20 percent of the APC payment rate as determined under § 419.43(h).

* * * * *

6. Section 419.43 is amended by—

a. Adding new paragraphs (d)(5) and (d)(6).

b. Adding a new paragraph (h)(4).

The additions read as follows:

§ 419.43 Adjustments to national program payment and beneficiary copayment amounts.

* * * * *

(d) * * *

(5) *Reconciliation.* For hospital outpatient services (or groups of services) as defined in paragraph (d)(1) of this section performed on or after January 1, 2009—

(i) CMS may specify an alternative to the overall ancillary cost-to-charge ratio otherwise applicable under paragraph (d)(5)(ii) of this section. A hospital may also request that its Medicare contractor use a different (higher or lower) cost-to-charge ratio based on substantial evidence presented by the hospital. Such a request must be approved by the CMS.

(ii) The overall ancillary cost-to-charge ratio applied at the time a claim is processed is based on either the most recent settled cost report or the most recent tentative settled cost report, whichever is from the latest cost reporting period.

(iii) The Medicare contractor may use a statewide average cost-to-charge ratio if it is unable to determine an accurate overall ancillary cost-to-charge ratio for a hospital in one of the following circumstances:

(A) A new hospital that has not yet submitted its first Medicare cost report. (For purposes of this paragraph, a new hospital is defined as an entity that has not accepted assignment of an existing hospital's provider agreement in accordance with § 489.18 of this chapter.)

(B) A hospital whose overall ancillary cost-to-charge ratio is in excess of 3 standard deviations above the corresponding national geometric mean. This mean is recalculated annually by CMS and published in the annual notice of prospective payment rates issued in accordance with § 419.50(a).

(C) Any other hospital for whom accurate data to calculate an overall ancillary cost-to-charge ratio are not available to the Medicare contractor.

(iv) Any reconciliation of outlier payments will be based on an overall ancillary cost-to-charge ratio calculated based on a ratio of costs to charges computed from the relevant cost report and charge data determined at the time the cost report coinciding with the service is settled.

(6) *Time value of money.* Effective for services performed on or after January 1, 2009, at the time of any reconciliation under paragraph (d)(5)(iv) of this section, outlier payments may be adjusted to account for the time value of any underpayments or overpayments. Any adjustment will be based on a widely available index to be established in advance by CMS, and will be applied from the midpoint of the cost reporting period to the date of reconciliation.

* * * * *

(h) * * *

(4) *Beneficiary copayment.* The beneficiary copayment for services to which the adjustment to the conversion factor specified under paragraph (h)(1) of this section applies is the product of the national beneficiary copayment amount calculated under § 419.41 and the ratio of the adjusted conversion factor calculated under paragraph (h)(1) of this section divided by the conversion factor specified under § 419.32(b)(1).

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance; and Program No. 93.774, Medicare—Supplementary Medical Insurance Program)

(Catalog of Federal Domestic Assistance Program No. 93.778, Medical Assistance Program)

Dated: June 26, 2008.

Kerry Weems,

Acting Administrator, Centers for Medicare & Medicaid Services.

Dated: July 2, 2008.

Michael O. Leavitt,

Secretary.

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ADDENDUM A.--PROPOSED OPPS APCS FOR CY 2009

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0001	Level I Photochemotherapy	S	0.5112	$33.58	$7.00	$6.72
0002	Fine Needle Biopsy/Aspiration	T	1.5340	$100.76		$20.16
0003	Bone Marrow Biopsy/Aspiration	T	3.2496	$213.45		$42.69
0004	Level I Needle Biopsy/ Aspiration Except Bone Marrow	T	4.5254	$297.25		$59.45
0005	Level II Needle Biopsy/Aspiration Except Bone Marrow	T	7.3814	$484.84		$96.97
0006	Level I Incision & Drainage	T	1.4267	$93.71		$18.75
0007	Level II Incision & Drainage	T	12.8052	$841.10		$168.22
0008	Level III Incision and Drainage	T	19.5771	$1,285.90		$257.18
0012	Level I Debridement & Destruction	T	0.3156	$20.73		$4.15
0013	Level II Debridement & Destruction	T	0.8332	$54.73		$10.95
0015	Level III Debridement & Destruction	T	1.5126	$99.35		$19.87
0016	Level IV Debridement & Destruction	T	2.7062	$177.75		$35.55
0017	Level VI Debridement & Destruction	T	20.6214	$1,354.50		$270.90
0019	Level I Excision/ Biopsy	T	4.3877	$288.20	$71.87	$57.64
0020	Level II Excision/ Biopsy	T	7.9864	$524.58		$104.92
0021	Level III Excision/ Biopsy	T	15.8699	$1,042.40	$219.48	$208.48
0022	Level IV Excision/ Biopsy	T	21.7477	$1,428.48	$354.45	$285.70
0028	Level I Breast Surgery	T	21.5003	$1,412.23	$303.74	$282.45
0029	Level II Breast Surgery	T	33.7028	$2,213.73	$581.52	$442.75
0030	Level III Breast Surgery	T	40.6119	$2,667.55	$747.07	$533.51
0031	Smoking Cessation Services	X	0.1717	$11.28		$2.26
0034	Mental Health Services Composite	S	2.6501	$174.07		$34.82
0035	Vascular Puncture and Minor Diagnostic Procedures	X	0.2298	$15.09		$3.02

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0037	Level IV Needle Biopsy/Aspiration Except Bone Marrow	T	13.5257	$888.42	$228.76	$177.69
0039	Level I Implantation of Neurostimulator	S	182.4712	$11,985.44		$2,397.09
0040	Percutaneous Implantation of Neurostimulator Electrodes, Excluding Cranial Nerve	S	64.4162	$4,231.11		$846.23
0041	Level I Arthroscopy	T	29.4350	$1,933.41		$386.69
0042	Level II Arthroscopy	T	49.2291	$3,233.56	$804.74	$646.72
0045	Bone/Joint Manipulation Under Anesthesia	T	15.5334	$1,020.30	$268.47	$204.06
0047	Arthroplasty without Prosthesis	T	37.8828	$2,488.29	$537.03	$497.66
0048	Level I Arthroplasty or Implantation with Prosthesis	T	52.8676	$3,472.56		$694.52
0049	Level I Musculoskeletal Procedures Except Hand and Foot	T	22.3967	$1,471.10		$294.22
0050	Level II Musculoskeletal Procedures Except Hand and Foot	T	29.4401	$1,933.74		$386.75
0051	Level III Musculoskeletal Procedures Except Hand and Foot	T	45.4359	$2,984.41		$596.89
0052	Level IV Musculoskeletal Procedures Except Hand and Foot	T	85.4915	$5,615.42		$1,123.09
0053	Level I Hand Musculoskeletal Procedures	T	16.9978	$1,116.48	$253.49	$223.30
0054	Level II Hand Musculoskeletal Procedures	T	28.1744	$1,850.61		$370.13
0055	Level I Foot Musculoskeletal Procedures	T	21.6078	$1,419.29	$355.34	$283.86
0056	Level II Foot Musculoskeletal Procedures	T	47.1767	$3,098.75		$619.75
0057	Bunion Procedures	T	31.0283	$2,038.06	$475.91	$407.62
0058	Level I Strapping and Cast Application	S	1.1147	$73.22		$14.65
0060	Manipulation Therapy	S	0.4025	$26.44		$5.29
0061	Laminectomy, Laparoscopy, or Incision for Implantation of Neurostimulator Electr	S	80.4914	$5,287.00		$1,057.40
0062	Level I Treatment Fracture/Dislocation	T	25.6821	$1,686.90	$372.87	$337.38

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0063	Level II Treatment Fracture/Dislocation	T	42.5770	$2,796.63		$559.33
0064	Level III Treatment Fracture/Dislocation	T	62.0926	$4,078.49	$835.79	$815.70
0065	Level I Stereotactic Radiosurgery, MRgFUS, and MEG	S	15.1533	$995.33		$199.07
0066	Level II Stereotactic Radiosurgery, MRgFUS, and MEG	S	40.4116	$2,654.40		$530.88
0067	Level III Stereotactic Radiosurgery, MRgFUS, and MEG	S	55.7874	$3,664.34		$732.87
0069	Thoracoscopy	T	33.8939	$2,226.29	$591.64	$445.26
0070	Thoracentesis/Lavage Procedures	T	5.3627	$352.24		$70.45
0071	Level I Endoscopy Upper Airway	T	0.9326	$61.26		$12.26
0072	Level II Endoscopy Upper Airway	T	1.7542	$115.22		$23.05
0073	Level III Endoscopy Upper Airway	T	4.3638	$286.63	$69.15	$57.33
0074	Level IV Endoscopy Upper Airway	T	17.9233	$1,177.27	$292.25	$235.46
0075	Level V Endoscopy Upper Airway	T	23.4400	$1,539.63	$445.92	$307.93
0076	Level I Endoscopy Lower Airway	T	10.2410	$672.67	$189.82	$134.54
0077	Level I Pulmonary Treatment	S	0.3971	$26.08	$7.74	$5.22
0078	Level II Pulmonary Treatment	S	1.4146	$92.92		$18.59
0079	Ventilation Initiation and Management	S	2.7751	$182.28		$36.46
0080	Diagnostic Cardiac Catheterization	T	39.5675	$2,598.95	$838.92	$519.79
0082	Coronary or Non-Coronary Atherectomy	T	89.0122	$5,846.68		$1,169.34
0083	Coronary or Non-Coronary Angioplasty and Percutaneous Valvuloplasty	T	48.2679	$3,170.43		$634.09
0084	Level I Electrophysiologic Procedures	S	10.5097	$690.32		$138.07
0085	Level II Electrophysiologic Procedures	T	48.8767	$3,210.42		$642.09
0086	Level III Electrophysiologic Procedures	T	99.5911	$6,541.54		$1,308.31
0088	Thrombectomy	T	40.2393	$2,643.08	$655.22	$528.62
0089	Insertion/Replacement of Permanent Pacemaker	T	114.6104	$7,528.07	$1,634.44	$1,505.62

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
	and Electrodes					
0090	Insertion/Replacement of Pacemaker Pulse Generator	T	94.7306	$6,222.28	$1,562.51	$1,244.46
0091	Level II Vascular Ligation	T	43.1274	$2,832.78		$566.56
0092	Level I Vascular Ligation	T	27.1216	$1,781.46		$356.30
0093	Vascular Reconstruction/Fistula Repair without Device	T	27.2558	$1,790.27		$358.06
0094	Level I Resuscitation and Cardioversion	S	2.4550	$161.25	$46.29	$32.25
0095	Cardiac Rehabilitation	S	0.5713	$37.53	$13.86	$7.51
0096	Non-Invasive Vascular Studies	S	1.4496	$95.22	$37.42	$19.05
0097	Cardiac and Ambulatory Blood Pressure Monitoring	X	1.0044	$65.97	$23.79	$13.20
0099	Electrocardiograms	S	0.4021	$26.41		$5.29
0100	Cardiac Stress Tests	X	2.5931	$170.33	$41.44	$34.07
0101	Tilt Table Evaluation	S	4.3029	$282.63	$100.24	$56.53
0103	Miscellaneous Vascular Procedures	T	15.8354	$1,040.13		$208.03
0104	Transcatheter Placement of Intracoronary Stents	T	83.1148	$5,459.31		$1,091.87
0105	Repair/Revision/Removal of Pacemakers, AICDs, or Vascular Devices	T	22.2934	$1,464.32		$292.87
0106	Insertion/Replacement of Pacemaker Leads and/or Electrodes	T	49.6204	$3,259.27		$651.86
0107	Insertion of Cardioverter-Defibrillator	T	327.1195	$21,486.52		$4,297.31
0108	Insertion/Replacement/Repair of Cardioverter-Defibrillator Leads	T	406.8227	$26,721.74		$5,344.35
0110	Transfusion	S	3.3941	$222.94		$44.59
0111	Blood Product Exchange	S	11.7199	$769.81	$198.40	$153.97
0112	Apheresis and Stem Cell Procedures	S	30.7556	$2,020.15	$433.29	$404.03
0113	Excision Lymphatic System	T	23.7542	$1,560.27		$312.06
0114	Thyroid/Lymphadenectomy Procedures	T	47.1418	$3,096.46		$619.30

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0115	Cannula/Access Device Procedures	T	30.5339	$2,005.59		$401.12
0121	Level I Tube or Catheter Changes or Repositioning	T	4.5975	$301.98		$60.40
0126	Level I Urinary and Anal Procedures	T	1.0401	$68.32	$16.21	$13.67
0127	Level IV Stereotactic Radiosurgery, MRgFUS, and MEG	S	115.8206	$7,607.56		$1,521.52
0128	Echocardiogram with Contrast	S	8.5914	$564.32	$216.29	$112.87
0129	Level I Closed Treatment Fracture Finger/Toe/Trunk	T	1.5788	$103.70		$20.74
0130	Level I Laparoscopy	T	37.5470	$2,466.24	$659.53	$493.25
0131	Level II Laparoscopy	T	46.3867	$3,046.86	$1,001.89	$609.38
0132	Level III Laparoscopy	T	71.7816	$4,714.90	$1,239.22	$942.98
0133	Level I Skin Repair	T	1.3704	$90.01	$25.67	$18.01
0134	Level II Skin Repair	T	3.5321	$232.00		$46.40
0135	Level III Skin Repair	T	4.7503	$312.02		$62.41
0136	Level IV Skin Repair	T	16.0086	$1,051.51		$210.31
0137	Level V Skin Repair	T	20.8007	$1,366.27		$273.26
0138	Level II Closed Treatment Fracture Finger/Toe/Trunk	T	6.0607	$398.09		$79.62
0139	Level III Closed Treatment Fracture Finger/Toe/Trunk	T	20.4295	$1,341.89		$268.38
0140	Esophageal Dilation without Endoscopy	T	6.4892	$426.24	$91.40	$85.25
0141	Level I Upper GI Procedures	T	8.7109	$572.17	$143.38	$114.44
0142	Small Intestine Endoscopy	T	9.5559	$627.67	$152.78	$125.54
0143	Lower GI Endoscopy	T	9.0436	$594.02	$186.06	$118.81
0146	Level I Sigmoidoscopy and Anoscopy	T	5.5535	$364.78		$72.96
0147	Level II Sigmoidoscopy and Anoscopy	T	9.1698	$602.31		$120.47
0148	Level I Anal/Rectal Procedures	T	5.7614	$378.43		$75.69

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0149	Level III Anal/Rectal Procedures	T	23.3417	$1,533.18		$306.64
0150	Level IV Anal/Rectal Procedures	T	31.2003	$2,049.36	$437.12	$409.88
0151	Endoscopic Retrograde Cholangio-Pancreatography (ERCP)	T	21.7949	$1,431.58		$286.32
0152	Level I Percutaneous Abdominal and Biliary Procedures	T	30.1057	$1,977.46		$395.50
0153	Peritoneal and Abdominal Procedures	T	23.2665	$1,528.24	$371.60	$305.65
0154	Hernia/Hydrocele Procedures	T	31.6898	$2,081.51	$464.85	$416.31
0155	Level II Anal/Rectal Procedures	T	12.2474	$804.46		$160.90
0156	Level III Urinary and Anal Procedures	T	3.1503	$206.92		$41.39
0157	Colorectal Cancer Screening: Barium Enema	S	2.6593	$174.67		$34.94
0158	Colorectal Cancer Screening: Colonoscopy	T	7.9982	$525.35		$131.34
0159	Colorectal Cancer Screening: Flexible Sigmoidoscopy	S	5.0526	$331.87		$82.97
0160	Level I Cystourethroscopy and other Genitourinary Procedures	T	7.1684	$470.85		$94.17
0161	Level II Cystourethroscopy and other Genitourinary Procedures	T	18.9529	$1,244.90		$248.98
0162	Level III Cystourethroscopy and other Genitourinary Procedures	T	25.6811	$1,686.84		$337.37
0163	Level IV Cystourethroscopy and other Genitourinary Procedures	T	36.4225	$2,392.38		$478.48
0164	Level II Urinary and Anal Procedures	T	2.2063	$144.92		$28.99
0165	Level IV Urinary and Anal Procedures	T	20.2632	$1,330.97		$266.20
0166	Level I Urethral Procedures	T	20.0824	$1,319.09		$263.82
0168	Level II Urethral Procedures	T	30.5507	$2,006.69		$401.34
0169	Lithotripsy	T	42.4594	$2,788.90	$997.74	$557.78
0170	Dialysis	S	6.5091	$427.54		$85.51
0172	Level I Partial Hospitalization (3 services)	P	2.1284	$139.80		$27.96

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0173	Level II Partial Hospitalization (4 or more services)	P	2.6501	$174.07		$34.82
0181	Level II Male Genital Procedures	T	35.5509	$2,335.13	$621.82	$467.03
0183	Level I Male Genital Procedures	T	22.8775	$1,502.69		$300.54
0184	Prostate Biopsy	T	11.8068	$775.52		$155.11
0188	Level II Female Reproductive Proc	T	1.4203	$93.29		$18.66
0189	Level III Female Reproductive Proc	T	3.0399	$199.67		$39.94
0190	Level I Hysteroscopy	T	22.0023	$1,445.20	$424.28	$289.04
0191	Level I Female Reproductive Proc	T	0.1824	$11.98		$2.40
0192	Level IV Female Reproductive Proc	T	6.3303	$415.80		$83.16
0193	Level V Female Reproductive Proc	T	19.8841	$1,306.07		$261.22
0195	Level VI Female Reproductive Procedures	T	33.9125	$2,227.51	$483.80	$445.51
0202	Level VII Female Reproductive Procedures	T	43.6282	$2,865.67	$981.50	$573.14
0203	Level IV Nerve Injections	T	14.6571	$962.74	$240.33	$192.55
0204	Level I Nerve Injections	T	2.5055	$164.57	$40.13	$32.92
0206	Level II Nerve Injections	T	3.6940	$242.64	$52.09	$48.53
0207	Level III Nerve Injections	T	7.3510	$482.84		$96.57
0208	Laminotomies and Laminectomies	T	48.3964	$3,178.87		$635.78
0209	Level II Extended EEG and Sleep Studies	S	11.4227	$750.29	$268.73	$150.06
0213	Level I Extended EEG and Sleep Studies	S	2.3220	$152.52	$53.58	$30.51
0215	Level I Nerve and Muscle Tests	S	0.5969	$39.21		$7.85
0216	Level III Nerve and Muscle Tests	S	2.7194	$178.62		$35.73
0218	Level II Nerve and Muscle Tests	S	1.2004	$78.85		$15.77
0220	Level I Nerve Procedures	T	18.4356	$1,210.92		$242.19
0221	Level II Nerve Procedures	T	36.1780	$2,376.32		$475.27
0222	Level II Implantation of Neurostimulator	S	241.9400	$15,891.59		$3,178.32
0224	Implantation of Catheter/Reservoir/Shunt	T	42.2017	$2,771.98		$554.40
0225	Implantation of Neurostimulator Electrodes,	S	101.1630	$6,644.79		$1,328.96

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
	Cranial Nerve					
0227	Implantation of Drug Infusion Device	T	184.6865	$12,130.95		$2,426.19
0229	Transcatherter Placement of Intravascular Shunts	T	90.7212	$5,958.93		$1,191.79
0230	Level I Eye Tests & Treatments	S	0.6359	$41.77		$8.36
0231	Level III Eye Tests & Treatments	S	2.1019	$138.06		$27.62
0232	Level I Anterior Segment Eye Procedures	T	4.5980	$302.02	$75.66	$60.41
0233	Level II Anterior Segment Eye Procedures	T	16.3116	$1,071.41	$266.33	$214.29
0234	Level III Anterior Segment Eye Procedures	T	23.9886	$1,575.67	$511.31	$315.14
0235	Level I Posterior Segment Eye Procedures	T	5.8210	$382.35		$76.47
0237	Level II Posterior Segment Eye Procedures	T	22.0653	$1,449.34		$289.87
0238	Level I Repair and Plastic Eye Procedures	T	2.9984	$196.95		$39.39
0239	Level II Repair and Plastic Eye Procedures	T	7.8833	$517.81		$103.57
0240	Level III Repair and Plastic Eye Procedures	T	19.1444	$1,257.48	$309.52	$251.50
0241	Level IV Repair and Plastic Eye Procedures	T	25.4908	$1,674.34	$383.45	$334.87
0242	Level V Repair and Plastic Eye Procedures	T	38.2210	$2,510.51	$597.36	$502.11
0243	Strabismus/Muscle Procedures	T	24.5085	$1,609.82	$430.35	$321.97
0244	Corneal and Amniotic Membrane Transplant	T	37.6829	$2,475.16	$803.26	$495.04
0245	Level I Cataract Procedures without IOL Insert	T	14.1643	$930.37	$212.54	$186.08
0246	Cataract Procedures with IOL Insert	T	24.1528	$1,586.45	$495.96	$317.29
0247	Laser Eye Procedures	T	5.3324	$350.25	$104.31	$70.05
0249	Level II Cataract Procedures without IOL Insert	T	31.3050	$2,056.24	$524.67	$411.25
0250	Level I ENT Procedures	T	1.1335	$74.45	$25.10	$14.89
0251	Level II ENT Procedures	T	3.1568	$207.35		$41.47
0252	Level III ENT Procedures	T	7.7504	$509.08	$109.16	$101.82
0253	Level IV ENT Procedures	T	17.1953	$1,129.46	$282.29	$225.90
0254	Level V ENT Procedures	T	24.6341	$1,618.07		$323.62
0256	Level VI ENT Procedures	T	41.6247	$2,734.08		$546.82

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0259	Level VII ENT Procedures	T	383.6563	$25,200.08	$8,543.66	$5,040.02
0260	Level I Plain Film Except Teeth	X	0.6979	$45.84		$9.17
0261	Level II Plain Film Except Teeth Including Bone Density Measurement	X	1.1555	$75.90		$15.18
0262	Plain Film of Teeth	X	0.5358	$35.19		$7.04
0263	Level I Miscellaneous Radiology Procedures	X	2.9629	$194.62		$38.93
0265	Level I Diagnostic and Screening Ultrasound	S	0.9644	$63.35	$22.35	$12.67
0266	Level II Diagnostic and Screening Ultrasound	S	1.5058	$98.91	$37.80	$19.79
0267	Level III Diagnostic and Screening Ultrasound	S	2.3495	$154.32	$60.50	$30.87
0269	Level II Echocardiogram Without Contrast Except Transesophageal	S	6.4958	$426.67		$85.34
0270	Transesophageal Echocardiogram Without Contrast	S	8.3205	$546.52	$141.32	$109.31
0272	Fluoroscopy	X	1.2985	$85.29	$31.64	$17.06
0274	Myelography	S	5.8631	$385.11		$77.03
0275	Arthrography	S	4.0974	$269.13	$69.09	$53.83
0276	Level I Digestive Radiology	S	1.3716	$90.09	$34.97	$18.02
0277	Level II Digestive Radiology	S	2.2278	$146.33	$54.52	$29.27
0278	Diagnostic Urography	S	2.6725	$175.54	$59.40	$35.11
0279	Level II Angiography and Venography	S	29.6349	$1,946.54		$389.31
0280	Level III Angiography and Venography	S	45.0529	$2,959.25		$591.85
0282	Miscellaneous Computed Axial Tomography	S	1.6117	$105.86	$37.81	$21.18
0283	Computed Tomography with Contrast	S	4.7266	$310.46	$100.37	$62.10
0284	Magnetic Resonance Imaging and Magnetic Resonance Angiography with Contrast	S	6.5748	$431.86	$148.40	$86.38
0288	Bone Density:Axial Skeleton	S	1.1143	$73.19	$28.90	$14.64
0293	Level V Anterior Segment Eye Procedures	T	113.2439	$7,438.31		$1,487.67
0299	Hyperthermia and Radiation Treatment	S	5.8229	$382.47		$76.50

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
	Procedures					
0300	Level I Radiation Therapy	S	1.3962	$91.71		$18.35
0301	Level II Radiation Therapy	S	2.2319	$146.60		$29.32
0303	Treatment Device Construction	X	2.9327	$192.63	$66.95	$38.53
0304	Level I Therapeutic Radiation Treatment Preparation	X	1.5618	$102.59	$38.68	$20.52
0305	Level II Therapeutic Radiation Treatment Preparation	X	3.9871	$261.89	$91.38	$52.38
0307	Myocardial Positron Emission Tomography (PET) imaging	S	17.4083	$1,143.45	$238.72	$228.69
0308	Non-Myocardial Positron Emission Tomography (PET) imaging	S	16.1159	$1,058.56		$211.72
0310	Level III Therapeutic Radiation Treatment Preparation	X	13.7096	$900.50	$325.27	$180.10
0312	Radioelement Applications	S	7.9492	$522.14		$104.43
0313	Brachytherapy	S	11.4819	$754.18		$150.84
0315	Level III Implantation of Neurostimulator	S	269.8886	$17,727.36		$3,545.48
0317	Level II Miscellaneous Radiology Procedures	X	5.1751	$339.92		$67.99
0320	Electroconvulsive Therapy	S	5.8540	$384.51	$80.06	$76.91
0322	Brief Individual Psychotherapy	S	1.3362	$87.77		$17.56
0323	Extended Individual Psychotherapy	S	1.6400	$107.72		$21.55
0324	Family Psychotherapy	S	2.5065	$164.64		$32.93
0325	Group Psychotherapy	S	0.9540	$62.66	$13.71	$12.54
0330	Dental Procedures	S	7.9447	$521.84		$104.37
0332	Computed Tomography without Contrast	S	2.9900	$196.40	$75.24	$39.28
0333	Computed Tomography without Contrast followed by Contrast)	S	5.2620	$345.63	$119.01	$69.13
0336	Magnetic Resonance Imaging and Magnetic Resonance Angiography without Contrast	S	5.4285	$356.57	$137.40	$71.32

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0337	Magnetic Resonance Imaging and Magnetic Resonance Angiography without Contrast f	S	8.3173	$546.31	$199.53	$109.27
0340	Minor Ancillary Procedures	X	0.6481	$42.57		$8.52
0341	Skin Tests	X	0.0847	$5.56	$2.14	$1.12
0342	Level I Pathology	X	0.1558	$10.23		$2.05
0343	Level III Pathology	X	0.5322	$34.96	$10.84	$7.00
0344	Level IV Pathology	X	0.8373	$55.00	$15.66	$11.00
0345	Level I Transfusion Laboratory Procedures	X	0.2210	$14.52		$2.91
0346	Level II Transfusion Laboratory Procedures	X	0.3909	$25.68		$5.14
0347	Level III Transfusion Laboratory Procedures	X	0.8145	$53.50	$11.28	$10.70
0350	Administration of flu and PPV vaccine	S	0.3810	$25.03		$0.00
0360	Level I Alimentary Tests	X	1.5404	$101.18	$33.88	$20.24
0361	Level II Alimentary Tests	X	4.0162	$263.80	$83.23	$52.76
0363	Level I Otorhinolaryngologic Function Tests	X	0.8762	$57.55	$17.10	$11.51
0364	Level I Audiometry	X	0.4638	$30.46	$7.06	$6.10
0365	Level II Audiometry	X	1.2904	$84.76	$18.52	$16.96
0366	Level III Audiometry	X	1.7950	$117.90	$25.79	$23.58
0367	Level I Pulmonary Test	X	0.5744	$37.73	$13.76	$7.55
0368	Level II Pulmonary Tests	X	0.8437	$55.42	$21.09	$11.09
0369	Level III Pulmonary Tests	X	2.7139	$178.26	$44.18	$35.66
0370	Allergy Tests	X	1.3792	$90.59		$18.12
0373	Level I Neuropsychological Testing	X	1.3147	$86.35		$17.27
0375	Ancillary Outpatient Services When Patient Expires	S	72.6284	$4,770.52		$954.11
0377	Level II Cardiac Imaging	S	11.9216	$783.06	$158.84	$156.62
0378	Level II Pulmonary Imaging	S	5.0294	$330.35	$125.33	$66.07
0379	Injection adenosine 6 MG	K		$12.60		$2.52
0381	Single Allergy Tests	X	0.3866	$25.39		$5.08

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0382	Level II Neuropsychological Testing	X	2.5409	$166.90		$33.38
0383	Cardiac Computed Tomographic Imaging	S	4.3282	$284.29	$111.16	$56.86
0384	GI Procedures with Stents	T	25.7802	$1,693.35		$338.67
0385	Level I Prosthetic Urological Procedures	S	95.4091	$6,266.85		$1,253.37
0386	Level II Prosthetic Urological Procedures	S	149.3352	$9,808.93		$1,961.79
0387	Level II Hysteroscopy	T	36.4505	$2,394.21	$655.55	$478.85
0388	Discography	S	20.6787	$1,358.26	$289.72	$271.66
0389	Level I Non-imaging Nuclear Medicine	S	1.8483	$121.40	$33.81	$24.28
0390	Level I Endocrine Imaging	S	2.0747	$136.27	$52.15	$27.26
0391	Level II Endocrine Imaging	S	3.4189	$224.57	$66.18	$44.92
0392	Level II Non-imaging Nuclear Medicine	S	2.8090	$184.51	$49.22	$36.91
0393	Hematologic Processing & Studies	S	6.0567	$397.83	$82.04	$79.57
0394	Hepatobiliary Imaging	S	4.4916	$295.03	$102.61	$59.01
0395	GI Tract Imaging	S	3.7913	$249.03	$89.73	$49.81
0396	Bone Imaging	S	3.8172	$250.73	$95.02	$50.15
0397	Vascular Imaging	S	3.0344	$199.31	$49.36	$39.87
0398	Level I Cardiac Imaging	S	4.8197	$316.58	$100.06	$63.32
0400	Hematopoietic Imaging	S	3.9437	$259.04	$93.22	$51.81
0401	Level I Pulmonary Imaging	S	3.2732	$215.00	$77.73	$43.00
0402	Level II Nervous System Imaging	S	8.8659	$582.35		$116.47
0403	Level I Nervous System Imaging	S	2.8408	$186.60	$72.45	$37.32
0404	Renal and Genitourinary Studies	S	5.0433	$331.26	$84.11	$66.26
0406	Level I Tumor/Infection Imaging	S	4.6416	$304.88	$92.73	$60.98
0407	Level I Radionuclide Therapy	S	3.3609	$220.76	$78.13	$44.16
0408	Level III Tumor/Infection Imaging	S	16.4653	$1,081.51		$216.31
0409	Red Blood Cell Tests	X	0.1187	$7.80	$2.20	$1.56
0412	IMRT Treatment Delivery	S	5.5272	$363.05		$72.61

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0413	Level II Radionuclide Therapy	S	5.6710	$372.49		$74.50
0414	Level II Tumor/Infection Imaging	S	8.5213	$559.71	$214.44	$111.95
0415	Level II Endoscopy Lower Airway	T	25.1730	$1,653.46	$459.92	$330.70
0418	Insertion of Left Ventricular Pacing Elect.	T	131.5909	$8,643.42		$1,728.69
0422	Level II Upper GI Procedures	T	26.4591	$1,737.94	$448.81	$347.59
0423	Level II Percutaneous Abdominal and Biliary Procedures	T	46.0975	$3,027.87		$605.58
0425	Level II Arthroplasty or Implantation with Prosthesis	T	120.5685	$7,919.42		$1,583.89
0426	Level II Strapping and Cast Application	S	2.4021	$157.78		$31.56
0427	Level II Tube or Catheter Changes or Repositioning	T	15.5051	$1,018.44		$203.69
0428	Level III Sigmoidoscopy and Anoscopy	T	23.8940	$1,569.45		$313.89
0429	Level V Cystourethroscopy and other Genitourinary Procedures	T	45.9136	$3,015.79		$603.16
0432	Health and Behavior Services	S	0.4341	$28.51		$5.71
0433	Level II Pathology	X	0.2499	$16.41	$5.17	$3.29
0434	Cardiac Defect Repair	T	138.5843	$9,102.77		$1,820.56
0436	Level I Drug Administration	S	0.3810	$25.03		$5.01
0437	Level II Drug Administration	S	0.5581	$36.66		$7.34
0438	Level III Drug Administration	S	1.1315	$74.32		$14.87
0439	Level IV Drug Administration	S	1.9305	$126.80		$25.36
0440	Level V Drug Administration	S	2.9088	$191.06		$38.22
0442	Dosimetric Drug Administration	S	29.7403	$1,953.46		$390.70
0604	Level 1 Hospital Clinic Visits	V	0.8425	$55.34		$11.07
0605	Level 2 Hospital Clinic Visits	V	1.0387	$68.23		$13.65
0606	Level 3 Hospital Clinic Visits	V	1.3354	$87.71		$17.55
0607	Level 4 Hospital Clinic Visits	V	1.7777	$116.77		$23.36

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0608	Level 5 Hospital Clinic Visits	V	2.3605	$155.05		$31.01
0609	Level 1 Type A Emergency Visits	V	0.8162	$53.61	$12.70	$10.73
0613	Level 2 Type A Emergency Visits	V	1.3239	$86.96	$21.06	$17.40
0614	Level 3 Type A Emergency Visits	V	2.0761	$136.37	$34.50	$27.28
0615	Level 4 Type A Emergency Visits	V	3.3393	$219.34	$48.49	$43.87
0616	Level 5 Emergency Visits	V	4.9566	$325.57	$72.86	$65.12
0617	Critical Care	S	7.4380	$488.56	$111.59	$97.72
0618	Trauma Response with Critical Care	S	15.0884	$991.07		$198.22
0621	Level I Vascular Access Procedures	T	11.1392	$731.67		$146.34
0622	Level II Vascular Access Procedures	T	24.7775	$1,627.49		$325.50
0623	Level III Vascular Access Procedures	T	29.5674	$1,942.11		$388.43
0624	Phlebotomy and Minor Vascular Access Device Procedures	X	0.6000	$39.41	$12.65	$7.89
0626	Level 1 Type B Emergency Visits	V	0.7385	$48.51		$9.71
0627	Level 2 Type B Emergency Visits	V	0.9869	$64.82		$12.97
0628	Level 3 Type B Emergency Visits	V	1.4056	$92.33		$18.47
0629	Level 4 Type B Emergency Visits	V	2.3836	$156.56		$31.32
0648	Level IV Breast Surgery	T	57.9012	$3,803.18		$760.64
0651	Complex Interstitial Radiation Source Application	S	18.1875	$1,194.63		$238.93
0652	Insertion of Intraperitoneal and Pleural Catheters	T	29.6599	$1,948.18		$389.64
0653	Vascular Reconstruction/Fistula Repair with Device	T	45.5184	$2,989.83		$597.97
0654	Insertion/Replacement of a permanent dual chamber pacemaker	T	108.2256	$7,108.69		$1,421.74
0655	Insertion/Replacement/Conversion of a permanent dual chamber pacemaker	T	141.3486	$9,284.34		$1,856.87
0656	Transcatheter Placement of Intracoronary Drug-Eluting Stents	T	113.6926	$7,467.78		$1,493.56

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0659	Hyperbaric Oxygen	S	1.5663	$102.88		$20.58
0660	Level II Otorhinolaryngologic Function Tests	X	1.5269	$100.29	$28.06	$20.06
0661	Level V Pathology	X	2.5473	$167.32	$60.52	$33.47
0662	CT Angiography	S	5.4448	$357.64	$118.88	$71.53
0664	Level I Proton Beam Radiation Therapy	S	14.0758	$924.55		$184.91
0665	Bone Density:AppendicularSkeleton	S	0.5032	$33.05	$12.95	$6.61
0667	Level II Proton Beam Radiation Therapy	S	16.8212	$1,104.88		$220.98
0668	Level I Angiography and Venography	S	10.3886	$682.36		$136.48
0672	Level III Posterior Segment Eye Procedures	T	37.8896	$2,488.74		$497.75
0673	Level IV Anterior Segment Eye Procedures	T	40.1189	$2,635.17	$649.56	$527.04
0674	Prostate Cryoablation	T	120.7521	$7,931.48		$1,586.30
0676	Thrombolysis and Thrombectomy	T	2.4493	$160.88		$32.18
0678	External Counterpulsation	T	1.5515	$101.91		$20.39
0679	Level II Resuscitation and Cardioversion	S	5.4894	$360.57	$95.30	$72.12
0680	Insertion of Patient Activated Event Recorders	S	71.5537	$4,699.93		$939.99
0681	Knee Arthroplasty	T	214.1624	$14,067.04		$2,813.41
0682	Level V Debridement & Destruction	T	7.3423	$482.27	$158.65	$96.46
0683	Level II Photochemotherapy	S	2.9323	$192.61		$38.53
0685	Level III Needle Biopsy/Aspiration Except Bone Marrow	T	9.6161	$631.62		$126.33
0687	Revision/Removal of Neurostimulator Electrodes	T	19.4577	$1,278.06	$391.49	$255.62
0688	Revision/Removal of Neurostimulator Pulse Generator Receiver	T	29.1033	$1,911.62	$762.66	$382.33
0689	Level II Electronic Analysis of Devices	S	0.5805	$38.13		$7.63
0690	Level I Electronic Analysis of Devices	S	0.3456	$22.70	$8.67	$4.54
0691	Level IV Electronic Analysis of Devices	S	2.6410	$173.47	$50.49	$34.70
0692	Level III Electronic Analysis of Devices	S	1.7241	$113.25		$22.65
0694	Mohs Surgery	T	4.3668	$286.83	$91.69	$57.37

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0697	Level I Echocardiogram Without Contrast Except Transesophageal	S	3.4563	$227.02		$45.41
0698	Level II Eye Tests & Treatments	S	0.9139	$60.03		$12.01
0699	Level IV Eye Tests & Treatments	T	14.3730	$944.08		$188.82
0701	Sr89 strontium	K	9.6387	$633.11		$126.63
0702	Sm 153 lexidronm	K	22.6536	$1,487.98		$297.60
0726	Dexrazoxane HCl injection	K		$177.53		$35.51
0728	Filgrastim 300 mcg injection	K		$195.48		$39.10
0730	Pamidronate disodium	K		$27.79		$5.56
0731	Sargramostim injection	K		$24.63		$4.93
0732	Mesna injection	K		$7.72		$1.55
0735	Ampho b cholesteryl sulfate	K		$11.77		$2.36
0736	Amphotericin b liposome inj	K		$16.84		$3.37
0738	Rasburicase	K		$147.46		$29.50
0747	Chlorothiazide sodium inj	K		$162.00		$32.40
0750	Dolasetron mesylate	K		$4.11		$0.83
0751	Mechlorethamine hcl inj	K		$141.72		$28.35
0752	Dactinomycin actinomycin d	K		$484.12		$96.83
0759	Naltrexone, depot form	K		$1.85		$0.37
0760	Anadulafungin injection	K		$1.50		$0.30
0763	Dolasetron mesylate oral	K		$48.24		$9.65
0764	Granisetron HCl injection	K		$4.86		$0.98
0765	Granisetron HCl 1 mg oral	K		$46.07		$9.22
0768	Ondansetron hcl injection	K		$0.22		$0.05
0769	Ondansetron HCl 8mg oral	K		$4.52		$0.91
0800	Leuprolide acetate	K		$433.32		$86.67
0802	Etoposide oral	K		$28.99		$5.80
0804	Vivaglobin, inj	K		$6.94		$1.39

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0807	Aldesleukin/single use vial	K		$752.92		$150.59
0809	Bcg live intravesical vac	K		$111.60		$22.32
0810	Goserelin acetate implant	K		$186.15		$37.23
0812	Carmus bischl nitro inj	K		$153.87		$30.78
0814	Asparaginase injection	K		$55.94		$11.19
0820	Daunorubicin	K		$16.82		$3.37
0821	Daunorubicin citrate liposom	K		$55.01		$11.01
0823	Docetaxel	K		$319.70		$63.94
0825	Nelarabine injection	G		$89.95		$17.66
0827	Floxuridine injection	K		$50.16		$10.04
0828	Gemcitabine HCl	K		$129.29		$25.86
0830	Irinotecan injection	K		$123.85		$24.77
0831	Ifosfomide injection	K		$37.21		$7.45
0832	Idarubicin hcl injection	K		$270.86		$54.18
0834	Interferon alfa-2a inj	K		$40.15		$8.03
0835	Inj cosyntropin	K		$64.36		$12.88
0836	Interferon alfa-2b inj	K		$13.89		$2.78
0838	Interferon gamma 1-b inj	K		$303.74		$60.75
0840	Inj melphalan hydrochl	K		$1,534.12		$306.83
0842	Fludarabine phosphate inj	K		$196.97		$39.40
0843	Pegaspargase/singl dose vial	K		$2,054.11		$410.83
0844	Pentostatin injection	K		$1,794.41		$358.89
0849	Rituximab cancer treatment	K		$510.74		$102.15
0850	Streptozocin injection	K		$187.04		$37.41
0851	Thiotepa injection	K		$39.63		$7.93
0852	Topotecan	K		$881.59		$176.32
0855	Vinorelbine tartrate	K		$15.91		$3.19

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0856	Porfimer sodium	K		$2,456.31		$491.27
0858	Inj cladribine	K		$30.05		$6.01
0861	Leuprolide acetate injeciton	K		$7.32		$1.47
0863	Paclitaxel injection	K		$11.72		$2.35
0864	Mitoxantrone hydrochl	K		$87.02		$17.41
0865	Interferon alfa-n3 inj	K		$8.95		$1.79
0868	Oral aprepitant	K		$5.17		$1.04
0873	Hyalgan/supartz inj per dose	K		$99.33		$19.87
0874	Synvisc inj per dose	K		$176.66		$35.34
0875	Euflexxa inj per dose	K		$107.97		$21.60
0877	Orthovisc inj per dose	K		$174.32		$34.87
0878	Gallium nitrate injection	K		$1.59		$0.32
0883	Fondaparinux sodium	K		$5.61		$1.13
0884	Rho d immune globulin inj	K		$88.01		$17.61
0887	Azathioprine parenteral	K		$49.10		$9.82
0888	Cyclosporine oral	K		$3.59		$0.72
0890	Lymphocyte immune globulin	K		$376.55		$75.31
0891	Tacrolimus oral	K		$3.84		$0.77
0898	Gamma globulin 2 CC inj	K		$22.67		$4.54
0899	Gamma globulin 3 CC inj	K		$34.00		$6.80
0900	Alglucerase injection	K		$38.92		$7.79
0901	Alpha 1 proteinase inhibitor	K		$3.59		$0.72
0902	Botulinum toxin a per unit	K		$5.12		$1.03
0903	Cytomegalovirus imm IV /vial	K		$862.24		$172.45
0904	Gamma globulin 4 CC inj	K		$45.34		$9.07
0906	RSV-ivig	K		$15.87		$3.18
0910	Interferon beta-1b / .25 MG	K		$114.42		$22.89

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0913	Ganciclovir long act implant	K		$4,680.00		$936.00
0916	Injection imiglucerase /unit	K		$3.93		$0.79
0917	Adenosine injection	K		$66.89		$13.38
0919	Gamma globulin 5 CC inj	K		$56.68		$11.34
0920	Gamma globulin 6 CC inj	K		$68.02		$13.61
0921	Gamma globulin 7 CC inj	K		$79.31		$15.87
0922	Gamma globulin 8 CC inj	K		$90.68		$18.14
0923	Gamma globulin 9 CC inj	K		$102.05		$20.41
0924	Gamma globulin 10 CC inj	K		$113.35		$22.67
0925	Factor viii	K		$0.74		$0.15
0927	Factor viii recombinant	K		$1.06		$0.22
0928	Factor ix complex	K		$0.79		$0.16
0929	Anti-inhibitor	K		$1.41		$0.29
0931	Factor IX non-recombinant	K		$0.88		$0.18
0932	Factor IX recombinant	K		$1.05		$0.21
0933	Gamma globulin > 10 CC inj	K		$113.35		$22.67
0934	Capecitabine, oral	K		$15.00		$3.00
0935	Clonidine hydrochloride	K		$54.95		$10.99
0943	Octagam injection	K		$33.43		$6.69
0944	Gammagard liquid injection	K		$31.19		$6.24
0945	Rhophylac injection	K		$5.22		$1.05
0946	HepaGam B IM injection	K		$47.43		$9.49
0947	Flebogamma injection	K		$31.92		$6.39
0948	Gamunex injection	K		$32.82		$6.57
0949	Frozen plasma, pooled, sd	R	0.9487	$62.31		$12.47
0950	Whole blood for transfusion	R	3.6167	$237.56		$47.52
0951	Reclast injection	G		$216.61		$42.50

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0952	Cryoprecipitate each unit	R	0.6677	$43.86		$8.78
0954	RBC leukocytes reduced	R	2.9296	$192.43		$38.49
0955	Plasma, frz between 8-24hour	R	1.1188	$73.49		$14.70
0956	Plasma protein fract,5%,50ml	R	1.1645	$76.49		$15.30
0957	Platelets, each unit	R	1.2019	$78.95		$15.79
0958	Plaelet rich plasma unit	R	5.8879	$386.74		$77.35
0959	Red blood cells unit	R	2.1306	$139.95		$27.99
0960	Washed red blood cells unit	R	4.7822	$314.11		$62.83
0961	Albumin (human),5%, 50ml	K	0.3094	$20.32		$4.07
0963	Albumin (human), 5%, 250 ml	K	1.1065	$72.68		$14.54
0964	Albumin (human), 25%, 20 ml	K	0.3777	$24.81		$4.97
0965	Albumin (human), 25%, 50ml	K	1.0888	$71.52		$14.31
0966	Plasmaprotein fract,5%,250ml	R	3.2250	$211.83		$42.37
0967	Blood split unit	R	0.4667	$30.65		$6.13
0968	Platelets leukoreduced irrad	R	2.1748	$142.85		$28.57
0969	RBC leukoreduced irradiated	R	3.9175	$257.32		$51.47
0999	Edetate calcium disodium inj	K		$49.28		$9.86
1009	Cryoprecipitatereducedplasma	R	1.3214	$86.79		$17.36
1010	Blood, l/r, cmv-neg	R	2.4044	$157.93		$31.59
1011	Platelets, hla-m, l/r, unit	R	10.3632	$680.70		$136.14
1013	Platelets leukocytes reduced	R	1.6253	$106.76		$21.36
1015	Injection glatiramer acetate	K		$54.24		$10.85
1016	Blood, l/r, froz/degly/wash	R	4.5799	$300.83		$60.17
1017	Plt, aph/pher, l/r, cmv-neg	R	7.3121	$480.29		$96.06
1018	Blood, l/r, irradiated	R	3.6066	$236.90		$47.38
1019	Plate pheres leukoredu irrad	R	10.0323	$658.96		$131.80
1020	Plt, pher, l/r cmv-neg, irr	R	9.9964	$656.60		$131.32

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
1021	RBC, frz/deg/wsh, l/r, irrad	R	7.2738	$477.77		$95.56
1022	RBC, l/r, cmv-neg, irrad	R	4.5604	$299.55		$59.91
1023	Pralidoxime chloride inj	K		$86.41		$17.29
1052	Injection, voriconazole	K		$5.14		$1.03
1064	I131 iodide cap, rx	K	0.2447	$16.07		$3.22
1083	Adalimumab injection	K		$324.32		$64.87
1084	Denileukin diftitox	K		$1,383.43		$276.69
1086	Temozolomide	K		$7.52		$1.51
1138	Hepagam B intravenous, inj	K		$47.43		$9.49
1139	Protein C concentrate	K		$11.96		$2.40
1140	Integra matrix tissue	K		$18.94		$3.79
1141	Primatrix tissue	K		$37.74		$7.55
1142	Supprelin LA implant	G		$14,379.26		$2,821.59
1150	I131 iodide sol, rx	K	0.1603	$10.53		$2.11
1166	Cytarabine liposome	K		$407.12		$81.43
1167	Inj, epirubicin hcl	K		$6.12		$1.23
1168	Inj, temsirolimus	G		$47.78		$9.38
1178	Busulfan injection	K		$9.53		$1.91
1186	Acetylcysteine injection	K		$2.13		$0.43
1189	Foscarnet sodium injection	K		$10.19		$2.04
1203	Verteporfin injection	K		$8.98		$1.80
1204	Cyclosporin parenteral	K		$19.44		$3.89
1206	Dimecaprol injection	K		$26.17		$5.24
1207	Octreotide injection, depot	K		$99.84		$19.97
1208	Factor VIII (porcine)	K	0.0178	$1.17		$0.24
1209	Diethylstilbestrol injection	K	1.2964	$85.15		$17.03
1211	Oxytetracycline injection	K	2.5729	$169.00		$33.80

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
1212	Diphtheria antitoxin	K	1.5227	$100.02		$20.01
1213	VWF complex, not Humate-P	K		$0.64		$0.13
1214	Inj IVIG Privigen 500 mg	K		$33.54		$6.71
1215	Inj iron dextran	K		$11.38		$2.28
1216	Lyme disease vaccine, im	K	1.2166	$79.91		$15.99
1217	Penicillin g benzathine inj	K		$32.28		$6.46
1218	Triflupromazine hcl inj	K	0.3066	$20.14		$4.03
1280	Corticotropin injection	K		$2,311.08		$462.22
1436	Etidronate disodium inj	K		$70.06		$14.02
1491	New Technology - Level IA ($0-$10)	S		$5.00		$1.00
1492	New Technology - Level IB ($10-$20)	S		$15.00		$3.00
1493	New Technology - Level IC ($20-$30)	S		$25.00		$5.00
1494	New Technology - Level ID ($30-$40)	S		$35.00		$7.00
1495	New Technology - Level IE ($40-$50)	S		$45.00		$9.00
1496	New Technology - Level IA ($0-$10)	T		$5.00		$1.00
1497	New Technology - Level IB($10-$20)	T		$15.00		$3.00
1498	New Technology - Level IC ($20-$30)	T		$25.00		$5.00
1499	New Technology - Level ID($30-$40)	T		$35.00		$7.00
1500	New Technology - Level IE ($40-$50)	T		$45.00		$9.00
1502	New Technology - Level II ($50-$100)	S		$75.00		$15.00
1503	New Technology - Level III ($100-$200)	S		$150.00		$30.00
1504	New Technology - Level IV ($200-$300)	S		$250.00		$50.00
1505	New Technology - Level V ($300-$400)	S		$350.00		$70.00
1506	New Technology - Level VI ($400-$500)	S		$450.00		$90.00
1507	New Technology - Level VII ($500-$600)	S		$550.00		$110.00
1508	New Technology - Level VIII ($600-$700)	S		$650.00		$130.00
1509	New Technology - Level IX ($700-$800)	S		$750.00		$150.00

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
1510	New Technology - Level X ($800-$900)	S		$850.00		$170.00
1511	New Technology - Level XI ($900-$1000)	S		$950.00		$190.00
1512	New Technology - Level XII ($1000-$1100)	S		$1,050.00		$210.00
1513	New Technology - Level XIII ($1100-$1200)	S		$1,150.00		$230.00
1514	New Technology - Level XIV ($1200-$1300)	S		$1,250.00		$250.00
1515	New Technology - Level XV ($1300-$1400)	S		$1,350.00		$270.00
1516	New Technology - Level XVI ($1400-$1500)	S		$1,450.00		$290.00
1517	New Technology - Level XVII ($1500-$1600)	S		$1,550.00		$310.00
1518	New Technology - Level XVIII ($1600-$1700)	S		$1,650.00		$330.00
1519	New Technology - Level IXX ($1700-$1800)	S		$1,750.00		$350.00
1520	New Technology - Level XX ($1800-$1900)	S		$1,850.00		$370.00
1521	New Technology - Level XXI ($1900-$2000)	S		$1,950.00		$390.00
1522	New Technology - Level XXII ($2000-$2500)	S		$2,250.00		$450.00
1523	New Technology - Level XXIII ($2500-$3000)	S		$2,750.00		$550.00
1524	New Technology - Level XXIV ($3000-$3500)	S		$3,250.00		$650.00
1525	New Technology - Level XXV ($3500-$4000)	S		$3,750.00		$750.00
1526	New Technology - Level XXVI ($4000-$4500)	S		$4,250.00		$850.00
1527	New Technology - Level XXVII ($4500-$5000)	S		$4,750.00		$950.00
1528	New Technology - Level XXVIII ($5000-$5500)	S		$5,250.00		$1,050.00
1529	New Technology - Level XXIX ($5500-$6000)	S		$5,750.00		$1,150.00
1530	New Technology - Level XXX ($6000-$6500)	S		$6,250.00		$1,250.00
1531	New Technology - Level XXXI ($6500-$7000)	S		$6,750.00		$1,350.00
1532	New Technology - Level XXXII ($7000-$7500)	S		$7,250.00		$1,450.00
1533	New Technology - Level XXXIII ($7500-$8000)	S		$7,750.00		$1,550.00
1534	New Technology - Level XXXIV ($8000-$8500)	S		$8,250.00		$1,650.00
1535	New Technology - Level XXXV ($8500-$9000)	S		$8,750.00		$1,750.00
1536	New Technology - Level XXXVI ($9000-$9500)	S		$9,250.00		$1,850.00

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
1537	New Technology - Level XXXVII ($9500-$10000)	S		$9,750.00		$1,950.00
1539	New Technology - Level II ($50 - $100)	T		$75.00		$15.00
1540	New Technology - Level III ($100-$200)	T		$150.00		$30.00
1541	New Technology - Level IV ($200-$300)	T		$250.00		$50.00
1542	New Technology - Level V ($300-$400)	T		$350.00		$70.00
1543	New Technology - Level VI ($400-$500)	T		$450.00		$90.00
1544	New Technology - Level VII ($500-$600)	T		$550.00		$110.00
1545	New Technology - Level VIII ($600-$700)	T		$650.00		$130.00
1546	New Technology - Level IX ($700-$800)	T		$750.00		$150.00
1547	New Technology - Level X ($800-$900)	T		$850.00		$170.00
1548	New Technology - Level XI ($900-$1000)	T		$950.00		$190.00
1549	New Technology - Level XII ($1000-$1100)	T		$1,050.00		$210.00
1550	New Technology - Level XIII ($1100-$1200)	T		$1,150.00		$230.00
1551	New Technology - Level XIV ($1200-$1300)	T		$1,250.00		$250.00
1552	New Technology - Level XV ($1300-$1400)	T		$1,350.00		$270.00
1553	New Technology - Level XVI ($1400-$1500)	T		$1,450.00		$290.00
1554	New Technology - Level XVII ($1500-$1600)	T		$1,550.00		$310.00
1555	New Technology - Level XVIII ($1600-$1700)	T		$1,650.00		$330.00
1556	New Technology - Level XIX ($1700-$1800)	T		$1,750.00		$350.00
1557	New Technology - Level XX ($1800-$1900)	T		$1,850.00		$370.00
1558	New Technology - Level XXI ($1900-$2000)	T		$1,950.00		$390.00
1559	New Technology - Level XXII ($2000-$2500)	T		$2,250.00		$450.00
1560	New Technology - Level XXIII ($2500-$3000)	T		$2,750.00		$550.00
1561	New Technology - Level XXIV ($3000-$3500)	T		$3,250.00		$650.00
1562	New Technology - Level XXV ($3500-$4000)	T		$3,750.00		$750.00
1563	New Technology - Level XXVI ($4000-$4500)	T		$4,250.00		$850.00
1564	New Technology - Level XXVII ($4500-$5000)	T		$4,750.00		$950.00

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
1565	New Technology - Level XXVIII ($5000-$5500)	T		$5,250.00		$1,050.00
1566	New Technology - Level XXIX ($5500-$6000)	T		$5,750.00		$1,150.00
1567	New Technology - Level XXX ($6000-$6500)	T		$6,250.00		$1,250.00
1568	New Technology - Level XXXI ($6500-$7000)	T		$6,750.00		$1,350.00
1569	New Technology - Level XXXII ($7000-$7500)	T		$7,250.00		$1,450.00
1570	New Technology - Level XXXIII ($7500-$8000)	T		$7,750.00		$1,550.00
1571	New Technology - Level XXXIV ($8000-$8500)	T		$8,250.00		$1,650.00
1572	New Technology - Level XXXV ($8500-$9000)	T		$8,750.00		$1,750.00
1573	New Technology - Level XXXVI ($9000-$9500)	T		$9,250.00		$1,850.00
1574	New Technology - Level XXXVII ($9500-$10000)	T		$9,750.00		$1,950.00
1605	Abciximab injection	K		$415.06		$83.02
1607	Eptifibatide injection	K		$16.70		$3.34
1608	Etanercept injection	K		$163.89		$32.78
1609	Rho(D) immune globulin h, sd	K		$15.32		$3.07
1612	Daclizumab, parenteral	K		$309.72		$61.95
1613	Trastuzumab	K		$58.95		$11.79
1629	Nonmetabolic act d/e tissue	K		$10.61		$2.13
1630	Hep b ig, im	K		$117.70		$23.54
1631	Baclofen intrathecal trial	K		$68.44		$13.69
1632	Metabolic active D/E tissue	K		$29.60		$5.92
1633	Alefacept	K		$26.16		$5.24
1643	Y90 ibritumomab, rx	K	230.7968	$15,159.66		$3,031.94
1645	I131 tositumomab, rx	K	160.6856	$10,554.47		$2,110.90
1670	Tetanus immune globulin inj	K		$97.86		$19.58
1675	P32 Na phosphate	K	1.5948	$104.75		$20.95
1676	P32 chromic phosphate	K	2.4062	$158.05		$31.61
1682	Aprotonin, 10,000 kiu	K		$2.60		$0.52

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
1683	Basiliximab	K		$1,471.15		$294.23
1684	Corticorelin ovine triflutal	K		$4.19		$0.84
1685	Darbepoetin alfa, non-esrd	K		$2.72		$0.55
1686	Epoetin alfa, non-esrd	K		$8.90		$1.78
1687	Digoxin immune fab (ovine)	K		$479.14		$95.83
1688	Ethanolamine oleate	K		$118.22		$23.65
1689	Fomepizole	K		$13.85		$2.77
1690	Hemin	K		$7.23		$1.45
1693	Lepirudin	K		$157.97		$31.60
1694	Ziconotide injection	K		$6.39		$1.28
1695	Nesiritide injection	K		$32.86		$6.58
1696	Palifermin injection	K		$11.15		$2.23
1697	Pegaptanib sodium injection	K		$1,011.57		$202.32
1700	Inj secretin synthetic human	K		$19.93		$3.99
1701	Treprostinil injection	K		$54.83		$10.97
1703	Ovine, 1000 USP units	K		$132.50		$26.50
1704	Humate-P, inj	K		$0.88		$0.18
1705	Factor viia	K		$1.17		$0.24
1709	Azacitidine injection	K		$4.39		$0.88
1710	Clofarabine injection	K		$113.00		$22.60
1711	Vantas implant	K		$1,479.64		$295.93
1712	Paclitaxel protein bound	K		$8.69		$1.74
1716	Brachytx, non-str, Gold-198	U	0.5161	$33.90		$6.78
1717	Brachytx, non-str, HDR Ir-192	U	3.2258	$211.88		$42.38
1719	Brachytx, NS, Non-HDRIr-192	U	0.9851	$64.71		$12.95
1738	Oxaliplatin	K		$9.31		$1.87
1739	Pegademase bovine, 25 iu	K		$195.62		$39.13

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
1740	Diazoxide injection	K		$112.16		$22.44
1741	Urofollitropin, 75 iu	K		$48.25		$9.65
2210	Methyldopate hcl injection	K		$14.91		$2.99
2616	Brachytx, non-str,Yttrium-90	U	204.7634	$13,449.68		$2,689.94
2632	Iodine I-125 sodium iodide	U	0.5488	$36.05		$7.21
2634	Brachytx, non-str, HA, I-125	U	0.6518	$42.81		$8.57
2635	Brachytx, non-str, HA, P-103	U	0.4101	$26.94		$5.39
2636	Brachy linear, non-str,P-103	U	0.9201	$60.44		$12.09
2638	Brachytx, stranded, I-125	U	0.6144	$40.36		$8.08
2639	Brachytx, non-stranded,I-125	U	0.5553	$36.47		$7.30
2640	Brachytx, stranded, P-103	U	1.0130	$66.54		$13.31
2641	Brachytx, non-stranded,P-103	U	0.9658	$63.44		$12.69
2642	Brachytx, stranded, C-131	U	1.5178	$99.70		$19.94
2643	Brachytx, non-stranded,C-131	U	0.9051	$59.45		$11.89
2698	Brachytx, stranded, NOS	U	0.6144	$40.36		$8.08
2699	Brachytx, non-stranded, NOS	U	0.4101	$26.94		$5.39
2731	Immune globulin, powder	K		$27.54		$5.51
2770	Quinupristin/dalfopristin	K		$125.56		$25.12
3030	Sumatriptan succinate	K		$65.35		$13.07
3041	Bivalirudin	K		$2.04		$0.41
3043	Gamma globulin 1 CC inj	K		$11.34		$2.27
3050	Sermorelin acetate injection	K		$1.72		$0.35
7000	Amifostine	K		$501.57		$100.32
7005	Gonadorelin hydroch	K		$176.89		$35.38
7011	Oprelvekin injection	K		$242.32		$48.47
7015	Oral busulfan	K		$2.45		$0.49
7034	Somatropin injection	K		$47.18		$9.44

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
7035	Teniposide	K		$281.98		$56.40
7036	Urokinase 250,000 IU inj	K		$449.09		$89.82
7038	Monoclonal antibodies	K		$968.26		$193.66
7041	Tirofiban HCl	K		$7.28		$1.46
7042	Capecitabine, oral	K		$4.52		$0.91
7043	Infliximab injection	K		$54.00		$10.80
7045	Inj trimetrexate glucoronate	K		$146.89		$29.38
7046	Doxorubicin hcl liposome inj	K		$405.69		$81.14
7048	Alteplase recombinant	K		$31.57		$6.32
7049	Filgrastim 480 mcg injection	K		$300.85		$60.17
7051	Leuprolide acetate implant	K		$1,577.83		$315.57
7308	Aminolevulinic acid hcl top	K		$107.67		$21.54
8000	Cardiac Electrophysiologic Evaluation and Ablation Composite	T	139.9160	$9,190.24		$1,838.05
8001	LDR Prostate Brachytherapy Composite	T	53.5230	$3,515.60		$703.12
8002	Level I Extended Assessment & Management Composite	V	5.5444	$364.18		$72.84
8003	Level II Extended Assessment & Management Composite	V	10.2222	$671.43		$134.29
8004	Ultrasound Composite	S	2.9608	$194.48		$38.90
8005	CT and CTA without Contrast Composite	S	6.4509	$423.72		$84.75
8006	CT and CTA with Contrast Composite	S	9.7470	$640.22		$128.05
8007	MRI and MRA without Contrast Composite	S	11.0520	$725.94		$145.19
8008	MRI and MRA with Contrast Composite	S	15.2927	$1,004.49		$200.90
9001	Linezolid injection	K		$27.56		$5.52
9002	Tenecteplase injection	K		$2,007.72		$401.55
9003	Palivizumab	K		$802.95		$160.59
9004	Gemtuzumab ozogamicin	K		$2,383.14		$476.63

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
9005	Reteplase injection	K		$818.01		$163.61
9006	Tacrolimus injection	K		$137.38		$27.48
9012	Arsenic trioxide	K		$33.83		$6.77
9015	Mycophenolate mofetil oral	K		$2.85		$0.57
9018	Botulinum toxin type B	K		$8.55		$1.71
9019	Caspofungin acetate	K		$17.53		$3.51
9020	Sirolimus, oral	K		$7.78		$1.56
9022	IM inj interferon beta 1-a	K		$129.80		$25.96
9023	Rho d immune globulin	K		$27.89		$5.58
9024	Amphotericin b lipid complex	K		$10.26		$2.06
9032	Baclofen 10 MG injection	K		$187.25		$37.45
9033	Cidofovir injection	K		$748.06		$149.62
9038	Inj estrogen conjugate	K		$69.91		$13.99
9042	Glucagon hydrochloride	K		$67.37		$13.48
9044	Ibutilide fumarate injection	K		$317.20		$63.44
9046	Iron sucrose injection	K		$0.35		$0.07
9047	Itraconazole injection	K		$39.15		$7.83
9054	Metabolically active tissue	K		$36.02		$7.21
9104	Antithymocyte globuln rabbit	K		$338.22		$67.65
9108	Thyrotropin injection	K		$823.13		$164.63
9110	Alemtuzumab injection	K		$540.67		$108.14
9115	Zoledronic acid	K		$206.68		$41.34
9119	Injection, pegfilgrastim 6mg	K		$2,158.59		$431.72
9120	Injection, Fulvestrant	K		$79.83		$15.97
9121	Injection, argatroban	K		$19.82		$3.97
9122	Triptorelin pamoate	K		$146.35		$29.27
9124	Daptomycin injection	K		$0.34		$0.07

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
9125	Risperidone, long acting	K		$4.84		$0.97
9126	Natalizumab injection	K		$7.39		$1.48
9133	Rabies ig, im/sc	K		$66.55		$13.31
9134	Rabies ig, heat treated	K		$76.60		$15.32
9135	Varicella-zoster ig, im	K		$109.89		$21.98
9137	Bcg vaccine, percut	K		$114.69		$22.94
9139	Rabies vaccine, im	K		$149.67		$29.94
9140	Rabies vaccine, id	K	1.9332	$126.98		$25.40
9143	Meningococcal vaccine, sc	K		$92.10		$18.42
9144	Encephalitis vaccine, sc	K		$100.15		$20.03
9145	Meningococcal vaccine, im	K		$80.45		$16.09
9156	Nonmetabolic active tissue	K		$84.67		$16.94
9207	Bortezomib injection	K		$33.78		$6.76
9208	Agalsidase beta injection	K		$127.14		$25.43
9209	Laronidase injection	K		$23.89		$4.78
9210	Palonosetron HCl	K		$16.89		$3.38
9213	Pemetrexed injection	K		$45.33		$9.07
9214	Bevacizumab injection	K		$56.35		$11.27
9215	Cetuximab injection	K		$48.87		$9.78
9216	Abarelix injection	K		$67.33		$13.47
9217	Leuprolide acetate suspnsion	K		$216.69		$43.34
9219	Mycophenolic acid	K		$2.41		$0.49
9222	Injectable human tissue	K		$764.93		$152.99
9224	Galsulfase injection	K		$314.00		$62.80
9225	Fluocinolone acetonide implt	K		$18,980.00		$3,796.00
9227	Micafungin sodium injection	K		$1.32		$0.27
9228	Tigecycline injection	K		$1.00		$0.20

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
9229	Ibandronate sodium injection	K		$136.35		$27.27
9230	Abatacept injection	K		$18.34		$3.67
9231	Decitabine injection	K		$26.60		$5.32
9232	Idursulfase injection	K		$446.44		$89.29
9233	Ranibizumab injection	K		$397.53		$79.51
9234	Alglucosidase alfa injection	K		$124.80		$24.96
9235	Panitumumab injection	K		$80.70		$16.14
9236	Eculizumab injection	G		$173.06		$33.96
9237	Inj, lanreotide acetate	K		$23.90		$4.78
9238	Inj, levetiracetam	G		$0.43		$0.09
9240	Injection, ixabepilone	G		$65.15		$12.79
9241	Injection, doripenem	G		$0.81		$0.16
9300	Omalizumab injection	K		$17.48		$3.50
9354	Veritas collagen matrix, cm2	G		$11.77		$2.31
9355	Neuromatrix nerve cuff, cm	G		$208.67		$40.95
9500	Platelets, irradiated	R	2.5730	$169.00		$33.80
9501	Platelet pheres leukoreduced	R	7.8915	$518.35		$103.67
9502	Platelet pheresis irradiated	R	7.0111	$460.52		$92.11
9503	Fr frz plasma donor retested	R	1.0046	$65.99		$13.20
9504	RBC deglycerolized	R	5.5204	$362.60		$72.52
9505	RBC irradiated	R	3.9231	$257.68		$51.54
9506	Granulocytes, pheresis unit	R	25.5369	$1,677.37		$335.48
9507	Platelets, pheresis	R	7.2005	$472.96		$94.60
9508	Plasma 1 donor frz w/in 8 hr	R	1.1757	$77.22		$15.45

ADDENDUM AA.--PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2009 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject to Multiple Procedure Discounting	Comment Indicator	Payment Indicator	CY 2009 Second Year Transition Payment Weight	CY 2009 Second Year Transition Payment
0016T	Thermotx choroid vasc lesion	Y		R2	5.6770	$234.95
0017T	Photocoagulat macular drusen	Y		R2	5.6770	$234.95
0027T	Endoscopic epidural lysis	Y		G2	17.9800	$744.09
0031T	Speculoscopy	N		N1		
0032T	Speculoscopy w/direct sample	N		N1		
0046T	Cath lavage, mammary duct(s)	Y		R2	15.4780	$640.54
0047T	Cath lavage, mammary duct(s)	Y		R2	15.4780	$640.54
0062T	Rep intradisc annulus;1 lev	Y		G2	28.7130	$1,188.25
0063T	Rep intradisc annulus;>1lev	Y		G2	28.7130	$1,188.25
0084T*	Temp prostate urethral stent	Y	CH	R2	2.1520	$89.05
0088T	Rf tongue base vol reduxn	Y		G2	16.7710	$694.03
0099T*	Implant corneal ring	Y		R2	15.9090	$658.37
0100T	Prosth retina receive&gen	Y		G2	36.9540	$1,529.29
0101T	Extracorp shockwv tx,hi enrg	Y		G2	28.7130	$1,188.25
0102T	Extracorp shockwv tx,anesth	Y		G2	28.7130	$1,188.25
0123T	Scleral fistulization	Y		G2	23.3960	$968.22
0124T*	Conjunctival drug placement	Y		R2	4.4840	$185.58
0137T	Prostate saturation sampling	Y		G2	11.5150	$476.55
0170T	Anorectal fistula plug rpr	Y		G2	30.4300	$1,259.30
0176T	Aqu canal dilat w/o retent	Y		A2	35.3420	$1,462.60
0177T	Aqu canal dilat w retent	Y		A2	35.3420	$1,462.60
0186T	Suprachoroidal drug delivery	Y		G2	21.5200	$890.60
10021	Fna w/o image	Y		P2	1.4960	$61.91
10022	Fna w/image	Y		G2	4.4140	$182.65
10040	Acne surgery	Y		P2	0.8130	$33.63
10060	Drainage of skin abscess	Y		P3	1.1210	$46.41
10061	Drainage of skin abscess	Y		P2	1.3920	$57.59
10080	Drainage of pilonidal cyst	Y		P2	1.3920	$57.59
10081	Drainage of pilonidal cyst	Y		P3	2.8740	$118.92
10120	Remove foreign body	Y	CH	P3	1.5650	$64.78
10121	Remove foreign body	Y		A2	12.9940	$537.76
10140	Drainage of hematoma/fluid	Y		P3	1.6670	$68.97
10160	Puncture drainage of lesion	Y		P2	1.3920	$57.59
10180	Complex drainage, wound	Y		A2	14.8020	$612.58
11000	Debride infected skin	Y		P3	0.5370	$22.24
11001	Debride infected skin add-on	Y		P3	0.1790	$7.41

Note: the Medicare program payment is 80 percent of the total payment amount and beneficiary coinsurance is 20 percent of the total payment amount, except for screening flexible sigmoidoscopies and screening colonoscopies for which the program payment is 75 percent and the beneficiary coinsurance is 25 percent.

*Refers to codes designated as "office-based," whose designation as office-based is temporary because we have insufficient claims data. We will reconsider this designation when new claims data become available.

HCPCS Code	Short Descriptor	Subject to Multiple Procedure Discounting	Comment Indicator	Payment Indicator	CY 2009 Second Year Transition Payment Weight	CY 2009 Second Year Transition Payment
11010	Debride skin, fx	Y		A2	5.1030	$211.20
11011	Debride skin/muscle, fx	Y		A2	5.1030	$211.20
11012	Debride skin/muscle/bone, fx	Y		A2	5.1030	$211.20
11040	Debride skin, partial	Y		P3	0.4990	$20.63
11041	Debride skin, full	Y		P3	0.5530	$22.88
11042	Debride skin/tissue	Y		A2	3.2570	$134.79
11043	Debride tissue/muscle	Y		A2	3.2570	$134.79
11044	Debride tissue/muscle/bone	Y		A2	8.5660	$354.49
11055	Trim skin lesion	Y		P3	0.5840	$24.17
11056	Trim skin lesions, 2 to 4	Y		P3	0.6390	$26.43
11057	Trim skin lesions, over 4	Y		P3	0.7240	$29.97
11100	Biopsy, skin lesion	Y	CH	P3	1.3390	$55.43
11101	Biopsy, skin add-on	Y		P3	0.3040	$12.57
11200	Removal of skin tags	Y		P2	0.8130	$33.63
11201	Remove skin tags add-on	Y		P3	0.1250	$5.16
11300	Shave skin lesion	Y		P2	0.8130	$33.63
11301	Shave skin lesion	Y		P2	0.8130	$33.63
11302	Shave skin lesion	Y		P2	0.8130	$33.63
11303	Shave skin lesion	Y		P2	1.4750	$61.05
11305	Shave skin lesion	Y		P2	0.8130	$33.63
11306	Shave skin lesion	Y		P2	0.8130	$33.63
11307	Shave skin lesion	Y		P2	0.8130	$33.63
11308	Shave skin lesion	Y		P2	0.8130	$33.63
11310	Shave skin lesion	Y		P2	0.8130	$33.63
11311	Shave skin lesion	Y		P2	0.8130	$33.63
11312	Shave skin lesion	Y		P2	0.8130	$33.63
11313	Shave skin lesion	Y		P2	0.8130	$33.63
11400	Exc tr-ext b9+marg 0.5 < cm	Y		P3	1.5030	$62.20
11401	Exc tr-ext b9+marg 0.6-1 cm	Y		P3	1.6900	$69.94
11402	Exc tr-ext b9+marg 1.1-2 cm	Y		P3	1.8460	$76.38
11403	Exc tr-ext b9+marg 2.1-3 cm	Y		P3	1.9700	$81.54
11404	Exc tr-ext b9+marg 3.1-4 cm	Y		A2	11.6630	$482.66
11406	Exc tr-ext b9+marg > 4.0 cm	Y		A2	12.9940	$537.76
11420	Exc h-f-nk-sp b9+marg 0.5 <	Y		P3	1.4180	$58.66
11421	Exc h-f-nk-sp b9+marg 0.6-1	Y		P3	1.7060	$70.58
11422	Exc h-f-nk-sp b9+marg 1.1-2	Y		P3	1.8610	$77.03
11423	Exc h-f-nk-sp b9+marg 2.1-3	Y		P3	2.0720	$85.73
11424	Exc h-f-nk-sp b9+marg 3.1-4	Y		A2	12.9940	$537.76
11426	Exc h-f-nk-sp b9+marg > 4 cm	Y		A2	15.8610	$656.38
11440	Exc face-mm b9+marg 0.5 < cm	Y		P3	1.6040	$66.39

Note: the Medicare program payment is 80 percent of the total payment amount and beneficiary coinsurance is 20 percent of the total payment amount, except for screening flexible sigmoidoscopies and screening colonoscopies for which the program payment is 75 percent and the beneficiary coinsurance is 25 percent.

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HCPCS Code	Short Descriptor	Subject to Multiple Procedure Discounting	Comment Indicator	Payment Indicator	CY 2009 Second Year Transition Payment Weight	CY 2009 Second Year Transition Payment
11441	Exc face-mm b9+marg 0.6-1 cm	Y		P3	1.8530	$76.70
11442	Exc face-mm b9+marg 1.1-2 cm	Y		P3	2.0400	$84.44
11443	Exc face-mm b9+marg 2.1-3 cm	Y		P3	2.2510	$93.14
11444	Exc face-mm b9+marg 3.1-4 cm	Y		A2	7.8190	$323.56
11446	Exc face-mm b9+marg > 4 cm	Y		A2	15.8610	$656.38
11450	Removal, sweat gland lesion	Y		A2	15.8610	$656.38
11451	Removal, sweat gland lesion	Y		A2	15.8610	$656.38
11462	Removal, sweat gland lesion	Y		A2	15.8610	$656.38
11463	Removal, sweat gland lesion	Y		A2	15.8610	$656.38
11470	Removal, sweat gland lesion	Y		A2	15.8610	$656.38
11471	Removal, sweat gland lesion	Y		A2	15.8610	$656.38
11600	Exc tr-ext mlg+marg 0.5 < cm	Y		P3	2.1180	$87.66
11601	Exc tr-ext mlg+marg 0.6-1 cm	Y		P3	2.5470	$105.39
11602	Exc tr-ext mlg+marg 1.1-2 cm	Y		P3	2.7960	$115.70
11603	Exc tr-ext mlg+marg 2.1-3 cm	Y		P3	2.9670	$122.79
11604	Exc tr-ext mlg+marg 3.1-4 cm	Y		A2	8.8260	$365.25
11606	Exc tr-ext mlg+marg > 4 cm	Y		A2	12.9940	$537.76
11620	Exc h-f-nk-sp mlg+marg 0.5 <	Y		P3	2.1810	$90.24
11621	Exc h-f-nk-sp mlg+marg 0.6-1	Y		P3	2.5780	$106.68
11622	Exc h-f-nk-sp mlg+marg 1.1-2	Y		P3	2.8660	$118.60
11623	Exc h-f-nk-sp mlg+marg 2.1-3	Y		P3	3.0760	$127.30
11624	Exc h-f-nk-sp mlg+marg 3.1-4	Y		A2	12.9940	$537.76
11626	Exc h-f-nk-sp mlg+mar > 4 cm	Y		A2	15.8610	$656.38
11640	Exc face-mm malig+marg 0.5 <	Y		P3	2.3050	$95.40
11641	Exc face-mm malig+marg 0.6-1	Y		P3	2.7180	$112.48
11642	Exc face-mm malig+marg 1.1-2	Y		P3	3.0140	$124.72
11643	Exc face-mm malig+marg 2.1-3	Y		P3	3.2400	$134.07
11644	Exc face-mm malig+marg 3.1-4	Y		A2	12.9940	$537.76
11646	Exc face-mm mlg+marg > 4 cm	Y		A2	15.8610	$656.38
11719	Trim nail(s)	Y		P3	0.2730	$11.28
11720	Debride nail, 1-5	Y		P3	0.3350	$13.86
11721	Debride nail, 6 or more	Y		P3	0.4050	$16.76
11730	Removal of nail plate	Y		P2	0.8130	$33.63
11732	Remove nail plate, add-on	Y		P3	0.4050	$16.76
11740	Drain blood from under nail	Y		P2	0.3080	$12.74
11750	Removal of nail bed	Y		P3	2.1490	$88.95
11752	Remove nail bed/finger tip	Y		P3	2.9670	$122.79
11755	Biopsy, nail unit	Y		P3	1.4800	$61.23
11760	Repair of nail bed	Y		G2	3.4450	$142.56
11762	Reconstruction of nail bed	Y		P3	2.7330	$113.12

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11765	Excision of nail fold, toe	Y		P2	0.8130	$33.63
11770	Removal of pilonidal lesion	Y		A2	16.6150	$687.59
11771	Removal of pilonidal lesion	Y		A2	16.6150	$687.59
11772	Removal of pilonidal lesion	Y		A2	16.6150	$687.59
11900	Injection into skin lesions	Y		P3	0.6620	$27.39
11901	Added skin lesions injection	Y		P3	0.7170	$29.65
11920	Correct skin color defects	Y	CH	P3	2.1180	$87.66
11921	Correct skin color defects	Y	CH	P3	2.3280	$96.36
11922	Correct skin color defects	Y		P3	0.7550	$31.26
11950	Therapy for contour defects	Y		P3	0.7710	$31.91
11951	Therapy for contour defects	Y		P3	0.9500	$39.32
11952	Therapy for contour defects	Y	CH	P3	1.1370	$47.05
11954	Therapy for contour defects	Y		P2	1.3370	$55.31
11960	Insert tissue expander(s)	Y		A2	15.3990	$637.27
11970	Replace tissue expander	Y		A2	28.1660	$1,165.64
11971	Remove tissue expander(s)	Y		A2	14.5290	$601.28
11976	Removal of contraceptive cap	Y		P3	1.4020	$58.01
11980	Implant hormone pellet(s)	N		P2	0.6320	$26.16
11981	Insert drug implant device	N		P2	0.6320	$26.16
11982	Remove drug implant device	N		P2	0.6320	$26.16
11983	Remove/insert drug implant	N		P2	0.6320	$26.16
12001	Repair superficial wound(s)	Y		P2	1.3370	$55.31
12002	Repair superficial wound(s)	Y		P2	1.3370	$55.31
12004	Repair superficial wound(s)	Y		P2	1.3370	$55.31
12005	Repair superficial wound(s)	Y		A2	1.7430	$72.15
12006	Repair superficial wound(s)	Y		A2	1.7430	$72.15
12007	Repair superficial wound(s)	Y		A2	1.7430	$72.15
12011	Repair superficial wound(s)	Y		P2	1.3370	$55.31
12013	Repair superficial wound(s)	Y		P2	1.3370	$55.31
12014	Repair superficial wound(s)	Y		P2	1.3370	$55.31
12015	Repair superficial wound(s)	Y		G2	1.3370	$55.31
12016	Repair superficial wound(s)	Y		A2	1.7430	$72.15
12017	Repair superficial wound(s)	Y		A2	1.7430	$72.15
12018	Repair superficial wound(s)	Y		A2	1.7430	$72.15
12020	Closure of split wound	Y		A2	3.3920	$140.36
12021	Closure of split wound	Y		A2	2.7980	$115.77
12031	Layer closure of wound(s)	Y		P2	1.3370	$55.31
12032	Layer closure of wound(s)	Y		P2	1.3370	$55.31
12034	Layer closure of wound(s)	Y		A2	1.7430	$72.15
12035	Layer closure of wound(s)	Y		A2	1.7430	$72.15

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12036	Layer closure of wound(s)	Y		A2	2.7980	$115.77
12037	Layer closure of wound(s)	Y		A2	5.5320	$228.93
12041	Layer closure of wound(s)	Y		P2	1.3370	$55.31
12042	Layer closure of wound(s)	Y		P2	1.3370	$55.31
12044	Layer closure of wound(s)	Y		A2	1.7430	$72.15
12045	Layer closure of wound(s)	Y		A2	2.7980	$115.77
12046	Layer closure of wound(s)	Y		A2	2.7980	$115.77
12047	Layer closure of wound(s)	Y		A2	5.5320	$228.93
12051	Layer closure of wound(s)	Y		P2	1.3370	$55.31
12052	Layer closure of wound(s)	Y		P2	1.3370	$55.31
12053	Layer closure of wound(s)	Y		P2	1.3370	$55.31
12054	Layer closure of wound(s)	Y		A2	1.7430	$72.15
12055	Layer closure of wound(s)	Y		A2	2.7980	$115.77
12056	Layer closure of wound(s)	Y		A2	2.7980	$115.77
12057	Layer closure of wound(s)	Y		A2	5.5320	$228.93
13100	Repair of wound or lesion	Y		A2	6.1260	$253.51
13101	Repair of wound or lesion	Y		A2	6.1260	$253.51
13102	Repair wound/lesion add-on	Y		A2	3.3920	$140.36
13120	Repair of wound or lesion	Y		A2	2.7980	$115.77
13121	Repair of wound or lesion	Y		A2	2.7980	$115.77
13122	Repair wound/lesion add-on	Y		A2	2.7980	$115.77
13131	Repair of wound or lesion	Y		A2	2.7980	$115.77
13132	Repair of wound or lesion	Y		A2	2.7980	$115.77
13133	Repair wound/lesion add-on	Y		A2	2.7980	$115.77
13150	Repair of wound or lesion	Y		A2	6.1260	$253.51
13151	Repair of wound or lesion	Y		A2	6.1260	$253.51
13152	Repair of wound or lesion	Y		A2	6.1260	$253.51
13153	Repair wound/lesion add-on	Y		A2	2.7980	$115.77
13160	Late closure of wound	Y		A2	15.3990	$637.27
14000	Skin tissue rearrangement	Y		A2	13.0620	$540.56
14001	Skin tissue rearrangement	Y		A2	13.8160	$571.77
14020	Skin tissue rearrangement	Y		A2	13.8160	$571.77
14021	Skin tissue rearrangement	Y		A2	13.8160	$571.77
14040	Skin tissue rearrangement	Y		A2	13.0620	$540.56
14041	Skin tissue rearrangement	Y		A2	13.8160	$571.77
14060	Skin tissue rearrangement	Y		A2	13.8160	$571.77
14061	Skin tissue rearrangement	Y		A2	13.8160	$571.77
14300	Skin tissue rearrangement	Y		A2	17.5670	$727.00
14350	Skin tissue rearrangement	Y		A2	16.1530	$668.48
15002	Wnd prep, ch/inf, trk/arm/lg	Y		A2	6.1260	$253.51

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15003	Wnd prep, ch/inf addl 100 cm	Y		A2	6.1260	$253.51
15004	Wnd prep ch/inf, f/n/hf/g	Y		A2	6.1260	$253.51
15005	Wnd prep, f/n/hf/g, addl cm	Y		A2	6.1260	$253.51
15040	Harvest cultured skin graft	Y		A2	2.7980	$115.77
15050	Skin pinch graft	Y		A2	6.1260	$253.51
15100	Skin splt grft, trnk/arm/leg	Y		A2	15.3990	$637.27
15101	Skin splt grft t/a/l, add-on	Y		A2	16.1530	$668.48
15110	Epidrm autogrft trnk/arm/leg	Y		A2	7.5720	$313.36
15111	Epidrm autogrft t/a/l add-on	Y		A2	6.2400	$258.25
15115	Epidrm a-grft face/nck/hf/g	Y		A2	7.5720	$313.36
15116	Epidrm a-grft f/n/hf/g addl	Y		A2	6.2400	$258.25
15120	Skn splt a-grft fac/nck/hf/g	Y		A2	15.3990	$637.27
15121	Skn splt a-grft f/n/hf/g add	Y		A2	16.1530	$668.48
15130	Derm autograft, trnk/arm/leg	Y		A2	13.0620	$540.56
15131	Derm autograft t/a/l add-on	Y		A2	11.7310	$485.46
15135	Derm autograft face/nck/hf/g	Y		A2	13.0620	$540.56
15136	Derm autograft, f/n/hf/g add	Y		A2	11.7310	$485.46
15150	Cult epiderm grft t/arm/leg	Y		A2	7.5720	$313.36
15151	Cult epiderm grft t/a/l addl	Y		A2	6.2400	$258.25
15152	Cult epiderm graft t/a/l +%	Y		A2	6.2400	$258.25
15155	Cult epiderm graft, f/n/hf/g	Y		A2	7.5720	$313.36
15156	Cult epidrm grft f/n/hfg add	Y		A2	6.2400	$258.25
15157	Cult epiderm grft f/n/hfg +%	Y		A2	6.2400	$258.25
15200	Skin full graft, trunk	Y		A2	13.8160	$571.77
15201	Skin full graft trunk add-on	Y		A2	11.6160	$480.72
15220	Skin full graft sclp/arm/leg	Y		A2	13.0620	$540.56
15221	Skin full graft add-on	Y		A2	6.1260	$253.51
15240	Skin full grft face/genit/hf	Y		A2	13.8160	$571.77
15241	Skin full graft add-on	Y		A2	6.1260	$253.51
15260	Skin full graft een & lips	Y		A2	13.0620	$540.56
15261	Skin full graft add-on	Y		A2	11.6160	$480.72
15300	Apply skinallogrft, t/arm/lg	Y		A2	6.1260	$253.51
15301	Apply sknallogrft t/a/l addl	Y		A2	6.1260	$253.51
15320	Apply skin allogrft f/n/hf/g	Y		A2	6.1260	$253.51
15321	Aply sknallogrft f/n/hfg add	Y		A2	6.1260	$253.51
15330	Aply acell alogrft t/arm/leg	Y		A2	6.1260	$253.51
15331	Aply acell grft t/a/l add-on	Y		A2	6.1260	$253.51
15335	Apply acell graft, f/n/hf/g	Y		A2	6.1260	$253.51
15336	Aply acell grft f/n/hf/g add	Y		A2	6.1260	$253.51
15340	Apply cult skin substitute	Y		G2	3.4450	$142.56

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15341	Apply cult skin sub add-on	Y		G2	3.4450	$142.56
15360	Apply cult derm sub, t/a/l	Y		G2	3.4450	$142.56
15361	Aply cult derm sub t/a/l add	Y		G2	3.4450	$142.56
15365	Apply cult derm sub f/n/hf/g	Y		G2	3.4450	$142.56
15366	Apply cult derm f/hf/g add	Y		G2	3.4450	$142.56
15400	Apply skin xenograft, t/a/l	Y		A2	6.1260	$253.51
15401	Apply skn xenogrft t/a/l add	Y		A2	6.1260	$253.51
15420	Apply skin xgraft, f/n/hf/g	Y		A2	6.1260	$253.51
15421	Apply skn xgrft f/n/hf/g add	Y		A2	6.1260	$253.51
15430	Apply acellular xenograft	Y		A2	6.1260	$253.51
15431	Apply acellular xgraft add	Y		A2	6.1260	$253.51
15570	Form skin pedicle flap	Y		A2	16.1530	$668.48
15572	Form skin pedicle flap	Y		A2	16.1530	$668.48
15574	Form skin pedicle flap	Y		A2	16.1530	$668.48
15576	Form skin pedicle flap	Y		A2	16.1530	$668.48
15600	Skin graft	Y		A2	16.1530	$668.48
15610	Skin graft	Y		A2	16.1530	$668.48
15620	Skin graft	Y		A2	17.5670	$727.00
15630	Skin graft	Y		A2	16.1530	$668.48
15650	Transfer skin pedicle flap	Y		A2	18.5930	$769.43
15731	Forehead flap w/vasc pedicle	Y		A2	16.1530	$668.48
15732	Muscle-skin graft, head/neck	Y		A2	16.1530	$668.48
15734	Muscle-skin graft, trunk	Y		A2	16.1530	$668.48
15736	Muscle-skin graft, arm	Y		A2	16.1530	$668.48
15738	Muscle-skin graft, leg	Y		A2	16.1530	$668.48
15740	Island pedicle flap graft	Y		A2	13.0620	$540.56
15750	Neurovascular pedicle graft	Y		A2	15.3990	$637.27
15760	Composite skin graft	Y		A2	15.3990	$637.27
15770	Derma-fat-fascia graft	Y		A2	16.1530	$668.48
15775	Hair transplant punch grafts	Y		A2	4.4780	$185.30
15776	Hair transplant punch grafts	Y		A2	4.4780	$185.30
15780	Abrasion treatment of skin	Y		P3	8.9320	$369.66
15781	Abrasion treatment of skin	Y		P2	4.2790	$177.09
15782	Abrasion treatment of skin	Y		P2	4.2790	$177.09
15783	Abrasion treatment of skin	Y		P2	2.6390	$109.23
15786	Abrasion, lesion, single	Y		P2	0.8130	$33.63
15787	Abrasion, lesions, add-on	Y	CH	P3	0.6700	$27.72
15788	Chemical peel, face, epiderm	Y		P2	0.8130	$33.63
15789	Chemical peel, face, dermal	Y		P2	1.4750	$61.05
15792	Chemical peel, nonfacial	Y		P2	1.4750	$61.05

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15793	Chemical peel, nonfacial	Y		P2	0.8130	$33.63
15819	Plastic surgery, neck	Y		G2	3.4450	$142.56
15820	Revision of lower eyelid	Y		A2	16.1530	$668.48
15821	Revision of lower eyelid	Y		A2	16.1530	$668.48
15822	Revision of upper eyelid	Y		A2	16.1530	$668.48
15823	Revision of upper eyelid	Y		A2	18.5930	$769.43
15824	Removal of forehead wrinkles	Y		A2	16.1530	$668.48
15825	Removal of neck wrinkles	Y		A2	16.1530	$668.48
15826	Removal of brow wrinkles	Y		A2	16.1530	$668.48
15828	Removal of face wrinkles	Y		A2	16.1530	$668.48
15829	Removal of skin wrinkles	Y		A2	18.5930	$769.43
15830	Exc skin abd	Y		A2	16.6150	$687.59
15832	Excise excessive skin tissue	Y		A2	16.6150	$687.59
15833	Excise excessive skin tissue	Y		A2	16.6150	$687.59
15834	Excise excessive skin tissue	Y		A2	16.6150	$687.59
15835	Excise excessive skin tissue	Y		A2	14.4150	$596.54
15836	Excise excessive skin tissue	Y		A2	13.7490	$568.97
15837	Excise excessive skin tissue	Y		G2	15.4780	$640.54
15838	Excise excessive skin tissue	Y		G2	15.4780	$640.54
15839	Excise excessive skin tissue	Y		A2	13.7490	$568.97
15840	Graft for face nerve palsy	Y		A2	17.5670	$727.00
15841	Graft for face nerve palsy	Y		A2	17.5670	$727.00
15842	Flap for face nerve palsy	Y		G2	20.2870	$839.55
15845	Skin and muscle repair, face	Y		A2	17.5670	$727.00
15847	Exc skin abd add-on	Y		A2	16.6150	$687.59
15850	Removal of sutures	Y		G2	2.6390	$109.23
15851	Removal of sutures	Y		P3	1.0980	$45.44
15852	Dressing change not for burn	N		G2	0.6320	$26.16
15860	Test for blood flow in graft	N		G2	0.6320	$26.16
15876	Suction assisted lipectomy	Y		A2	16.1530	$668.48
15877	Suction assisted lipectomy	Y		A2	16.1530	$668.48
15878	Suction assisted lipectomy	Y		A2	16.1530	$668.48
15879	Suction assisted lipectomy	Y		A2	16.1530	$668.48
15920	Removal of tail bone ulcer	Y		A2	5.1030	$211.20
15922	Removal of tail bone ulcer	Y		A2	17.5670	$727.00
15931	Remove sacrum pressure sore	Y		A2	16.6150	$687.59
15933	Remove sacrum pressure sore	Y		A2	16.6150	$687.59
15934	Remove sacrum pressure sore	Y		A2	16.1530	$668.48
15935	Remove sacrum pressure sore	Y		A2	17.5670	$727.00
15936	Remove sacrum pressure sore	Y		A2	15.2300	$630.29

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15937	Remove sacrum pressure sore	Y		A2	17.5670	$727.00
15940	Remove hip pressure sore	Y		A2	16.6150	$687.59
15941	Remove hip pressure sore	Y		A2	16.6150	$687.59
15944	Remove hip pressure sore	Y		A2	16.1530	$668.48
15945	Remove hip pressure sore	Y		A2	17.5670	$727.00
15946	Remove hip pressure sore	Y		A2	17.5670	$727.00
15950	Remove thigh pressure sore	Y		A2	16.6150	$687.59
15951	Remove thigh pressure sore	Y		A2	18.0290	$746.11
15952	Remove thigh pressure sore	Y		A2	13.8160	$571.77
15953	Remove thigh pressure sore	Y		A2	15.2300	$630.29
15956	Remove thigh pressure sore	Y		A2	13.8160	$571.77
15958	Remove thigh pressure sore	Y		A2	15.2300	$630.29
16000	Initial treatment of burn(s)	Y		P3	0.5920	$24.49
16020	Dress/debrid p-thick burn, s	Y		P3	0.8960	$37.06
16025	Dress/debrid p-thick burn, m	Y		A2	1.5280	$63.25
16030	Dress/debrid p-thick burn, l	Y		A2	1.9140	$79.21
16035	Incision of burn scab, initi	Y		G2	1.4750	$61.05
17000	Destruct premalg lesion	Y		P2	0.8130	$33.63
17003	Destruct premalg les, 2-14	Y		P3	0.0780	$3.22
17004	Destroy premlg lesions 15+	Y		P3	1.8690	$77.35
17106	Destruction of skin lesions	Y		P2	2.6390	$109.23
17107	Destruction of skin lesions	Y		P2	2.6390	$109.23
17108	Destruction of skin lesions	Y		P2	2.6390	$109.23
17110	Destruct b9 lesion, 1-14	Y		P2	0.8130	$33.63
17111	Destruct lesion, 15 or more	Y		P2	1.4750	$61.05
17250	Chemical cautery, tissue	Y		P3	1.0130	$41.90
17260	Destruction of skin lesions	Y		P3	1.0670	$44.15
17261	Destruction of skin lesions	Y		P2	1.4750	$61.05
17262	Destruction of skin lesions	Y		P2	1.4750	$61.05
17263	Destruction of skin lesions	Y		P2	1.4750	$61.05
17264	Destruction of skin lesions	Y		P2	1.4750	$61.05
17266	Destruction of skin lesions	Y	CH	P3	2.5160	$104.10
17270	Destruction of skin lesions	Y		P2	1.4750	$61.05
17271	Destruction of skin lesions	Y		P2	1.4750	$61.05
17272	Destruction of skin lesions	Y		P2	1.4750	$61.05
17273	Destruction of skin lesions	Y		P3	2.2970	$95.07
17274	Destruction of skin lesions	Y		P2	2.6390	$109.23
17276	Destruction of skin lesions	Y		P2	2.6390	$109.23
17280	Destruction of skin lesions	Y		P2	1.4750	$61.05
17281	Destruction of skin lesions	Y		P3	1.9630	$81.22

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17282	Destruction of skin lesions	Y		P3	2.2430	$92.82
17283	Destruction of skin lesions	Y		P2	2.6390	$109.23
17284	Destruction of skin lesions	Y		P2	2.6390	$109.23
17286	Destruction of skin lesions	Y		P2	2.6390	$109.23
17311	Mohs, 1 stage, h/n/hf/g	Y		P2	4.2590	$176.25
17312	Mohs addl stage	Y		P2	4.2590	$176.25
17313	Mohs, 1 stage, t/a/l	Y		P2	4.2590	$176.25
17314	Mohs, addl stage, t/a/l	Y		P2	4.2590	$176.25
17315	Mohs surg, addl block	Y		P3	0.8800	$36.42
17340	Cryotherapy of skin	Y		P3	0.3190	$13.21
17360	Skin peel therapy	Y		P2	0.8130	$33.63
17380	Hair removal by electrolysis	Y		R2	0.8130	$33.63
19000	Drainage of breast lesion	Y		P3	1.5110	$62.52
19001	Drain breast lesion add-on	Y		P3	0.2030	$8.38
19020	Incision of breast lesion	Y		A2	14.8020	$612.58
19030	Injection for breast x-ray	N		N1		
19100	Bx breast percut w/o image	Y		A2	5.0350	$208.36
19101	Biopsy of breast, open	Y		A2	15.7400	$651.39
19102	Bx breast percut w/image	Y		A2	6.4280	$266.00
19103	Bx breast percut w/device	Y		A2	11.2590	$465.96
19105	Cryosurg ablate fa, each	Y		G2	32.8700	$1,360.30
19110	Nipple exploration	Y		A2	15.7400	$651.39
19112	Excise breast duct fistula	Y		A2	16.4940	$682.60
19120	Removal of breast lesion	Y		A2	16.4940	$682.60
19125	Excision, breast lesion	Y		A2	16.4940	$682.60
19126	Excision, addl breast lesion	Y		A2	16.4940	$682.60
19290	Place needle wire, breast	N		N1		
19291	Place needle wire, breast	N		N1		
19295	Place breast clip, percut	N		N1		
19296	Place po breast cath for rad	Y		A2	44.0140	$1,821.46
19297	Place breast cath for rad	Y		A2	44.0140	$1,821.46
19298	Place breast rad tube/caths	Y		A2	44.0140	$1,821.46
19300	Removal of breast tissue	Y		A2	17.9080	$741.11
19301	Partical mastectomy	Y		A2	16.4940	$682.60
19302	P-mastectomy w/ln removal	Y		A2	31.5290	$1,304.80
19303	Mast, simple, complete	Y		A2	23.8590	$987.37
19304	Mast, subq	Y		A2	23.8590	$987.37
19316	Suspension of breast	Y		A2	23.8590	$987.37
19318	Reduction of large breast	Y		A2	27.2280	$1,126.80
19324	Enlarge breast	Y		A2	27.2280	$1,126.80

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19325	Enlarge breast with implant	Y		A2	44.0140	$1,821.46
19328	Removal of breast implant	Y		A2	20.3590	$842.54
19330	Removal of implant material	Y		A2	20.3590	$842.54
19340	Immediate breast prosthesis	Y		A2	25.0600	$1,037.08
19342	Delayed breast prosthesis	Y		A2	34.2450	$1,417.20
19350	Breast reconstruction	Y		A2	17.9080	$741.11
19355	Correct inverted nipple(s)	Y		A2	23.8590	$987.37
19357	Breast reconstruction	Y		A2	36.6840	$1,518.14
19366	Breast reconstruction	Y		A2	24.8840	$1,029.80
19370	Surgery of breast capsule	Y		A2	23.8590	$987.37
19371	Removal of breast capsule	Y		A2	23.8590	$987.37
19380	Revise breast reconstruction	Y		A2	28.2530	$1,169.23
19396	Design custom breast implant	Y		G2	32.8700	$1,360.30
20000	Incision of abscess	Y		P2	1.3920	$57.59
20005	Incision of deep abscess	Y		A2	16.1770	$669.48
20103	Explore wound, extremity	Y		G2	15.6130	$646.14
20150	Excise epiphyseal bar	Y		G2	44.3140	$1,833.87
20200	Muscle biopsy	Y		A2	12.9940	$537.76
20205	Deep muscle biopsy	Y		A2	13.7490	$568.97
20206	Needle biopsy, muscle	Y		A2	6.4280	$266.00
20220	Bone biopsy, trocar/needle	Y		A2	6.8580	$283.83
20225	Bone biopsy, trocar/needle	Y		A2	12.6700	$524.35
20240	Bone biopsy, excisional	Y		A2	15.8610	$656.38
20245	Bone biopsy, excisional	Y		A2	16.6150	$687.59
20250	Open bone biopsy	Y		A2	16.9310	$700.69
20251	Open bone biopsy	Y		A2	16.9310	$700.69
20500	Injection of sinus tract	Y		P3	1.2380	$51.24
20501	Inject sinus tract for x-ray	N		N1		
20520	Removal of foreign body	Y		P3	2.0870	$86.37
20525	Removal of foreign body	Y		A2	16.6150	$687.59
20526	Ther injection, carp tunnel	Y		P3	0.6620	$27.39
20550	Inj tendon sheath/ligament	Y		P3	0.5060	$20.95
20551	Inj tendon origin/insertion	Y		P3	0.4990	$20.63
20552	Inj trigger point, 1/2 muscl	Y		P3	0.4830	$19.98
20553	Inject trigger points, =/> 3	Y		P3	0.5370	$22.24
20555	Place ndl musc/tis for rt	Y		G2	28.7130	$1,188.25
20600	Drain/inject, joint/bursa	Y		P3	0.5140	$21.27
20605	Drain/inject, joint/bursa	Y		P3	0.5760	$23.85
20610	Drain/inject, joint/bursa	Y		P3	0.8100	$33.52
20612	Aspirate/inj ganglion cyst	Y		P3	0.5530	$22.88

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20615	Treatment of bone cyst	Y		P3	2.2970	$95.07
20650	Insert and remove bone pin	Y		A2	16.9310	$700.69
20662	Application of pelvis brace	Y		R2	21.8440	$903.97
20663	Application of thigh brace	Y		R2	21.8440	$903.97
20665	Removal of fixation device	N		G2	0.6320	$26.16
20670	Removal of support implant	Y		A2	11.6630	$482.66
20680	Removal of support implant	Y		A2	16.6150	$687.59
20690	Apply bone fixation device	Y		A2	19.6120	$811.62
20692	Apply bone fixation device	Y		A2	20.3660	$842.83
20693	Adjust bone fixation device	Y		A2	16.9310	$700.69
20694	Remove bone fixation device	Y		A2	14.8460	$614.38
20822	Replantation digit, complete	Y		G2	27.4790	$1,137.17
20900	Removal of bone for graft	Y		A2	20.3660	$842.83
20902	Removal of bone for graft	Y		A2	21.7800	$901.35
20910	Remove cartilage for graft	Y		A2	16.1530	$668.48
20912	Remove cartilage for graft	Y		A2	16.1530	$668.48
20920	Removal of fascia for graft	Y		A2	15.2300	$630.29
20922	Removal of fascia for graft	Y		A2	13.8160	$571.77
20924	Removal of tendon for graft	Y		A2	21.7800	$901.35
20926	Removal of tissue for graft	Y		A2	9.7400	$403.08
20950	Fluid pressure, muscle	Y		G2	1.3920	$57.59
20972	Bone/skin graft, metatarsal	Y		G2	46.0110	$1,904.14
20973	Bone/skin graft, great toe	Y		R2	46.0110	$1,904.14
20975	Electrical bone stimulation	N		N1		
20979	Us bone stimulation	N	CH	P3	0.5140	$21.27
20982	Ablate, bone tumor(s) perq	Y		G2	44.3140	$1,833.87
20985	Cptr-asst dir ms px	N		N1		
20986	Cptr-asst dir ms px io img	N		N1		
20987	Cptr-asst dir ms px pre img	N		N1		
21010	Incision of jaw joint	Y		A2	17.2680	$714.63
21015	Resection of facial tumor	Y		A2	14.3950	$595.72
21025	Excision of bone, lower jaw	Y		A2	25.5540	$1,057.52
21026	Excision of facial bone(s)	Y		A2	25.5540	$1,057.52
21029	Contour of face bone lesion	Y		A2	25.5540	$1,057.52
21030	Excise max/zygoma b9 tumor	Y		P3	5.4440	$225.28
21031	Remove exostosis, mandible	Y		P3	4.5090	$186.60
21032	Remove exostosis, maxilla	Y		P3	4.6030	$190.47
21034	Excise max/zygoma mlg tumor	Y		A2	26.3080	$1,088.73
21040	Excise mandible lesion	Y		A2	17.2680	$714.63
21044	Removal of jaw bone lesion	Y		A2	25.5540	$1,057.52

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21046	Remove mandible cyst complex	Y		A2	25.5540	$1,057.52
21047	Excise lwr jaw cyst w/repair	Y		A2	25.5540	$1,057.52
21048	Remove maxilla cyst complex	Y		R2	40.5970	$1,680.05
21050	Removal of jaw joint	Y		A2	26.3080	$1,088.73
21060	Remove jaw joint cartilage	Y		A2	25.5540	$1,057.52
21070	Remove coronoid process	Y		A2	26.3080	$1,088.73
21073*	Mnpj of tmj w/anesth	Y		P3	4.2520	$175.97
21076	Prepare face/oral prosthesis	Y		P3	7.1650	$296.50
21077	Prepare face/oral prosthesis	Y		P3	17.2340	$713.22
21079	Prepare face/oral prosthesis	Y		P3	12.4290	$514.37
21080	Prepare face/oral prosthesis	Y		P3	14.2590	$590.10
21081	Prepare face/oral prosthesis	Y		P3	13.1610	$544.66
21082	Prepare face/oral prosthesis	Y		P3	12.5460	$519.20
21083	Prepare face/oral prosthesis	Y		P3	12.3900	$512.76
21084	Prepare face/oral prosthesis	Y		P3	14.2360	$589.14
21085	Prepare face/oral prosthesis	Y		P3	5.6620	$234.30
21086	Prepare face/oral prosthesis	Y		P3	12.1800	$504.05
21087	Prepare face/oral prosthesis	Y		P3	12.1880	$504.38
21088	Prepare face/oral prosthesis	Y		R2	40.5970	$1,680.05
21100	Maxillofacial fixation	Y		A2	25.5540	$1,057.52
21110	Interdental fixation	Y		P2	7.5590	$312.82
21116	Injection, jaw joint x-ray	N		N1		
21120	Reconstruction of chin	Y		A2	23.7370	$982.35
21121	Reconstruction of chin	Y		A2	23.7370	$982.35
21122	Reconstruction of chin	Y		A2	23.7370	$982.35
21123	Reconstruction of chin	Y		A2	23.7370	$982.35
21125	Augmentation, lower jaw bone	Y		A2	23.7370	$982.35
21127	Augmentation, lower jaw bone	Y		A2	36.0770	$1,492.99
21137	Reduction of forehead	Y		G2	24.0260	$994.28
21138	Reduction of forehead	Y		G2	40.5970	$1,680.05
21139	Reduction of forehead	Y		G2	40.5970	$1,680.05
21150	Reconstruct midface, lefort	Y		G2	40.5970	$1,680.05
21181	Contour cranial bone lesion	Y		A2	23.7370	$982.35
21198	Reconstr lwr jaw segment	Y		G2	40.5970	$1,680.05
21199	Reconstr lwr jaw w/advance	Y		G2	40.5970	$1,680.05
21206	Reconstruct upper jaw bone	Y		A2	28.7470	$1,189.67
21208	Augmentation of facial bones	Y		A2	32.0230	$1,325.24
21209	Reduction of facial bones	Y		A2	28.7470	$1,189.67
21210	Face bone graft	Y		A2	32.0230	$1,325.24
21215	Lower jaw bone graft	Y		A2	32.0230	$1,325.24

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21230	Rib cartilage graft	Y		A2	32.0230	$1,325.24
21235	Ear cartilage graft	Y		A2	23.7370	$982.35
21240	Reconstruction of jaw joint	Y		A2	27.7220	$1,147.24
21242	Reconstruction of jaw joint	Y		A2	28.7470	$1,189.67
21243	Reconstruction of jaw joint	Y		A2	28.7470	$1,189.67
21244	Reconstruction of lower jaw	Y		A2	32.0230	$1,325.24
21245	Reconstruction of jaw	Y		A2	32.0230	$1,325.24
21246	Reconstruction of jaw	Y		A2	32.0230	$1,325.24
21248	Reconstruction of jaw	Y		A2	32.0230	$1,325.24
21249	Reconstruction of jaw	Y		A2	32.0230	$1,325.24
21260	Revise eye sockets	Y		G2	40.5970	$1,680.05
21267	Revise eye sockets	Y		A2	32.0230	$1,325.24
21270	Augmentation, cheek bone	Y		A2	28.7470	$1,189.67
21275	Revision, orbitofacial bones	Y		A2	32.0230	$1,325.24
21280	Revision of eyelid	Y		A2	28.7470	$1,189.67
21282	Revision of eyelid	Y		A2	16.8340	$696.66
21295	Revision of jaw muscle/bone	Y		A2	7.7040	$318.80
21296	Revision of jaw muscle/bone	Y		A2	15.9370	$659.53
21310	Treatment of nose fracture	Y		A2	2.3290	$96.37
21315	Treatment of nose fracture	Y		A2	10.1610	$420.51
21320	Treatment of nose fracture	Y		A2	13.6410	$564.51
21325	Treatment of nose fracture	Y		A2	19.4370	$804.36
21330	Treatment of nose fracture	Y		A2	20.4620	$846.79
21335	Treatment of nose fracture	Y		A2	23.7370	$982.35
21336	Treat nasal septal fracture	Y		A2	19.9480	$825.51
21337	Treat nasal septal fracture	Y		A2	13.6410	$564.51
21338	Treat nasoethmoid fracture	Y		A2	19.4370	$804.36
21339	Treat nasoethmoid fracture	Y		A2	20.4620	$846.79
21340	Treatment of nose fracture	Y		A2	27.7220	$1,147.24
21345	Treat nose/jaw fracture	Y		A2	23.7370	$982.35
21355	Treat cheek bone fracture	Y		A2	26.3080	$1,088.73
21356	Treat cheek bone fracture	Y		A2	18.0220	$745.84
21360	Treat cheek bone fracture	Y		G2	24.0260	$994.28
21390	Treat eye socket fracture	Y		G2	40.5970	$1,680.05
21400	Treat eye socket fracture	Y		A2	9.0350	$373.90
21401	Treat eye socket fracture	Y		A2	14.3950	$595.72
21406	Treat eye socket fracture	Y		G2	40.5970	$1,680.05
21407	Treat eye socket fracture	Y		G2	40.5970	$1,680.05
21421	Treat mouth roof fracture	Y		A2	19.4370	$804.36
21440	Treat dental ridge fracture	Y		P3	7.4610	$308.75

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21445	Treat dental ridge fracture	Y		A2	19.4370	$804.36
21450	Treat lower jaw fracture	Y		A2	3.3150	$137.20
21451	Treat lower jaw fracture	Y		A2	9.2490	$382.75
21452	Treat lower jaw fracture	Y		A2	13.6410	$564.51
21453	Treat lower jaw fracture	Y		A2	26.3080	$1,088.73
21454	Treat lower jaw fracture	Y		A2	20.4620	$846.79
21461	Treat lower jaw fracture	Y		A2	27.7220	$1,147.24
21462	Treat lower jaw fracture	Y		A2	28.7470	$1,189.67
21465	Treat lower jaw fracture	Y		A2	27.7220	$1,147.24
21480	Reset dislocated jaw	Y		A2	2.3290	$96.37
21485	Reset dislocated jaw	Y		A2	13.6410	$564.51
21490	Repair dislocated jaw	Y		A2	26.3080	$1,088.73
21495	Treat hyoid bone fracture	Y		G2	16.7710	$694.03
21497	Interdental wiring	Y		A2	13.6410	$564.51
21501	Drain neck/chest lesion	Y		A2	14.8020	$612.58
21502	Drain chest lesion	Y		A2	16.1770	$669.48
21550	Biopsy of neck/chest	Y		G2	15.4780	$640.54
21555	Remove lesion, neck/chest	Y		A2	15.8610	$656.38
21556	Remove lesion, neck/chest	Y		A2	15.8610	$656.38
21557	Remove tumor, neck/chest	Y		G2	21.2110	$877.78
21600	Partial removal of rib	Y		A2	19.6120	$811.62
21610	Partial removal of rib	Y		A2	19.6120	$811.62
21685	Hyoid myotomy & suspension	Y		G2	7.5590	$312.82
21700	Revision of neck muscle	Y		A2	16.1770	$669.48
21720	Revision of neck muscle	Y		A2	16.9310	$700.69
21725	Revision of neck muscle	Y		A2	1.7380	$71.93
21800	Treatment of rib fracture	Y		A2	1.9910	$82.40
21805	Treatment of rib fracture	Y		A2	17.7790	$735.78
21820	Treat sternum fracture	Y		A2	1.9910	$82.40
21920	Biopsy soft tissue of back	Y		P3	3.1930	$132.14
21925	Biopsy soft tissue of back	Y		A2	15.8610	$656.38
21930	Remove lesion, back or flank	Y		A2	15.8610	$656.38
21935	Remove tumor, back	Y		A2	16.6150	$687.59
22102	Remove part, lumbar vertebra	Y		G2	47.2010	$1,953.37
22103	Remove extra spine segment	Y		G2	47.2010	$1,953.37
22305	Treat spine process fracture	Y		A2	1.9910	$82.40
22310	Treat spine fracture	Y		A2	4.1770	$172.84
22315	Treat spine fracture	Y		A2	11.1840	$462.82
22505	Manipulation of spine	Y		A2	12.8300	$530.97
22520	Percut vertebroplasty thor	Y		A2	30.1350	$1,247.09

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22521	Percut vertebroplasty lumb	Y		A2	30.1350	$1,247.09
22522	Percut vertebroplasty add'l	Y		A2	30.1350	$1,247.09
22523	Percut kyphoplasty, thor	Y		G2	83.3800	$3,450.59
22524	Percut kyphoplasty, lumbar	Y		G2	83.3800	$3,450.59
22525	Percut kyphoplasty, add-on	Y		G2	83.3800	$3,450.59
22526	Idet, single level	Y		G2	28.7130	$1,188.25
22527	Idet, 1 or more levels	Y		G2	28.7130	$1,188.25
22900	Remove abdominal wall lesion	Y		A2	18.0290	$746.11
23000	Removal of calcium deposits	Y		A2	12.9940	$537.76
23020	Release shoulder joint	Y		A2	27.4120	$1,134.43
23030	Drain shoulder lesion	Y		A2	13.4710	$557.47
23031	Drain shoulder bursa	Y		A2	15.5570	$643.79
23035	Drain shoulder bone lesion	Y		A2	16.9310	$700.69
23040	Exploratory shoulder surgery	Y		A2	20.3660	$842.83
23044	Exploratory shoulder surgery	Y		A2	21.7800	$901.35
23065	Biopsy shoulder tissues	Y		P3	2.1880	$90.56
23066	Biopsy shoulder tissues	Y		A2	15.8610	$656.38
23075	Removal of shoulder lesion	Y		A2	12.9940	$537.76
23076	Removal of shoulder lesion	Y		A2	15.8610	$656.38
23077	Remove tumor of shoulder	Y		A2	16.6150	$687.59
23100	Biopsy of shoulder joint	Y		A2	16.1770	$669.48
23101	Shoulder joint surgery	Y		A2	26.0810	$1,079.34
23105	Remove shoulder joint lining	Y		A2	21.7800	$901.35
23106	Incision of collarbone joint	Y		A2	21.7800	$901.35
23107	Explore treat shoulder joint	Y		A2	21.7800	$901.35
23120	Partial removal, collar bone	Y		A2	22.8050	$943.78
23125	Removal of collar bone	Y		A2	22.8050	$943.78
23130	Remove shoulder bone, part	Y		A2	30.6060	$1,266.59
23140	Removal of bone lesion	Y		A2	18.3460	$759.21
23145	Removal of bone lesion	Y		A2	22.8050	$943.78
23146	Removal of bone lesion	Y		A2	22.8050	$943.78
23150	Removal of humerus lesion	Y		A2	21.7800	$901.35
23155	Removal of humerus lesion	Y		A2	22.8050	$943.78
23156	Removal of humerus lesion	Y		A2	22.8050	$943.78
23170	Remove collar bone lesion	Y		A2	19.6120	$811.62
23172	Remove shoulder blade lesion	Y		A2	19.6120	$811.62
23174	Remove humerus lesion	Y		A2	19.6120	$811.62
23180	Remove collar bone lesion	Y		A2	21.7800	$901.35
23182	Remove shoulder blade lesion	Y		A2	21.7800	$901.35
23184	Remove humerus lesion	Y		A2	21.7800	$901.35

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23190	Partial removal of scapula	Y		A2	21.7800	$901.35
23195	Removal of head of humerus	Y		A2	22.8050	$943.78
23330	Remove shoulder foreign body	Y		A2	7.8190	$323.56
23331	Remove shoulder foreign body	Y		A2	14.5290	$601.28
23350	Injection for shoulder x-ray	N		N1		
23395	Muscle transfer,shoulder/arm	Y		A2	30.6060	$1,266.59
23397	Muscle transfers	Y		A2	53.4150	$2,210.51
23400	Fixation of shoulder blade	Y		A2	26.0810	$1,079.34
23405	Incision of tendon & muscle	Y		A2	19.6120	$811.62
23406	Incise tendon(s) & muscle(s)	Y		A2	19.6120	$811.62
23410	Repair rotator cuff, acute	Y		A2	30.6060	$1,266.59
23412	Repair rotator cuff, chronic	Y		A2	33.8820	$1,402.15
23415	Release of shoulder ligament	Y		A2	30.6060	$1,266.59
23420	Repair of shoulder	Y		A2	33.8820	$1,402.15
23430	Repair biceps tendon	Y		A2	29.5810	$1,224.16
23440	Remove/transplant tendon	Y		A2	29.5810	$1,224.16
23450	Repair shoulder capsule	Y		A2	50.1390	$2,074.94
23455	Repair shoulder capsule	Y		A2	53.4150	$2,210.51
23460	Repair shoulder capsule	Y		A2	50.1390	$2,074.94
23462	Repair shoulder capsule	Y		A2	33.8820	$1,402.15
23465	Repair shoulder capsule	Y		A2	50.1390	$2,074.94
23466	Repair shoulder capsule	Y		A2	33.8820	$1,402.15
23480	Revision of collar bone	Y		A2	29.5810	$1,224.16
23485	Revision of collar bone	Y		A2	53.4150	$2,210.51
23490	Reinforce clavicle	Y		A2	28.1660	$1,165.64
23491	Reinforce shoulder bones	Y		A2	47.7000	$1,974.00
23500	Treat clavicle fracture	Y		A2	1.9910	$82.40
23505	Treat clavicle fracture	Y		A2	11.1840	$462.82
23515	Treat clavicle fracture	Y		A2	36.2890	$1,501.79
23520	Treat clavicle dislocation	Y		A2	4.1770	$172.84
23525	Treat clavicle dislocation	Y		A2	4.1770	$172.84
23530	Treat clavicle dislocation	Y		A2	26.7720	$1,107.95
23532	Treat clavicle dislocation	Y		A2	19.9480	$825.51
23540	Treat clavicle dislocation	Y		A2	1.9910	$82.40
23545	Treat clavicle dislocation	Y		A2	4.1770	$172.84
23550	Treat clavicle dislocation	Y		A2	26.7720	$1,107.95
23552	Treat clavicle dislocation	Y		A2	28.1860	$1,166.46
23570	Treat shoulder blade fx	Y		A2	1.9910	$82.40
23575	Treat shoulder blade fx	Y		A2	4.1770	$172.84
23585	Treat scapula fracture	Y		A2	36.2890	$1,501.79

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23600	Treat humerus fracture	Y		P2	1.5400	$63.72
23605	Treat humerus fracture	Y		A2	11.1840	$462.82
23615	Treat humerus fracture	Y		A2	37.7030	$1,560.30
23616	Treat humerus fracture	Y		A2	37.7030	$1,560.30
23620	Treat humerus fracture	Y		P2	1.5400	$63.72
23625	Treat humerus fracture	Y		A2	11.1840	$462.82
23630	Treat humerus fracture	Y		A2	38.7280	$1,602.73
23650	Treat shoulder dislocation	Y		A2	1.9910	$82.40
23655	Treat shoulder dislocation	Y		A2	11.4990	$475.86
23660	Treat shoulder dislocation	Y		A2	26.7720	$1,107.95
23665	Treat dislocation/fracture	Y		A2	4.1770	$172.84
23670	Treat dislocation/fracture	Y		A2	36.2890	$1,501.79
23675	Treat dislocation/fracture	Y		A2	1.9910	$82.40
23680	Treat dislocation/fracture	Y		A2	26.7720	$1,107.95
23700	Fixation of shoulder	Y		A2	11.4990	$475.86
23800	Fusion of shoulder joint	Y		A2	49.1130	$2,032.51
23802	Fusion of shoulder joint	Y		A2	33.8820	$1,402.15
23921	Amputation follow-up surgery	Y		A2	11.6160	$480.72
23930	Drainage of arm lesion	Y		A2	13.4710	$557.47
23931	Drainage of arm bursa	Y		A2	14.8020	$612.58
23935	Drain arm/elbow bone lesion	Y		A2	16.1770	$669.48
24000	Exploratory elbow surgery	Y		A2	21.7800	$901.35
24006	Release elbow joint	Y		A2	21.7800	$901.35
24065	Biopsy arm/elbow soft tissue	Y		P3	3.0610	$126.66
24066	Biopsy arm/elbow soft tissue	Y		A2	12.9940	$537.76
24075	Remove arm/elbow lesion	Y		A2	12.9940	$537.76
24076	Remove arm/elbow lesion	Y		A2	15.8610	$656.38
24077	Remove tumor of arm/elbow	Y		A2	16.6150	$687.59
24100	Biopsy elbow joint lining	Y		A2	14.8460	$614.38
24101	Explore/treat elbow joint	Y		A2	21.7800	$901.35
24102	Remove elbow joint lining	Y		A2	21.7800	$901.35
24105	Removal of elbow bursa	Y		A2	16.9310	$700.69
24110	Remove humerus lesion	Y		A2	16.1770	$669.48
24115	Remove/graft bone lesion	Y		A2	20.3660	$842.83
24116	Remove/graft bone lesion	Y		A2	20.3660	$842.83
24120	Remove elbow lesion	Y		A2	16.9310	$700.69
24125	Remove/graft bone lesion	Y		A2	20.3660	$842.83
24126	Remove/graft bone lesion	Y		A2	20.3660	$842.83
24130	Removal of head of radius	Y		A2	20.3660	$842.83
24134	Removal of arm bone lesion	Y		A2	19.6120	$811.62

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24136	Remove radius bone lesion	Y		A2	19.6120	$811.62
24138	Remove elbow bone lesion	Y		A2	19.6120	$811.62
24140	Partial removal of arm bone	Y		A2	20.3660	$842.83
24145	Partial removal of radius	Y		A2	20.3660	$842.83
24147	Partial removal of elbow	Y		A2	19.6120	$811.62
24149	Radical resection of elbow	Y		G2	28.7130	$1,188.25
24152	Extensive radius surgery	Y		G2	44.3140	$1,833.87
24153	Extensive radius surgery	Y		G2	83.3800	$3,450.59
24155	Removal of elbow joint	Y		A2	28.1660	$1,165.64
24160	Remove elbow joint implant	Y		A2	19.6120	$811.62
24164	Remove radius head implant	Y		A2	20.3660	$842.83
24200	Removal of arm foreign body	Y		P3	2.2510	$93.14
24201	Removal of arm foreign body	Y		A2	12.9940	$537.76
24220	Injection for elbow x-ray	N		N1		
24300	Manipulate elbow w/anesth	Y		G2	15.1500	$626.96
24301	Muscle/tendon transfer	Y		A2	21.7800	$901.35
24305	Arm tendon lengthening	Y		A2	21.7800	$901.35
24310	Revision of arm tendon	Y		A2	16.9310	$700.69
24320	Repair of arm tendon	Y		A2	28.1660	$1,165.64
24330	Revision of arm muscles	Y		A2	47.7000	$1,974.00
24331	Revision of arm muscles	Y		A2	28.1660	$1,165.64
24332	Tenolysis, triceps	Y		G2	21.8440	$903.97
24340	Repair of biceps tendon	Y		A2	28.1660	$1,165.64
24341	Repair arm tendon/muscle	Y		A2	28.1660	$1,165.64
24342	Repair of ruptured tendon	Y		A2	28.1660	$1,165.64
24343	Repr elbow lat ligmnt w/tiss	Y		G2	28.7130	$1,188.25
24344	Reconstruct elbow lat ligmnt	Y		G2	83.3800	$3,450.59
24345	Repr elbw med ligmnt w/tissu	Y		A2	19.6120	$811.62
24346	Reconstruct elbow med ligmnt	Y		G2	44.3140	$1,833.87
24357	Repair elbow, perc	Y		G2	28.7130	$1,188.25
24358	Repair elbow w/deb, open	Y		G2	28.7130	$1,188.25
24359	Repair elbow deb/attch open	Y		G2	28.7130	$1,188.25
24360	Reconstruct elbow joint	Y		A2	26.9230	$1,114.16
24361	Reconstruct elbow joint	Y		A2	67.2440	$2,782.83
24362	Reconstruct elbow joint	Y		A2	34.2300	$1,416.56
24363	Replace elbow joint	Y		A2	70.5200	$2,918.40
24365	Reconstruct head of radius	Y		A2	26.9230	$1,114.16
24366	Reconstruct head of radius	Y		A2	67.2440	$2,782.83
24400	Revision of humerus	Y		A2	21.7800	$901.35
24410	Revision of humerus	Y		A2	21.7800	$901.35

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24420	Revision of humerus	Y		A2	28.1660	$1,165.64
24430	Repair of humerus	Y		A2	47.7000	$1,974.00
24435	Repair humerus with graft	Y		A2	49.1130	$2,032.51
24470	Revision of elbow joint	Y		A2	28.1660	$1,165.64
24495	Decompression of forearm	Y		A2	19.6120	$811.62
24498	Reinforce humerus	Y		A2	47.7000	$1,974.00
24500	Treat humerus fracture	Y		A2	1.9910	$82.40
24505	Treat humerus fracture	Y		A2	1.9910	$82.40
24515	Treat humerus fracture	Y		A2	37.7030	$1,560.30
24516	Treat humerus fracture	Y		A2	37.7030	$1,560.30
24530	Treat humerus fracture	Y		A2	1.9910	$82.40
24535	Treat humerus fracture	Y		A2	4.1770	$172.84
24538	Treat humerus fracture	Y		A2	17.7790	$735.78
24545	Treat humerus fracture	Y		A2	37.7030	$1,560.30
24546	Treat humerus fracture	Y		A2	38.7280	$1,602.73
24560	Treat humerus fracture	Y		A2	1.9910	$82.40
24565	Treat humerus fracture	Y		A2	1.9910	$82.40
24566	Treat humerus fracture	Y		A2	17.7790	$735.78
24575	Treat humerus fracture	Y		A2	36.2890	$1,501.79
24576	Treat humerus fracture	Y		A2	1.9910	$82.40
24577	Treat humerus fracture	Y		A2	4.1770	$172.84
24579	Treat humerus fracture	Y		A2	36.2890	$1,501.79
24582	Treat humerus fracture	Y		A2	17.7790	$735.78
24586	Treat elbow fracture	Y		A2	37.7030	$1,560.30
24587	Treat elbow fracture	Y		A2	38.7280	$1,602.73
24600	Treat elbow dislocation	Y		A2	1.9910	$82.40
24605	Treat elbow dislocation	Y		A2	12.8300	$530.97
24615	Treat elbow dislocation	Y		A2	36.2890	$1,501.79
24620	Treat elbow fracture	Y		A2	11.1840	$462.82
24635	Treat elbow fracture	Y		A2	36.2890	$1,501.79
24640	Treat elbow dislocation	Y		P3	1.2300	$50.92
24650	Treat radius fracture	Y		P2	1.5400	$63.72
24655	Treat radius fracture	Y		A2	4.1770	$172.84
24665	Treat radius fracture	Y		A2	28.1860	$1,166.46
24666	Treat radius fracture	Y		A2	37.7030	$1,560.30
24670	Treat ulnar fracture	Y		A2	1.9910	$82.40
24675	Treat ulnar fracture	Y		A2	1.9910	$82.40
24685	Treat ulnar fracture	Y		A2	26.7720	$1,107.95
24800	Fusion of elbow joint	Y		A2	29.5810	$1,224.16
24802	Fusion/graft of elbow joint	Y		A2	30.6060	$1,266.59

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24925	Amputation follow-up surgery	Y		A2	16.9310	$700.69
25000	Incision of tendon sheath	Y		A2	16.9310	$700.69
25001	Incise flexor carpi radialis	Y		G2	21.8440	$903.97
25020	Decompress forearm 1 space	Y		A2	16.9310	$700.69
25023	Decompress forearm 1 space	Y		A2	20.3660	$842.83
25024	Decompress forearm 2 spaces	Y		A2	20.3660	$842.83
25025	Decompress forearm 2 spaces	Y		A2	20.3660	$842.83
25028	Drainage of forearm lesion	Y		A2	14.8460	$614.38
25031	Drainage of forearm bursa	Y		A2	16.1770	$669.48
25035	Treat forearm bone lesion	Y		A2	16.1770	$669.48
25040	Explore/treat wrist joint	Y		A2	22.8050	$943.78
25065	Biopsy forearm soft tissues	Y		P3	3.1230	$129.24
25066	Biopsy forearm soft tissues	Y		A2	15.8610	$656.38
25075	Removal forearm lesion subcu	Y		A2	12.9940	$537.76
25076	Removal forearm lesion deep	Y		A2	16.6150	$687.59
25077	Remove tumor, forearm/wrist	Y		A2	16.6150	$687.59
25085	Incision of wrist capsule	Y		A2	16.9310	$700.69
25100	Biopsy of wrist joint	Y		A2	16.1770	$669.48
25101	Explore/treat wrist joint	Y		A2	20.3660	$842.83
25105	Remove wrist joint lining	Y		A2	21.7800	$901.35
25107	Remove wrist joint cartilage	Y		A2	20.3660	$842.83
25109	Excise tendon forearm/wrist	Y		G2	21.8440	$903.97
25110	Remove wrist tendon lesion	Y		A2	16.9310	$700.69
25111	Remove wrist tendon lesion	Y		A2	14.2990	$591.74
25112	Reremove wrist tendon lesion	Y		A2	15.7130	$650.25
25115	Remove wrist/forearm lesion	Y		A2	18.3460	$759.21
25116	Remove wrist/forearm lesion	Y		A2	18.3460	$759.21
25118	Excise wrist tendon sheath	Y		A2	19.6120	$811.62
25119	Partial removal of ulna	Y		A2	20.3660	$842.83
25120	Removal of forearm lesion	Y		A2	20.3660	$842.83
25125	Remove/graft forearm lesion	Y		A2	20.3660	$842.83
25126	Remove/graft forearm lesion	Y		A2	20.3660	$842.83
25130	Removal of wrist lesion	Y		A2	20.3660	$842.83
25135	Remove & graft wrist lesion	Y		A2	20.3660	$842.83
25136	Remove & graft wrist lesion	Y		A2	20.3660	$842.83
25145	Remove forearm bone lesion	Y		A2	19.6120	$811.62
25150	Partial removal of ulna	Y		A2	19.6120	$811.62
25151	Partial removal of radius	Y		A2	19.6120	$811.62
25210	Removal of wrist bone	Y		A2	19.7490	$817.29
25215	Removal of wrist bones	Y		A2	21.1630	$875.80

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25230	Partial removal of radius	Y		A2	21.7800	$901.35
25240	Partial removal of ulna	Y		A2	21.7800	$901.35
25246	Injection for wrist x-ray	N		N1		
25248	Remove forearm foreign body	Y		A2	16.1770	$669.48
25250	Removal of wrist prosthesis	Y		A2	18.2810	$756.52
25251	Removal of wrist prosthesis	Y		A2	18.2810	$756.52
25259	Manipulate wrist w/anesthes	Y		G2	19.9250	$824.57
25260	Repair forearm tendon/muscle	Y		A2	21.7800	$901.35
25263	Repair forearm tendon/muscle	Y		A2	19.6120	$811.62
25265	Repair forearm tendon/muscle	Y		A2	20.3660	$842.83
25270	Repair forearm tendon/muscle	Y		A2	21.7800	$901.35
25272	Repair forearm tendon/muscle	Y		A2	20.3660	$842.83
25274	Repair forearm tendon/muscle	Y		A2	21.7800	$901.35
25275	Repair forearm tendon sheath	Y		A2	21.7800	$901.35
25280	Revise wrist/forearm tendon	Y		A2	21.7800	$901.35
25290	Incise wrist/forearm tendon	Y		A2	20.3660	$842.83
25295	Release wrist/forearm tendon	Y		A2	16.9310	$700.69
25300	Fusion of tendons at wrist	Y		A2	20.3660	$842.83
25301	Fusion of tendons at wrist	Y		A2	20.3660	$842.83
25310	Transplant forearm tendon	Y		A2	28.1660	$1,165.64
25312	Transplant forearm tendon	Y		A2	29.5810	$1,224.16
25315	Revise palsy hand tendon(s)	Y		A2	28.1660	$1,165.64
25316	Revise palsy hand tendon(s)	Y		A2	47.7000	$1,974.00
25320	Repair/revise wrist joint	Y		A2	28.1660	$1,165.64
25332	Revise wrist joint	Y		A2	26.9230	$1,114.16
25335	Realignment of hand	Y		A2	28.1660	$1,165.64
25337	Reconstruct ulna/radioulnar	Y		A2	30.6060	$1,266.59
25350	Revision of radius	Y		A2	47.7000	$1,974.00
25355	Revision of radius	Y		A2	28.1660	$1,165.64
25360	Revision of ulna	Y		A2	20.3660	$842.83
25365	Revise radius & ulna	Y		A2	20.3660	$842.83
25370	Revise radius or ulna	Y		A2	28.1660	$1,165.64
25375	Revise radius & ulna	Y		A2	29.5810	$1,224.16
25390	Shorten radius or ulna	Y		A2	20.3660	$842.83
25391	Lengthen radius or ulna	Y		A2	29.5810	$1,224.16
25392	Shorten radius & ulna	Y		A2	20.3660	$842.83
25393	Lengthen radius & ulna	Y		A2	29.5810	$1,224.16
25394	Repair carpal bone, shorten	Y		G2	16.5780	$686.06
25400	Repair radius or ulna	Y		A2	28.1660	$1,165.64
25405	Repair/graft radius or ulna	Y		A2	49.1130	$2,032.51

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HCPCS Code	Short Descriptor	Subject to Multiple Procedure Discounting	Comment Indicator	Payment Indicator	CY 2009 Second Year Transition Payment Weight	CY 2009 Second Year Transition Payment
25415	Repair radius & ulna	Y		A2	47.7000	$1,974.00
25420	Repair/graft radius & ulna	Y		A2	49.1130	$2,032.51
25425	Repair/graft radius or ulna	Y		A2	28.1660	$1,165.64
25426	Repair/graft radius & ulna	Y		A2	29.5810	$1,224.16
25430	Vasc graft into carpal bone	Y		G2	27.4790	$1,137.17
25431	Repair nonunion carpal bone	Y		G2	27.4790	$1,137.17
25440	Repair/graft wrist bone	Y		A2	49.1130	$2,032.51
25441	Reconstruct wrist joint	Y		A2	67.2440	$2,782.83
25442	Reconstruct wrist joint	Y		A2	67.2440	$2,782.83
25443	Reconstruct wrist joint	Y		A2	34.2300	$1,416.56
25444	Reconstruct wrist joint	Y		A2	34.2300	$1,416.56
25445	Reconstruct wrist joint	Y		A2	34.2300	$1,416.56
25446	Wrist replacement	Y		A2	70.5200	$2,918.40
25447	Repair wrist joint(s)	Y		A2	26.9230	$1,114.16
25449	Remove wrist joint implant	Y		A2	26.9230	$1,114.16
25450	Revision of wrist joint	Y		A2	28.1660	$1,165.64
25455	Revision of wrist joint	Y		A2	28.1660	$1,165.64
25490	Reinforce radius	Y		A2	28.1660	$1,165.64
25491	Reinforce ulna	Y		A2	28.1660	$1,165.64
25492	Reinforce radius and ulna	Y		A2	28.1660	$1,165.64
25500	Treat fracture of radius	Y		P2	1.5400	$63.72
25505	Treat fracture of radius	Y		A2	4.1770	$172.84
25515	Treat fracture of radius	Y		A2	26.7720	$1,107.95
25520	Treat fracture of radius	Y		A2	4.1770	$172.84
25525	Treat fracture of radius	Y		A2	28.1860	$1,166.46
25526	Treat fracture of radius	Y		A2	29.2120	$1,208.89
25530	Treat fracture of ulna	Y		P2	1.5400	$63.72
25535	Treat fracture of ulna	Y		A2	1.9910	$82.40
25545	Treat fracture of ulna	Y		A2	26.7720	$1,107.95
25560	Treat fracture radius & ulna	Y		P2	1.5400	$63.72
25565	Treat fracture radius & ulna	Y		A2	4.1770	$172.84
25574	Treat fracture radius & ulna	Y		A2	36.2890	$1,501.79
25575	Treat fracture radius/ulna	Y		A2	36.2890	$1,501.79
25600	Treat fracture radius/ulna	Y		P2	1.5400	$63.72
25605	Treat fracture radius/ulna	Y		A2	4.1770	$172.84
25606	Treat fx distal radial	Y		A2	18.5340	$766.99
25607	Treat fx rad extra-articul	Y		A2	38.7280	$1,602.73
25608	Treat fx rad intra-articul	Y		A2	38.7280	$1,602.73
25609	Treat fx radial 3+ frag	Y		A2	38.7280	$1,602.73
25622	Treat wrist bone fracture	Y		P2	1.5400	$63.72

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25624	Treat wrist bone fracture	Y		A2	4.1770	$172.84
25628	Treat wrist bone fracture	Y		A2	26.7720	$1,107.95
25630	Treat wrist bone fracture	Y		P2	1.5400	$63.72
25635	Treat wrist bone fracture	Y		A2	4.1770	$172.84
25645	Treat wrist bone fracture	Y		A2	26.7720	$1,107.95
25650	Treat wrist bone fracture	Y		P2	1.5400	$63.72
25651	Pin ulnar styloid fracture	Y		G2	25.0480	$1,036.58
25652	Treat fracture ulnar styloid	Y		G2	41.5250	$1,718.48
25660	Treat wrist dislocation	Y		A2	1.9910	$82.40
25670	Treat wrist dislocation	Y		A2	18.5340	$766.99
25671	Pin radioulnar dislocation	Y		A2	16.4480	$680.68
25675	Treat wrist dislocation	Y		A2	1.9910	$82.40
25676	Treat wrist dislocation	Y		A2	17.7790	$735.78
25680	Treat wrist fracture	Y		A2	1.9910	$82.40
25685	Treat wrist fracture	Y		A2	18.5340	$766.99
25690	Treat wrist dislocation	Y		A2	11.1840	$462.82
25695	Treat wrist dislocation	Y		A2	17.7790	$735.78
25800	Fusion of wrist joint	Y		A2	49.1130	$2,032.51
25805	Fusion/graft of wrist joint	Y		A2	30.6060	$1,266.59
25810	Fusion/graft of wrist joint	Y		A2	50.1390	$2,074.94
25820	Fusion of hand bones	Y		A2	15.7130	$650.25
25825	Fuse hand bones with graft	Y		A2	50.1390	$2,074.94
25830	Fusion, radioulnar jnt/ulna	Y		A2	50.1390	$2,074.94
25907	Amputation follow-up surgery	Y		A2	16.9310	$700.69
25922	Amputate hand at wrist	Y		A2	16.9310	$700.69
25929	Amputation follow-up surgery	Y		A2	13.8160	$571.77
25931	Amputation follow-up surgery	Y		G2	21.8440	$903.97
26010	Drainage of finger abscess	Y		P2	1.3920	$57.59
26011	Drainage of finger abscess	Y		A2	10.1680	$420.81
26020	Drain hand tendon sheath	Y		A2	13.5450	$560.53
26025	Drainage of palm bursa	Y		A2	12.2130	$505.42
26030	Drainage of palm bursa(s)	Y		A2	13.5450	$560.53
26034	Treat hand bone lesion	Y		A2	13.5450	$560.53
26035	Decompress fingers/hand	Y		G2	16.5780	$686.06
26040	Release palm contracture	Y		A2	21.1630	$875.80
26045	Release palm contracture	Y		A2	19.7490	$817.29
26055	Incise finger tendon sheath	Y		A2	13.5450	$560.53
26060	Incision of finger tendon	Y		A2	13.5450	$560.53
26070	Explore/treat hand joint	Y		A2	13.5450	$560.53
26075	Explore/treat finger joint	Y		A2	15.7130	$650.25

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26080	Explore/treat finger joint	Y		A2	15.7130	$650.25
26100	Biopsy hand joint lining	Y		A2	13.5450	$560.53
26105	Biopsy finger joint lining	Y		A2	12.2130	$505.42
26110	Biopsy finger joint lining	Y		A2	12.2130	$505.42
26115	Removal hand lesion subcut	Y		A2	15.8610	$656.38
26116	Removal hand lesion, deep	Y		A2	15.8610	$656.38
26117	Remove tumor, hand/finger	Y		A2	16.6150	$687.59
26121	Release palm contracture	Y		A2	21.1630	$875.80
26123	Release palm contracture	Y		A2	21.1630	$875.80
26125	Release palm contracture	Y		A2	15.7130	$650.25
26130	Remove wrist joint lining	Y		A2	14.2990	$591.74
26135	Revise finger joint, each	Y		A2	21.1630	$875.80
26140	Revise finger joint, each	Y		A2	13.5450	$560.53
26145	Tendon excision, palm/finger	Y		A2	14.2990	$591.74
26160	Remove tendon sheath lesion	Y		A2	14.2990	$591.74
26170	Removal of palm tendon, each	Y		A2	14.2990	$591.74
26180	Removal of finger tendon	Y		A2	14.2990	$591.74
26185	Remove finger bone	Y		A2	15.7130	$650.25
26200	Remove hand bone lesion	Y		A2	13.5450	$560.53
26205	Remove/graft bone lesion	Y		A2	19.7490	$817.29
26210	Removal of finger lesion	Y		A2	13.5450	$560.53
26215	Remove/graft finger lesion	Y		A2	14.2990	$591.74
26230	Partial removal of hand bone	Y		A2	19.9900	$827.25
26235	Partial removal, finger bone	Y		A2	14.2990	$591.74
26236	Partial removal, finger bone	Y		A2	14.2990	$591.74
26250	Extensive hand surgery	Y		A2	14.2990	$591.74
26255	Extensive hand surgery	Y		A2	19.7490	$817.29
26260	Extensive finger surgery	Y		A2	14.2990	$591.74
26261	Extensive finger surgery	Y		A2	14.2990	$591.74
26262	Partial removal of finger	Y		A2	13.5450	$560.53
26320	Removal of implant from hand	Y		A2	12.9940	$537.76
26340	Manipulate finger w/anesth	Y		G2	5.9110	$244.62
26350	Repair finger/hand tendon	Y		A2	17.6630	$730.97
26352	Repair/graft hand tendon	Y		A2	21.1630	$875.80
26356	Repair finger/hand tendon	Y		A2	21.1630	$875.80
26357	Repair finger/hand tendon	Y		A2	21.1630	$875.80
26358	Repair/graft hand tendon	Y		A2	21.1630	$875.80
26370	Repair finger/hand tendon	Y		A2	21.1630	$875.80
26372	Repair/graft hand tendon	Y		A2	21.1630	$875.80
26373	Repair finger/hand tendon	Y		A2	19.7490	$817.29

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26390	Revise hand/finger tendon	Y		A2	21.1630	$875.80
26392	Repair/graft hand tendon	Y		A2	19.7490	$817.29
26410	Repair hand tendon	Y		A2	14.2990	$591.74
26412	Repair/graft hand tendon	Y		A2	19.7490	$817.29
26415	Excision, hand/finger tendon	Y		A2	21.1630	$875.80
26416	Graft hand or finger tendon	Y		A2	19.7490	$817.29
26418	Repair finger tendon	Y		A2	15.7130	$650.25
26420	Repair/graft finger tendon	Y		A2	21.1630	$875.80
26426	Repair finger/hand tendon	Y		A2	19.7490	$817.29
26428	Repair/graft finger tendon	Y		A2	19.7490	$817.29
26432	Repair finger tendon	Y		A2	14.2990	$591.74
26433	Repair finger tendon	Y		A2	14.2990	$591.74
26434	Repair/graft finger tendon	Y		A2	19.7490	$817.29
26437	Realignment of tendons	Y		A2	14.2990	$591.74
26440	Release palm/finger tendon	Y		A2	14.2990	$591.74
26442	Release palm & finger tendon	Y		A2	19.7490	$817.29
26445	Release hand/finger tendon	Y		A2	14.2990	$591.74
26449	Release forearm/hand tendon	Y		A2	19.7490	$817.29
26450	Incision of palm tendon	Y		A2	14.2990	$591.74
26455	Incision of finger tendon	Y		A2	14.2990	$591.74
26460	Incise hand/finger tendon	Y		A2	14.2990	$591.74
26471	Fusion of finger tendons	Y		A2	13.5450	$560.53
26474	Fusion of finger tendons	Y		A2	13.5450	$560.53
26476	Tendon lengthening	Y		A2	12.2130	$505.42
26477	Tendon shortening	Y		A2	12.2130	$505.42
26478	Lengthening of hand tendon	Y		A2	12.2130	$505.42
26479	Shortening of hand tendon	Y		A2	12.2130	$505.42
26480	Transplant hand tendon	Y		A2	19.7490	$817.29
26483	Transplant/graft hand tendon	Y		A2	19.7490	$817.29
26485	Transplant palm tendon	Y		A2	18.9950	$786.08
26489	Transplant/graft palm tendon	Y		A2	19.7490	$817.29
26490	Revise thumb tendon	Y		A2	19.7490	$817.29
26492	Tendon transfer with graft	Y		A2	19.7490	$817.29
26494	Hand tendon/muscle transfer	Y		A2	19.7490	$817.29
26496	Revise thumb tendon	Y		A2	19.7490	$817.29
26497	Finger tendon transfer	Y		A2	19.7490	$817.29
26498	Finger tendon transfer	Y		A2	21.1630	$875.80
26499	Revision of finger	Y		A2	19.7490	$817.29
26500	Hand tendon reconstruction	Y		A2	15.7130	$650.25
26502	Hand tendon reconstruction	Y		A2	21.1630	$875.80

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26508	Release thumb contracture	Y		A2	14.2990	$591.74
26510	Thumb tendon transfer	Y		A2	19.7490	$817.29
26516	Fusion of knuckle joint	Y		A2	17.6630	$730.97
26517	Fusion of knuckle joints	Y		A2	19.7490	$817.29
26518	Fusion of knuckle joints	Y		A2	19.7490	$817.29
26520	Release knuckle contracture	Y		A2	14.2990	$591.74
26525	Release finger contracture	Y		A2	14.2990	$591.74
26530	Revise knuckle joint	Y		A2	24.4830	$1,013.21
26531	Revise knuckle with implant	Y		A2	37.5060	$1,552.13
26535	Revise finger joint	Y		A2	26.9230	$1,114.16
26536	Revise/implant finger joint	Y		A2	34.2300	$1,416.56
26540	Repair hand joint	Y		A2	15.7130	$650.25
26541	Repair hand joint with graft	Y		A2	25.4640	$1,053.80
26542	Repair hand joint with graft	Y		A2	15.7130	$650.25
26545	Reconstruct finger joint	Y		A2	21.1630	$875.80
26546	Repair nonunion hand	Y		A2	21.1630	$875.80
26548	Reconstruct finger joint	Y		A2	21.1630	$875.80
26550	Construct thumb replacement	Y		A2	18.9950	$786.08
26555	Positional change of finger	Y		A2	19.7490	$817.29
26560	Repair of web finger	Y		A2	13.5450	$560.53
26561	Repair of web finger	Y		A2	19.7490	$817.29
26562	Repair of web finger	Y		A2	21.1630	$875.80
26565	Correct metacarpal flaw	Y		A2	22.1880	$918.23
26567	Correct finger deformity	Y		A2	22.1880	$918.23
26568	Lengthen metacarpal/finger	Y		A2	19.7490	$817.29
26580	Repair hand deformity	Y		A2	16.7380	$692.68
26587	Reconstruct extra finger	Y		A2	16.7380	$692.68
26590	Repair finger deformity	Y		A2	16.7380	$692.68
26591	Repair muscles of hand	Y		A2	19.7490	$817.29
26593	Release muscles of hand	Y		A2	14.2990	$591.74
26596	Excision constricting tissue	Y		A2	13.5450	$560.53
26600	Treat metacarpal fracture	Y		P2	1.5400	$63.72
26605	Treat metacarpal fracture	Y		A2	1.9910	$82.40
26607	Treat metacarpal fracture	Y		A2	11.1840	$462.82
26608	Treat metacarpal fracture	Y		A2	19.9480	$825.51
26615	Treat metacarpal fracture	Y		A2	28.1860	$1,166.46
26641	Treat thumb dislocation	Y		P2	1.5400	$63.72
26645	Treat thumb fracture	Y		A2	4.1770	$172.84
26650	Treat thumb fracture	Y		A2	17.7790	$735.78
26665	Treat thumb fracture	Y		A2	28.1860	$1,166.46

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26670	Treat hand dislocation	Y		P2	1.5400	$63.72
26675	Treat hand dislocation	Y		A2	4.1770	$172.84
26676	Pin hand dislocation	Y		A2	17.7790	$735.78
26685	Treat hand dislocation	Y		A2	18.5340	$766.99
26686	Treat hand dislocation	Y		A2	36.2890	$1,501.79
26700	Treat knuckle dislocation	Y		P2	1.5400	$63.72
26705	Treat knuckle dislocation	Y		A2	1.9910	$82.40
26706	Pin knuckle dislocation	Y		A2	11.1840	$462.82
26715	Treat knuckle dislocation	Y		A2	19.9480	$825.51
26720	Treat finger fracture, each	Y		P2	1.5400	$63.72
26725	Treat finger fracture, each	Y		P2	1.5400	$63.72
26727	Treat finger fracture, each	Y		A2	24.2490	$1,003.50
26735	Treat finger fracture, each	Y		A2	19.9480	$825.51
26740	Treat finger fracture, each	Y		P2	1.5400	$63.72
26742	Treat finger fracture, each	Y		A2	1.9910	$82.40
26746	Treat finger fracture, each	Y		A2	20.9730	$867.94
26750	Treat finger fracture, each	Y		P2	1.5400	$63.72
26755	Treat finger fracture, each	Y		G2	1.5400	$63.72
26756	Pin finger fracture, each	Y		A2	17.7790	$735.78
26765	Treat finger fracture, each	Y		A2	19.9480	$825.51
26770	Treat finger dislocation	Y		G2	1.5400	$63.72
26775	Treat finger dislocation	Y		P3	3.7380	$154.70
26776	Pin finger dislocation	Y		A2	17.7790	$735.78
26785	Treat finger dislocation	Y		A2	17.7790	$735.78
26820	Thumb fusion with graft	Y		A2	22.1880	$918.23
26841	Fusion of thumb	Y		A2	21.1630	$875.80
26842	Thumb fusion with graft	Y		A2	21.1630	$875.80
26843	Fusion of hand joint	Y		A2	19.7490	$817.29
26844	Fusion/graft of hand joint	Y		A2	19.7490	$817.29
26850	Fusion of knuckle	Y		A2	21.1630	$875.80
26852	Fusion of knuckle with graft	Y		A2	21.1630	$875.80
26860	Fusion of finger joint	Y		A2	19.7490	$817.29
26861	Fusion of finger jnt, add-on	Y		A2	18.9950	$786.08
26862	Fusion/graft of finger joint	Y		A2	21.1630	$875.80
26863	Fuse/graft added joint	Y		A2	19.7490	$817.29
26910	Amputate metacarpal bone	Y		A2	19.7490	$817.29
26951	Amputation of finger/thumb	Y		A2	13.5450	$560.53
26952	Amputation of finger/thumb	Y		A2	15.7130	$650.25
26990	Drainage of pelvis lesion	Y		A2	14.8460	$614.38
26991	Drainage of pelvis bursa	Y		A2	14.8460	$614.38

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27000	Incision of hip tendon	Y		A2	16.1770	$669.48
27001	Incision of hip tendon	Y		A2	20.3660	$842.83
27003	Incision of hip tendon	Y		A2	20.3660	$842.83
27033	Exploration of hip joint	Y		A2	28.1660	$1,165.64
27035	Denervation of hip joint	Y		A2	29.5810	$1,224.16
27040	Biopsy of soft tissues	Y		A2	7.8190	$323.56
27041	Biopsy of soft tissues	Y		A2	8.8260	$365.25
27047	Remove hip/pelvis lesion	Y		A2	15.8610	$656.38
27048	Remove hip/pelvis lesion	Y		A2	16.6150	$687.59
27049	Remove tumor, hip/pelvis	Y		A2	16.6150	$687.59
27050	Biopsy of sacroiliac joint	Y		A2	16.9310	$700.69
27052	Biopsy of hip joint	Y		A2	16.9310	$700.69
27060	Removal of ischial bursa	Y		A2	19.3710	$801.64
27062	Remove femur lesion/bursa	Y		A2	19.3710	$801.64
27065	Removal of hip bone lesion	Y		A2	19.3710	$801.64
27066	Removal of hip bone lesion	Y		A2	22.8050	$943.78
27067	Remove/graft hip bone lesion	Y		A2	22.8050	$943.78
27080	Removal of tail bone	Y		A2	19.6120	$811.62
27086	Remove hip foreign body	Y		A2	7.8190	$323.56
27087	Remove hip foreign body	Y		A2	16.9310	$700.69
27093	Injection for hip x-ray	N		N1		
27095	Injection for hip x-ray	N		N1		
27097	Revision of hip tendon	Y		A2	20.3660	$842.83
27098	Transfer tendon to pelvis	Y		A2	20.3660	$842.83
27100	Transfer of abdominal muscle	Y		A2	29.5810	$1,224.16
27105	Transfer of spinal muscle	Y		A2	29.5810	$1,224.16
27110	Transfer of iliopsoas muscle	Y		A2	29.5810	$1,224.16
27111	Transfer of iliopsoas muscle	Y		A2	29.5810	$1,224.16
27193	Treat pelvic ring fracture	Y		A2	1.9910	$82.40
27194	Treat pelvic ring fracture	Y		A2	12.8300	$530.97
27200	Treat tail bone fracture	Y		P2	1.5400	$63.72
27202	Treat tail bone fracture	Y		A2	26.0180	$1,076.74
27220	Treat hip socket fracture	Y		G2	1.5400	$63.72
27230	Treat thigh fracture	Y		A2	1.9910	$82.40
27238	Treat thigh fracture	Y		A2	4.1770	$172.84
27246	Treat thigh fracture	Y		A2	4.1770	$172.84
27250	Treat hip dislocation	Y		A2	1.9910	$82.40
27252	Treat hip dislocation	Y		A2	12.8300	$530.97
27256	Treat hip dislocation	Y		G2	1.5400	$63.72
27257	Treat hip dislocation	Y		A2	13.5850	$562.18

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27265	Treat hip dislocation	Y		A2	1.9910	$82.40
27266	Treat hip dislocation	Y		A2	12.8300	$530.97
27267	Cltx thigh fx	Y		G2	1.5400	$63.72
27275	Manipulation of hip joint	Y		A2	12.8300	$530.97
27301	Drain thigh/knee lesion	Y		A2	15.5570	$643.79
27305	Incise thigh tendon & fascia	Y		A2	16.1770	$669.48
27306	Incision of thigh tendon	Y		A2	16.9310	$700.69
27307	Incision of thigh tendons	Y		A2	16.9310	$700.69
27310	Exploration of knee joint	Y		A2	21.7800	$901.35
27323	Biopsy, thigh soft tissues	Y		A2	7.8190	$323.56
27324	Biopsy, thigh soft tissues	Y		A2	14.5290	$601.28
27325	Neurectomy, hamstring	Y		A2	14.2460	$589.54
27326	Neurectomy, popliteal	Y		A2	14.2460	$589.54
27327	Removal of thigh lesion	Y		A2	15.8610	$656.38
27328	Removal of thigh lesion	Y		A2	16.6150	$687.59
27329	Remove tumor, thigh/knee	Y		A2	18.0290	$746.11
27330	Biopsy, knee joint lining	Y		A2	21.7800	$901.35
27331	Explore/treat knee joint	Y		A2	21.7800	$901.35
27332	Removal of knee cartilage	Y		A2	21.7800	$901.35
27333	Removal of knee cartilage	Y		A2	21.7800	$901.35
27334	Remove knee joint lining	Y		A2	21.7800	$901.35
27335	Remove knee joint lining	Y		A2	21.7800	$901.35
27340	Removal of kneecap bursa	Y		A2	16.9310	$700.69
27345	Removal of knee cyst	Y		A2	18.3460	$759.21
27347	Remove knee cyst	Y		A2	18.3460	$759.21
27350	Removal of kneecap	Y		A2	21.7800	$901.35
27355	Remove femur lesion	Y		A2	20.3660	$842.83
27356	Remove femur lesion/graft	Y		A2	21.7800	$901.35
27357	Remove femur lesion/graft	Y		A2	22.8050	$943.78
27358	Remove femur lesion/fixation	Y		A2	22.8050	$943.78
27360	Partial removal, leg bone(s)	Y		A2	22.8050	$943.78
27370	Injection for knee x-ray	N		N1		
27372	Removal of foreign body	Y		A2	22.3300	$924.10
27380	Repair of kneecap tendon	Y		A2	14.8460	$614.38
27381	Repair/graft kneecap tendon	Y		A2	16.9310	$700.69
27385	Repair of thigh muscle	Y		A2	16.9310	$700.69
27386	Repair/graft of thigh muscle	Y		A2	16.9310	$700.69
27390	Incision of thigh tendon	Y		A2	14.8460	$614.38
27391	Incision of thigh tendons	Y		A2	16.1770	$669.48
27392	Incision of thigh tendons	Y		A2	16.9310	$700.69

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27393	Lengthening of thigh tendon	Y		A2	19.6120	$811.62
27394	Lengthening of thigh tendons	Y		A2	20.3660	$842.83
27395	Lengthening of thigh tendons	Y		A2	28.1660	$1,165.64
27396	Transplant of thigh tendon	Y		A2	20.3660	$842.83
27397	Transplants of thigh tendons	Y		A2	28.1660	$1,165.64
27400	Revise thigh muscles/tendons	Y		A2	28.1660	$1,165.64
27403	Repair of knee cartilage	Y		A2	21.7800	$901.35
27405	Repair of knee ligament	Y		A2	29.5810	$1,224.16
27407	Repair of knee ligament	Y		A2	49.1130	$2,032.51
27409	Repair of knee ligaments	Y		A2	29.5810	$1,224.16
27416	Osteochondral knee autograft	Y		G2	44.3140	$1,833.87
27418	Repair degenerated kneecap	Y		A2	28.1660	$1,165.64
27420	Revision of unstable kneecap	Y		A2	28.1660	$1,165.64
27422	Revision of unstable kneecap	Y		A2	33.8820	$1,402.15
27424	Revision/removal of kneecap	Y		A2	28.1660	$1,165.64
27425	Lat retinacular release open	Y		A2	26.0810	$1,079.34
27427	Reconstruction, knee	Y		A2	28.1660	$1,165.64
27428	Reconstruction, knee	Y		A2	49.1130	$2,032.51
27429	Reconstruction, knee	Y		A2	49.1130	$2,032.51
27430	Revision of thigh muscles	Y		A2	29.5810	$1,224.16
27435	Incision of knee joint	Y		A2	29.5810	$1,224.16
27437	Revise kneecap	Y		A2	25.8970	$1,071.73
27438	Revise kneecap with implant	Y		A2	34.2300	$1,416.56
27440	Revision of knee joint	Y		G2	36.9470	$1,529.02
27441	Revision of knee joint	Y		A2	26.9230	$1,114.16
27442	Revision of knee joint	Y		A2	26.9230	$1,114.16
27443	Revision of knee joint	Y		A2	26.9230	$1,114.16
27446	Revision of knee joint	Y	CH	J8	306.1580	$12,670.06
27496	Decompression of thigh/knee	Y		A2	19.3710	$801.64
27497	Decompression of thigh/knee	Y		A2	16.9310	$700.69
27498	Decompression of thigh/knee	Y		A2	16.9310	$700.69
27499	Decompression of thigh/knee	Y		A2	16.9310	$700.69
27500	Treatment of thigh fracture	Y		A2	4.1770	$172.84
27501	Treatment of thigh fracture	Y		A2	1.9910	$82.40
27502	Treatment of thigh fracture	Y		A2	11.1840	$462.82
27503	Treatment of thigh fracture	Y		A2	1.9910	$82.40
27508	Treatment of thigh fracture	Y		A2	1.9910	$82.40
27509	Treatment of thigh fracture	Y		A2	18.5340	$766.99
27510	Treatment of thigh fracture	Y		A2	4.1770	$172.84
27516	Treat thigh fx growth plate	Y		A2	1.9910	$82.40

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27517	Treat thigh fx growth plate	Y		A2	1.9910	$82.40
27520	Treat kneecap fracture	Y		A2	1.9910	$82.40
27530	Treat knee fracture	Y		A2	1.9910	$82.40
27532	Treat knee fracture	Y		A2	11.1840	$462.82
27538	Treat knee fracture(s)	Y		A2	1.9910	$82.40
27550	Treat knee dislocation	Y		A2	1.9910	$82.40
27552	Treat knee dislocation	Y		A2	11.4990	$475.86
27560	Treat kneecap dislocation	Y		A2	1.9910	$82.40
27562	Treat kneecap dislocation	Y		A2	11.4990	$475.86
27566	Treat kneecap dislocation	Y		A2	26.0180	$1,076.74
27570	Fixation of knee joint	Y		A2	11.4990	$475.86
27594	Amputation follow-up surgery	Y		A2	16.9310	$700.69
27600	Decompression of lower leg	Y		A2	16.9310	$700.69
27601	Decompression of lower leg	Y		A2	16.9310	$700.69
27602	Decompression of lower leg	Y		A2	16.9310	$700.69
27603	Drain lower leg lesion	Y		A2	14.8020	$612.58
27604	Drain lower leg bursa	Y		A2	16.1770	$669.48
27605	Incision of achilles tendon	Y		A2	14.4610	$598.45
27606	Incision of achilles tendon	Y		A2	14.8460	$614.38
27607	Treat lower leg bone lesion	Y		A2	16.1770	$669.48
27610	Explore/treat ankle joint	Y		A2	19.6120	$811.62
27612	Exploration of ankle joint	Y		A2	20.3660	$842.83
27613	Biopsy lower leg soft tissue	Y		P3	2.9520	$122.15
27614	Biopsy lower leg soft tissue	Y		A2	15.8610	$656.38
27615	Remove tumor, lower leg	Y		A2	20.3660	$842.83
27618	Remove lower leg lesion	Y		A2	12.9940	$537.76
27619	Remove lower leg lesion	Y		A2	16.6150	$687.59
27620	Explore/treat ankle joint	Y		A2	21.7800	$901.35
27625	Remove ankle joint lining	Y		A2	21.7800	$901.35
27626	Remove ankle joint lining	Y		A2	21.7800	$901.35
27630	Removal of tendon lesion	Y		A2	16.9310	$700.69
27635	Remove lower leg bone lesion	Y		A2	20.3660	$842.83
27637	Remove/graft leg bone lesion	Y		A2	20.3660	$842.83
27638	Remove/graft leg bone lesion	Y		A2	20.3660	$842.83
27640	Partial removal of tibia	Y		A2	27.4120	$1,134.43
27641	Partial removal of fibula	Y		A2	19.6120	$811.62
27647	Extensive ankle/heel surgery	Y		A2	28.1660	$1,165.64
27648	Injection for ankle x-ray	N		N1		
27650	Repair achilles tendon	Y		A2	28.1660	$1,165.64
27652	Repair/graft achilles tendon	Y		A2	47.7000	$1,974.00

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27654	Repair of achilles tendon	Y		A2	28.1660	$1,165.64
27656	Repair leg fascia defect	Y		A2	16.1770	$669.48
27658	Repair of leg tendon, each	Y		A2	14.8460	$614.38
27659	Repair of leg tendon, each	Y		A2	16.1770	$669.48
27664	Repair of leg tendon, each	Y		A2	16.1770	$669.48
27665	Repair of leg tendon, each	Y		A2	19.6120	$811.62
27675	Repair lower leg tendons	Y		A2	16.1770	$669.48
27676	Repair lower leg tendons	Y		A2	20.3660	$842.83
27680	Release of lower leg tendon	Y		A2	20.3660	$842.83
27681	Release of lower leg tendons	Y		A2	19.6120	$811.62
27685	Revision of lower leg tendon	Y		A2	20.3660	$842.83
27686	Revise lower leg tendons	Y		A2	20.3660	$842.83
27687	Revision of calf tendon	Y		A2	20.3660	$842.83
27690	Revise lower leg tendon	Y		A2	29.5810	$1,224.16
27691	Revise lower leg tendon	Y		A2	29.5810	$1,224.16
27692	Revise additional leg tendon	Y		A2	28.1660	$1,165.64
27695	Repair of ankle ligament	Y		A2	19.6120	$811.62
27696	Repair of ankle ligaments	Y		A2	19.6120	$811.62
27698	Repair of ankle ligament	Y		A2	19.6120	$811.62
27700	Revision of ankle joint	Y		A2	26.9230	$1,114.16
27704	Removal of ankle implant	Y		A2	16.1770	$669.48
27705	Incision of tibia	Y		A2	27.4120	$1,134.43
27707	Incision of fibula	Y		A2	16.1770	$669.48
27709	Incision of tibia & fibula	Y		A2	19.6120	$811.62
27726	Repair fibula nonunion	Y		G2	25.0480	$1,036.58
27730	Repair of tibia epiphysis	Y		A2	19.6120	$811.62
27732	Repair of fibula epiphysis	Y		A2	19.6120	$811.62
27734	Repair lower leg epiphyses	Y		A2	19.6120	$811.62
27740	Repair of leg epiphyses	Y		A2	19.6120	$811.62
27742	Repair of leg epiphyses	Y		A2	27.4120	$1,134.43
27745	Reinforce tibia	Y		A2	47.7000	$1,974.00
27750	Treatment of tibia fracture	Y		A2	1.9910	$82.40
27752	Treatment of tibia fracture	Y		A2	11.1840	$462.82
27756	Treatment of tibia fracture	Y		A2	18.5340	$766.99
27758	Treatment of tibia fracture	Y		A2	28.1860	$1,166.46
27759	Treatment of tibia fracture	Y		A2	37.7030	$1,560.30
27760	Cltx medial ankle fx	Y		A2	1.9910	$82.40
27762	Cltx med ankle fx w/mnpj	Y		A2	11.1840	$462.82
27766	Optx medial ankle fx	Y		A2	26.7720	$1,107.95
27767	Cltx post ankle fx	Y		G2	1.5400	$63.72

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27768	Cltx post ankle fx w/mnpj	Y		G2	1.5400	$63.72
27769	Optx post ankle fx	Y		G2	41.5250	$1,718.48
27780	Treatment of fibula fracture	Y		A2	1.9910	$82.40
27781	Treatment of fibula fracture	Y		A2	11.1840	$462.82
27784	Treatment of fibula fracture	Y		A2	26.7720	$1,107.95
27786	Treatment of ankle fracture	Y		A2	1.9910	$82.40
27788	Treatment of ankle fracture	Y		A2	1.9910	$82.40
27792	Treatment of ankle fracture	Y		A2	26.7720	$1,107.95
27808	Treatment of ankle fracture	Y		A2	1.9910	$82.40
27810	Treatment of ankle fracture	Y		A2	4.1770	$172.84
27814	Treatment of ankle fracture	Y		A2	26.7720	$1,107.95
27816	Treatment of ankle fracture	Y		A2	1.9910	$82.40
27818	Treatment of ankle fracture	Y		A2	4.1770	$172.84
27822	Treatment of ankle fracture	Y		A2	26.7720	$1,107.95
27823	Treatment of ankle fracture	Y		A2	36.2890	$1,501.79
27824	Treat lower leg fracture	Y		A2	1.9910	$82.40
27825	Treat lower leg fracture	Y		A2	11.1840	$462.82
27826	Treat lower leg fracture	Y		A2	26.7720	$1,107.95
27827	Treat lower leg fracture	Y		A2	36.2890	$1,501.79
27828	Treat lower leg fracture	Y		A2	37.7030	$1,560.30
27829	Treat lower leg joint	Y		A2	26.0180	$1,076.74
27830	Treat lower leg dislocation	Y		A2	1.9910	$82.40
27831	Treat lower leg dislocation	Y		A2	11.1840	$462.82
27832	Treat lower leg dislocation	Y		A2	26.0180	$1,076.74
27840	Treat ankle dislocation	Y		A2	4.1770	$172.84
27842	Treat ankle dislocation	Y		A2	11.4990	$475.86
27846	Treat ankle dislocation	Y		A2	26.7720	$1,107.95
27848	Treat ankle dislocation	Y		A2	26.7720	$1,107.95
27860	Fixation of ankle joint	Y		A2	11.4990	$475.86
27870	Fusion of ankle joint, open	Y		A2	49.1130	$2,032.51
27871	Fusion of tibiofibular joint	Y		A2	49.1130	$2,032.51
27884	Amputation follow-up surgery	Y		A2	16.9310	$700.69
27889	Amputation of foot at ankle	Y		A2	20.3660	$842.83
27892	Decompression of leg	Y		A2	16.9310	$700.69
27893	Decompression of leg	Y		A2	16.9310	$700.69
27894	Decompression of leg	Y		A2	16.9310	$700.69
28001	Drainage of bursa of foot	Y		P3	2.9210	$120.86
28002	Treatment of foot infection	Y		A2	16.9310	$700.69
28003	Treatment of foot infection	Y		A2	16.9310	$700.69
28005	Treat foot bone lesion	Y		A2	16.5470	$684.77

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28008	Incision of foot fascia	Y		A2	16.5470	$684.77
28010	Incision of toe tendon	Y		P3	2.1260	$87.98
28011	Incision of toe tendons	Y		A2	16.5470	$684.77
28020	Exploration of foot joint	Y		A2	15.7930	$653.56
28022	Exploration of foot joint	Y		A2	15.7930	$653.56
28024	Exploration of toe joint	Y		A2	15.7930	$653.56
28035	Decompression of tibia nerve	Y		A2	16.4140	$679.27
28043	Excision of foot lesion	Y		A2	15.8610	$656.38
28045	Excision of foot lesion	Y		A2	16.5470	$684.77
28046	Resection of tumor, foot	Y		A2	16.5470	$684.77
28050	Biopsy of foot joint lining	Y		A2	15.7930	$653.56
28052	Biopsy of foot joint lining	Y		A2	15.7930	$653.56
28054	Biopsy of toe joint lining	Y		A2	15.7930	$653.56
28055	Neurectomy, foot	Y		A2	16.4140	$679.27
28060	Partial removal, foot fascia	Y		A2	15.7930	$653.56
28062	Removal of foot fascia	Y		A2	16.5470	$684.77
28070	Removal of foot joint lining	Y		A2	16.5470	$684.77
28072	Removal of foot joint lining	Y		A2	16.5470	$684.77
28080	Removal of foot lesion	Y		A2	16.5470	$684.77
28086	Excise foot tendon sheath	Y		A2	15.7930	$653.56
28088	Excise foot tendon sheath	Y		A2	15.7930	$653.56
28090	Removal of foot lesion	Y		A2	16.5470	$684.77
28092	Removal of toe lesions	Y		A2	16.5470	$684.77
28100	Removal of ankle/heel lesion	Y		A2	15.7930	$653.56
28102	Remove/graft foot lesion	Y		A2	29.0150	$1,200.77
28103	Remove/graft foot lesion	Y		A2	29.0150	$1,200.77
28104	Removal of foot lesion	Y		A2	15.7930	$653.56
28106	Remove/graft foot lesion	Y		A2	29.0150	$1,200.77
28107	Remove/graft foot lesion	Y		A2	29.0150	$1,200.77
28108	Removal of toe lesions	Y		A2	15.7930	$653.56
28110	Part removal of metatarsal	Y		A2	16.5470	$684.77
28111	Part removal of metatarsal	Y		A2	16.5470	$684.77
28112	Part removal of metatarsal	Y		A2	16.5470	$684.77
28113	Part removal of metatarsal	Y		A2	16.5470	$684.77
28114	Removal of metatarsal heads	Y		A2	16.5470	$684.77
28116	Revision of foot	Y		A2	16.5470	$684.77
28118	Removal of heel bone	Y		A2	17.9610	$743.28
28119	Removal of heel spur	Y		A2	17.9610	$743.28
28120	Part removal of ankle/heel	Y		A2	22.2620	$921.28
28122	Partial removal of foot bone	Y		A2	16.5470	$684.77

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28124	Partial removal of toe	Y		P3	4.9370	$204.33
28126	Partial removal of toe	Y		A2	16.5470	$684.77
28130	Removal of ankle bone	Y		A2	16.5470	$684.77
28140	Removal of metatarsal	Y		A2	16.5470	$684.77
28150	Removal of toe	Y		A2	16.5470	$684.77
28153	Partial removal of toe	Y		A2	16.5470	$684.77
28160	Partial removal of toe	Y		A2	16.5470	$684.77
28171	Extensive foot surgery	Y		A2	16.5470	$684.77
28173	Extensive foot surgery	Y		A2	16.5470	$684.77
28175	Extensive foot surgery	Y		A2	16.5470	$684.77
28190	Removal of foot foreign body	Y		P3	3.0140	$124.72
28192	Removal of foot foreign body	Y		A2	12.9940	$537.76
28193	Removal of foot foreign body	Y		A2	8.8260	$365.25
28200	Repair of foot tendon	Y		A2	16.5470	$684.77
28202	Repair/graft of foot tendon	Y		A2	16.5470	$684.77
28208	Repair of foot tendon	Y		A2	16.5470	$684.77
28210	Repair/graft of foot tendon	Y		A2	29.0150	$1,200.77
28220	Release of foot tendon	Y		P3	4.6490	$192.40
28222	Release of foot tendons	Y		A2	14.4610	$598.45
28225	Release of foot tendon	Y		A2	14.4610	$598.45
28226	Release of foot tendons	Y		A2	14.4610	$598.45
28230	Incision of foot tendon(s)	Y		P3	4.5560	$188.54
28232	Incision of toe tendon	Y		P3	4.3530	$180.16
28234	Incision of foot tendon	Y		A2	15.7930	$653.56
28238	Revision of foot tendon	Y		A2	29.0150	$1,200.77
28240	Release of big toe	Y		A2	15.7930	$653.56
28250	Revision of foot fascia	Y		A2	16.5470	$684.77
28260	Release of midfoot joint	Y		A2	16.5470	$684.77
28261	Revision of foot tendon	Y		A2	16.5470	$684.77
28262	Revision of foot and ankle	Y		A2	17.9610	$743.28
28264	Release of midfoot joint	Y		A2	26.9300	$1,114.46
28270	Release of foot contracture	Y		A2	16.5470	$684.77
28272	Release of toe joint, each	Y		P3	4.2210	$174.68
28280	Fusion of toes	Y		A2	15.7930	$653.56
28285	Repair of hammertoe	Y		A2	16.5470	$684.77
28286	Repair of hammertoe	Y		A2	17.9610	$743.28
28288	Partial removal of foot bone	Y		A2	16.5470	$684.77
28289	Repair hallux rigidus	Y		A2	16.5470	$684.77
28290	Correction of bunion	Y		A2	20.3860	$843.67
28292	Correction of bunion	Y		A2	20.3860	$843.67

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HCPCS Code	Short Descriptor	Subject to Multiple Procedure Discounting	Comment Indicator	Payment Indicator	CY 2009 Second Year Transition Payment Weight	CY 2009 Second Year Transition Payment
28293	Correction of bunion	Y		A2	21.1410	$874.88
28294	Correction of bunion	Y		A2	21.1410	$874.88
28296	Correction of bunion	Y		A2	21.1410	$874.88
28297	Correction of bunion	Y		A2	21.1410	$874.88
28298	Correction of bunion	Y		A2	21.1410	$874.88
28299	Correction of bunion	Y		A2	23.5800	$975.83
28300	Incision of heel bone	Y		A2	28.2610	$1,169.56
28302	Incision of ankle bone	Y		A2	15.7930	$653.56
28304	Incision of midfoot bones	Y		A2	28.2610	$1,169.56
28305	Incise/graft midfoot bones	Y		A2	29.0150	$1,200.77
28306	Incision of metatarsal	Y		A2	17.9610	$743.28
28307	Incision of metatarsal	Y		A2	17.9610	$743.28
28308	Incision of metatarsal	Y		A2	15.7930	$653.56
28309	Incision of metatarsals	Y		A2	30.4290	$1,259.29
28310	Revision of big toe	Y		A2	16.5470	$684.77
28312	Revision of toe	Y		A2	16.5470	$684.77
28313	Repair deformity of toe	Y		A2	15.7930	$653.56
28315	Removal of sesamoid bone	Y		A2	17.9610	$743.28
28320	Repair of foot bones	Y		A2	30.4290	$1,259.29
28322	Repair of metatarsals	Y		A2	30.4290	$1,259.29
28340	Resect enlarged toe tissue	Y		A2	17.9610	$743.28
28341	Resect enlarged toe	Y		A2	17.9610	$743.28
28344	Repair extra toe(s)	Y		A2	17.9610	$743.28
28345	Repair webbed toe(s)	Y		A2	17.9610	$743.28
28400	Treatment of heel fracture	Y		A2	1.9910	$82.40
28405	Treatment of heel fracture	Y		A2	11.1840	$462.82
28406	Treatment of heel fracture	Y		A2	17.7790	$735.78
28415	Treat heel fracture	Y		A2	36.2890	$1,501.79
28420	Treat/graft heel fracture	Y		A2	28.1860	$1,166.46
28430	Treatment of ankle fracture	Y		P2	1.5400	$63.72
28435	Treatment of ankle fracture	Y		A2	1.9910	$82.40
28436	Treatment of ankle fracture	Y		A2	17.7790	$735.78
28445	Treat ankle fracture	Y		A2	26.7720	$1,107.95
28446	Osteochondral talus autogrft	Y		G2	46.0110	$1,904.14
28450	Treat midfoot fracture, each	Y		P2	1.5400	$63.72
28455	Treat midfoot fracture, each	Y		P2	1.5400	$63.72
28456	Treat midfoot fracture	Y		A2	17.7790	$735.78
28465	Treat midfoot fracture, each	Y		A2	26.7720	$1,107.95
28470	Treat metatarsal fracture	Y		P2	1.5400	$63.72
28475	Treat metatarsal fracture	Y		P2	1.5400	$63.72

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28476	Treat metatarsal fracture	Y		A2	17.7790	$735.78
28485	Treat metatarsal fracture	Y		A2	28.1860	$1,166.46
28490	Treat big toe fracture	Y		P2	1.5400	$63.72
28495	Treat big toe fracture	Y		P2	1.5400	$63.72
28496	Treat big toe fracture	Y		A2	17.7790	$735.78
28505	Treat big toe fracture	Y		A2	18.5340	$766.99
28510	Treatment of toe fracture	Y		P3	1.2770	$52.85
28515	Treatment of toe fracture	Y		P2	1.5400	$63.72
28525	Treat toe fracture	Y		A2	18.5340	$766.99
28530	Treat sesamoid bone fracture	Y		P3	1.2380	$51.24
28531	Treat sesamoid bone fracture	Y		A2	18.5340	$766.99
28540	Treat foot dislocation	Y		P2	1.5400	$63.72
28545	Treat foot dislocation	Y		A2	16.4480	$680.68
28546	Treat foot dislocation	Y		A2	17.7790	$735.78
28555	Repair foot dislocation	Y		A2	26.0180	$1,076.74
28570	Treat foot dislocation	Y	CH	P3	1.8530	$76.70
28575	Treat foot dislocation	Y		A2	11.1840	$462.82
28576	Treat foot dislocation	Y		A2	18.5340	$766.99
28585	Repair foot dislocation	Y		A2	18.5340	$766.99
28600	Treat foot dislocation	Y		P2	1.5400	$63.72
28605	Treat foot dislocation	Y		A2	1.9910	$82.40
28606	Treat foot dislocation	Y		A2	17.7790	$735.78
28615	Repair foot dislocation	Y		A2	26.7720	$1,107.95
28630	Treat toe dislocation	Y		P3	1.3860	$57.37
28635	Treat toe dislocation	Y		A2	11.4990	$475.86
28636	Treat toe dislocation	Y		A2	18.5340	$766.99
28645	Repair toe dislocation	Y		A2	18.5340	$766.99
28660	Treat toe dislocation	Y		P3	1.0200	$42.22
28665	Treat toe dislocation	Y		A2	11.4990	$475.86
28666	Treat toe dislocation	Y		A2	18.5340	$766.99
28675	Repair of toe dislocation	Y		A2	18.5340	$766.99
28705	Fusion of foot bones	Y		A2	30.4290	$1,259.29
28715	Fusion of foot bones	Y		A2	49.1130	$2,032.51
28725	Fusion of foot bones	Y		A2	30.4290	$1,259.29
28730	Fusion of foot bones	Y		A2	30.4290	$1,259.29
28735	Fusion of foot bones	Y		A2	30.4290	$1,259.29
28737	Revision of foot bones	Y		A2	31.4550	$1,301.72
28740	Fusion of foot bones	Y		A2	30.4290	$1,259.29
28750	Fusion of big toe joint	Y		A2	30.4290	$1,259.29
28755	Fusion of big toe joint	Y		A2	17.9610	$743.28

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28760	Fusion of big toe joint	Y		A2	30.4290	$1,259.29
28810	Amputation toe & metatarsal	Y		A2	15.7930	$653.56
28820	Amputation of toe	Y		A2	15.7930	$653.56
28825	Partial amputation of toe	Y		A2	15.7930	$653.56
28890	High energy eswt, plantar f	Y		P3	3.8080	$157.60
29000	Application of body cast	N		G2	1.0870	$44.99
29010	Application of body cast	N		P2	2.3430	$96.95
29015	Application of body cast	N		P2	2.3430	$96.95
29020	Application of body cast	N		G2	1.0870	$44.99
29025	Application of body cast	N		P2	1.0870	$44.99
29035	Application of body cast	N		P2	2.3430	$96.95
29040	Application of body cast	N		G2	1.0870	$44.99
29044	Application of body cast	N		P2	2.3430	$96.95
29046	Application of body cast	N		G2	2.3430	$96.95
29049	Application of figure eight	N	CH	P3	0.8640	$35.77
29055	Application of shoulder cast	N		P2	2.3430	$96.95
29058	Application of shoulder cast	N	CH	P3	1.0050	$41.57
29065	Application of long arm cast	N		P3	1.0050	$41.57
29075	Application of forearm cast	N		P3	0.9660	$39.96
29085	Apply hand/wrist cast	N	CH	P3	0.9890	$40.93
29086	Apply finger cast	N		P3	0.8180	$33.84
29105	Apply long arm splint	N		P3	0.8800	$36.42
29125	Apply forearm splint	N		P3	0.7630	$31.58
29126	Apply forearm splint	N		P3	0.8100	$33.52
29130	Application of finger splint	N		P3	0.3430	$14.18
29131	Application of finger splint	N		P3	0.5060	$20.95
29200	Strapping of chest	N		P3	0.4830	$19.98
29220	Strapping of low back	N		P3	0.5220	$21.59
29240	Strapping of shoulder	N		P3	0.5450	$22.56
29260	Strapping of elbow or wrist	N		P3	0.5220	$21.59
29280	Strapping of hand or finger	N		P3	0.5370	$22.24
29305	Application of hip cast	N		P2	2.3430	$96.95
29325	Application of hip casts	N		P2	2.3430	$96.95
29345	Application of long leg cast	N		P3	1.3160	$54.47
29355	Application of long leg cast	N		P3	1.2930	$53.50
29358	Apply long leg cast brace	N		P3	1.6120	$66.71
29365	Application of long leg cast	N		P3	1.2460	$51.57
29405	Apply short leg cast	N		P3	0.9340	$38.67
29425	Apply short leg cast	N		P3	0.9500	$39.32
29435	Apply short leg cast	N		P3	1.1920	$49.31

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29440	Addition of walker to cast	N		P3	0.5060	$20.95
29445	Apply rigid leg cast	N		P3	1.2620	$52.21
29450	Application of leg cast	N		P2	1.0870	$44.99
29505	Application, long leg splint	N		P3	0.8640	$35.77
29515	Application lower leg splint	N		P3	0.7320	$30.29
29520	Strapping of hip	N		P3	0.5220	$21.59
29530	Strapping of knee	N		P3	0.5220	$21.59
29540	Strapping of ankle and/or ft	N		P3	0.4050	$16.76
29550	Strapping of toes	N		P3	0.4130	$17.08
29580	Application of paste boot	N		P3	0.5450	$22.56
29590	Application of foot splint	N		P3	0.4440	$18.37
29700	Removal/revision of cast	N		P3	0.7320	$30.29
29705	Removal/revision of cast	N		P3	0.6150	$25.46
29710	Removal/revision of cast	N		P3	1.0830	$44.80
29715	Removal/revision of cast	N	CH	P3	0.9270	$38.35
29720	Repair of body cast	N		P3	0.9040	$37.39
29730	Windowing of cast	N		P3	0.5920	$24.49
29740	Wedging of cast	N		P3	0.8100	$33.52
29750	Wedging of clubfoot cast	N		P3	0.8410	$34.81
29800	Jaw arthroscopy/surgery	Y		A2	20.3640	$842.73
29804	Jaw arthroscopy/surgery	Y		A2	20.3640	$842.73
29805	Shoulder arthroscopy, dx	Y		A2	20.3640	$842.73
29806	Shoulder arthroscopy/surgery	Y		A2	30.0160	$1,242.19
29807	Shoulder arthroscopy/surgery	Y		A2	30.0160	$1,242.19
29819	Shoulder arthroscopy/surgery	Y		A2	30.0160	$1,242.19
29820	Shoulder arthroscopy/surgery	Y		A2	30.0160	$1,242.19
29821	Shoulder arthroscopy/surgery	Y		A2	30.0160	$1,242.19
29822	Shoulder arthroscopy/surgery	Y		A2	20.3640	$842.73
29823	Shoulder arthroscopy/surgery	Y		A2	30.0160	$1,242.19
29824	Shoulder arthroscopy/surgery	Y		A2	22.8030	$943.67
29825	Shoulder arthroscopy/surgery	Y		A2	30.0160	$1,242.19
29826	Shoulder arthroscopy/surgery	Y		A2	30.0160	$1,242.19
29827	Arthroscop rotator cuff repr	Y		A2	32.4560	$1,343.14
29828	Arthroscopy biceps tenodesis	Y		G2	48.0130	$1,986.97
29830	Elbow arthroscopy	Y		A2	20.3640	$842.73
29834	Elbow arthroscopy/surgery	Y		A2	20.3640	$842.73
29835	Elbow arthroscopy/surgery	Y		A2	20.3640	$842.73
29836	Elbow arthroscopy/surgery	Y		A2	20.3640	$842.73
29837	Elbow arthroscopy/surgery	Y		A2	20.3640	$842.73
29838	Elbow arthroscopy/surgery	Y		A2	20.3640	$842.73

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29840	Wrist arthroscopy	Y		A2	20.3640	$842.73
29843	Wrist arthroscopy/surgery	Y		A2	20.3640	$842.73
29844	Wrist arthroscopy/surgery	Y		A2	20.3640	$842.73
29845	Wrist arthroscopy/surgery	Y		A2	20.3640	$842.73
29846	Wrist arthroscopy/surgery	Y		A2	20.3640	$842.73
29847	Wrist arthroscopy/surgery	Y		A2	30.0160	$1,242.19
29848	Wrist endoscopy/surgery	Y		A2	30.1320	$1,246.99
29850	Knee arthroscopy/surgery	Y		A2	21.7780	$901.24
29851	Knee arthroscopy/surgery	Y		A2	31.4300	$1,300.71
29855	Tibial arthroscopy/surgery	Y		A2	31.4300	$1,300.71
29856	Tibial arthroscopy/surgery	Y		A2	31.4300	$1,300.71
29860	Hip arthroscopy, dx	Y		A2	31.4300	$1,300.71
29861	Hip arthroscopy/surgery	Y		A2	31.4300	$1,300.71
29862	Hip arthroscopy/surgery	Y		A2	39.7850	$1,646.45
29863	Hip arthroscopy/surgery	Y		A2	31.4300	$1,300.71
29866	Autgrft implnt, knee w/scope	Y		G2	48.0130	$1,986.97
29870	Knee arthroscopy, dx	Y		A2	20.3640	$842.73
29871	Knee arthroscopy/drainage	Y		A2	20.3640	$842.73
29873	Knee arthroscopy/surgery	Y		A2	20.3640	$842.73
29874	Knee arthroscopy/surgery	Y		A2	20.3640	$842.73
29875	Knee arthroscopy/surgery	Y		A2	21.7780	$901.24
29876	Knee arthroscopy/surgery	Y		A2	21.7780	$901.24
29877	Knee arthroscopy/surgery	Y		A2	21.7780	$901.24
29879	Knee arthroscopy/surgery	Y		A2	20.3640	$842.73
29880	Knee arthroscopy/surgery	Y		A2	21.7780	$901.24
29881	Knee arthroscopy/surgery	Y		A2	21.7780	$901.24
29882	Knee arthroscopy/surgery	Y		A2	20.3640	$842.73
29883	Knee arthroscopy/surgery	Y		A2	20.3640	$842.73
29884	Knee arthroscopy/surgery	Y		A2	20.3640	$842.73
29885	Knee arthroscopy/surgery	Y		A2	30.0160	$1,242.19
29886	Knee arthroscopy/surgery	Y		A2	20.3640	$842.73
29887	Knee arthroscopy/surgery	Y		A2	20.3640	$842.73
29888	Knee arthroscopy/surgery	Y		A2	30.0160	$1,242.19
29889	Knee arthroscopy/surgery	Y		A2	30.0160	$1,242.19
29891	Ankle arthroscopy/surgery	Y		A2	30.0160	$1,242.19
29892	Ankle arthroscopy/surgery	Y		A2	30.0160	$1,242.19
29893	Scope, plantar fasciotomy	Y		A2	25.3320	$1,048.34
29894	Ankle arthroscopy/surgery	Y		A2	20.3640	$842.73
29895	Ankle arthroscopy/surgery	Y		A2	20.3640	$842.73
29897	Ankle arthroscopy/surgery	Y		A2	20.3640	$842.73

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29898	Ankle arthroscopy/surgery	Y		A2	20.3640	$842.73
29899	Ankle arthroscopy/surgery	Y		A2	30.0160	$1,242.19
29900	Mcp joint arthroscopy, dx	Y		A2	20.3640	$842.73
29901	Mcp joint arthroscopy, surg	Y		A2	20.3640	$842.73
29902	Mcp joint arthroscopy, surg	Y		A2	20.3640	$842.73
29904	Subtalar arthro w/fb rmvl	Y		G2	28.7080	$1,188.05
29905	Subtalar arthro w/exc	Y		G2	28.7080	$1,188.05
29906	Subtalar arthro w/deb	Y		G2	28.7080	$1,188.05
29907	Subtalar arthro w/fusion	Y		G2	48.0130	$1,986.97
30000	Drainage of nose lesion	Y		P2	3.0790	$127.41
30020	Drainage of nose lesion	Y		P2	3.0790	$127.41
30100	Intranasal biopsy	Y		P3	1.8930	$78.32
30110	Removal of nose polyp(s)	Y		P3	2.9130	$120.53
30115	Removal of nose polyp(s)	Y		A2	13.6410	$564.51
30117	Removal of intranasal lesion	Y		A2	14.3950	$595.72
30118	Removal of intranasal lesion	Y		A2	18.0220	$745.84
30120	Revision of nose	Y		A2	12.3090	$509.40
30124	Removal of nose lesion	Y		R2	7.5590	$312.82
30125	Removal of nose lesion	Y		A2	25.5540	$1,057.52
30130	Excise inferior turbinate	Y		A2	14.3950	$595.72
30140	Resect inferior turbinate	Y		A2	17.2680	$714.63
30150	Partial removal of nose	Y		A2	26.3080	$1,088.73
30160	Removal of nose	Y		A2	27.7220	$1,147.24
30200	Injection treatment of nose	Y		P3	1.4880	$61.56
30210	Nasal sinus therapy	Y		P3	1.8850	$77.99
30220	Insert nasal septal button	Y		A2	9.2490	$382.75
30300	Remove nasal foreign body	N		P2	0.6320	$26.16
30310	Remove nasal foreign body	Y		A2	12.3090	$509.40
30320	Remove nasal foreign body	Y		A2	13.6410	$564.51
30400	Reconstruction of nose	Y		A2	27.7220	$1,147.24
30410	Reconstruction of nose	Y		A2	28.7470	$1,189.67
30420	Reconstruction of nose	Y		A2	28.7470	$1,189.67
30430	Revision of nose	Y		A2	18.0220	$745.84
30435	Revision of nose	Y		A2	28.7470	$1,189.67
30450	Revision of nose	Y		A2	32.0230	$1,325.24
30460	Revision of nose	Y		A2	32.0230	$1,325.24
30462	Revision of nose	Y		A2	36.0770	$1,492.99
30465	Repair nasal stenosis	Y		A2	36.0770	$1,492.99
30520	Repair of nasal septum	Y		A2	19.4370	$804.36
30540	Repair nasal defect	Y		A2	28.7470	$1,189.67

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30545	Repair nasal defect	Y		A2	28.7470	$1,189.67
30560	Release of nasal adhesions	Y		A2	3.3150	$137.20
30580	Repair upper jaw fistula	Y		A2	27.7220	$1,147.24
30600	Repair mouth/nose fistula	Y		A2	27.7220	$1,147.24
30620	Intranasal reconstruction	Y		A2	32.0230	$1,325.24
30630	Repair nasal septum defect	Y		A2	23.7370	$982.35
30801	Ablate inf turbinate, superf	Y		A2	7.7040	$318.80
30802	Cauterization, inner nose	Y		A2	7.7040	$318.80
30901	Control of nosebleed	Y	CH	P3	1.0130	$41.90
30903	Control of nosebleed	Y		A2	1.4070	$58.22
30905	Control of nosebleed	Y		A2	1.4070	$58.22
30906	Repeat control of nosebleed	Y		A2	1.4070	$58.22
30915	Ligation, nasal sinus artery	Y		A2	18.4810	$764.83
30920	Ligation, upper jaw artery	Y		A2	19.2360	$796.04
30930	Ther fx, nasal inf turbinate	Y		A2	15.8090	$654.23
31000	Irrigation, maxillary sinus	Y	CH	P3	2.4300	$100.55
31002	Irrigation, sphenoid sinus	Y		R2	7.5590	$312.82
31020	Exploration, maxillary sinus	Y		A2	17.2680	$714.63
31030	Exploration, maxillary sinus	Y		A2	26.3080	$1,088.73
31032	Explore sinus, remove polyps	Y		A2	27.7220	$1,147.24
31040	Exploration behind upper jaw	Y		R2	24.0260	$994.28
31050	Exploration, sphenoid sinus	Y		A2	25.5540	$1,057.52
31051	Sphenoid sinus surgery	Y		A2	27.7220	$1,147.24
31070	Exploration of frontal sinus	Y		A2	17.2680	$714.63
31075	Exploration of frontal sinus	Y		A2	27.7220	$1,147.24
31080	Removal of frontal sinus	Y		A2	27.7220	$1,147.24
31081	Removal of frontal sinus	Y		A2	27.7220	$1,147.24
31084	Removal of frontal sinus	Y		A2	27.7220	$1,147.24
31085	Removal of frontal sinus	Y		A2	27.7220	$1,147.24
31086	Removal of frontal sinus	Y		A2	27.7220	$1,147.24
31087	Removal of frontal sinus	Y		A2	27.7220	$1,147.24
31090	Exploration of sinuses	Y		A2	28.7470	$1,189.67
31200	Removal of ethmoid sinus	Y		A2	25.5540	$1,057.52
31201	Removal of ethmoid sinus	Y		A2	28.7470	$1,189.67
31205	Removal of ethmoid sinus	Y		A2	26.3080	$1,088.73
31231	Nasal endoscopy, dx	Y		P2	1.7110	$70.80
31233	Nasal/sinus endoscopy, dx	Y		A2	1.8730	$77.53
31235	Nasal/sinus endoscopy, dx	Y		A2	12.6640	$524.10
31237	Nasal/sinus endoscopy, surg	Y		A2	13.9960	$579.20
31238	Nasal/sinus endoscopy, surg	Y		A2	12.6640	$524.10

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31239	Nasal/sinus endoscopy, surg	Y		A2	18.8540	$780.26
31240	Nasal/sinus endoscopy, surg	Y		A2	13.9960	$579.20
31254	Revision of ethmoid sinus	Y		A2	17.4400	$721.74
31255	Removal of ethmoid sinus	Y		A2	19.8790	$822.69
31256	Exploration maxillary sinus	Y		A2	17.4400	$721.74
31267	Endoscopy, maxillary sinus	Y		A2	17.4400	$721.74
31276	Sinus endoscopy, surgical	Y		A2	17.4400	$721.74
31287	Nasal/sinus endoscopy, surg	Y		A2	17.4400	$721.74
31288	Nasal/sinus endoscopy, surg	Y		A2	17.4400	$721.74
31293	Nasal/sinus endoscopy, surg	Y	CH	G2	22.8610	$946.08
31300	Removal of larynx lesion	Y		A2	20.4620	$846.79
31320	Diagnostic incision, larynx	Y		A2	25.5540	$1,057.52
31400	Revision of larynx	Y		A2	25.5540	$1,057.52
31420	Removal of epiglottis	Y		A2	25.5540	$1,057.52
31500	Insert emergency airway	N		G2	2.3940	$99.09
31502	Change of windpipe airway	N		G2	1.3800	$57.10
31505	Diagnostic laryngoscopy	Y		P2	0.9100	$37.64
31510	Laryngoscopy with biopsy	Y		A2	13.9960	$579.20
31511	Remove foreign body, larynx	Y		A2	1.8730	$77.53
31512	Removal of larynx lesion	Y		A2	13.9960	$579.20
31513	Injection into vocal cord	Y		A2	1.8730	$77.53
31515	Laryngoscopy for aspiration	Y		A2	12.6640	$524.10
31520	Dx laryngoscopy, newborn	Y		G2	1.7110	$70.80
31525	Dx laryngoscopy excl nb	Y		A2	12.6640	$524.10
31526	Dx laryngoscopy w/oper scope	Y		A2	16.6860	$690.53
31527	Laryngoscopy for treatment	Y		A2	15.3550	$635.43
31528	Laryngoscopy and dilation	Y		A2	13.9960	$579.20
31529	Laryngoscopy and dilation	Y		A2	13.9960	$579.20
31530	Laryngoscopy w/fb removal	Y		A2	16.6860	$690.53
31531	Laryngoscopy w/fb & op scope	Y		A2	17.4400	$721.74
31535	Laryngoscopy w/biopsy	Y		A2	16.6860	$690.53
31536	Laryngoscopy w/bx & op scope	Y		A2	17.4400	$721.74
31540	Laryngoscopy w/exc of tumor	Y		A2	17.4400	$721.74
31541	Larynscop w/tumr exc + scope	Y		A2	18.8540	$780.26
31545	Remove vc lesion w/scope	Y		A2	18.8540	$780.26
31546	Remove vc lesion scope/graft	Y		A2	18.8540	$780.26
31560	Laryngoscop w/arytenoidectom	Y		A2	19.8790	$822.69
31561	Larynscop, remve cart + scop	Y		A2	19.8790	$822.69
31570	Laryngoscope w/vc inj	Y		A2	13.9960	$579.20
31571	Laryngoscop w/vc inj + scope	Y		A2	16.6860	$690.53

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31575	Diagnostic laryngoscopy	Y	CH	P3	1.3630	$56.40
31576	Laryngoscopy with biopsy	Y		A2	16.6860	$690.53
31577	Remove foreign body, larynx	Y		A2	4.9140	$203.36
31578	Removal of larynx lesion	Y		A2	16.6860	$690.53
31579	Diagnostic laryngoscopy	Y		P3	2.4140	$99.91
31580	Revision of larynx	Y		A2	28.7470	$1,189.67
31582	Revision of larynx	Y		A2	28.7470	$1,189.67
31588	Revision of larynx	Y		A2	28.7470	$1,189.67
31590	Reinnervate larynx	Y		A2	28.7470	$1,189.67
31595	Larynx nerve surgery	Y		A2	25.5540	$1,057.52
31603	Incision of windpipe	Y		A2	7.7040	$318.80
31605	Incision of windpipe	Y		G2	7.5590	$312.82
31611	Surgery/speech prosthesis	Y		A2	18.0220	$745.84
31612	Puncture/clear windpipe	Y		A2	15.9370	$659.53
31613	Repair windpipe opening	Y		A2	17.2680	$714.63
31614	Repair windpipe opening	Y		A2	25.5540	$1,057.52
31615	Visualization of windpipe	Y		A2	8.9180	$369.06
31620	Endobronchial us add-on	N		N1		
31622	Dx bronchoscope/wash	Y		A2	8.9180	$369.06
31623	Dx bronchoscope/brush	Y		A2	10.2490	$424.16
31624	Dx bronchoscope/lavage	Y		A2	10.2490	$424.16
31625	Bronchoscopy w/biopsy(s)	Y		A2	10.2490	$424.16
31628	Bronchoscopy/lung bx, each	Y		A2	10.2490	$424.16
31629	Bronchoscopy/needle bx, each	Y		A2	10.2490	$424.16
31630	Bronchoscopy dilate/fx repr	Y		A2	17.5310	$725.51
31631	Bronchoscopy, dilate w/stent	Y		A2	17.5310	$725.51
31632	Bronchoscopy/lung bx, add'l	Y		G2	9.9880	$413.34
31633	Bronchoscopy/needle bx add'l	Y		G2	9.9880	$413.34
31635	Bronchoscopy w/fb removal	Y		A2	10.2490	$424.16
31636	Bronchoscopy, bronch stents	Y		A2	17.5310	$725.51
31637	Bronchoscopy, stent add-on	Y		A2	8.9180	$369.06
31638	Bronchoscopy, revise stent	Y		A2	17.5310	$725.51
31640	Bronchoscopy w/tumor excise	Y		A2	17.5310	$725.51
31641	Bronchoscopy, treat blockage	Y		A2	17.5310	$725.51
31643	Diag bronchoscope/catheter	Y		A2	10.2490	$424.16
31645	Bronchoscopy, clear airways	Y		A2	8.9180	$369.06
31646	Bronchoscopy, reclear airway	Y		A2	8.9180	$369.06
31656	Bronchoscopy, inj for x-ray	Y		A2	8.9180	$369.06
31715	Injection for bronchus x-ray	N		N1		
31717	Bronchial brush biopsy	Y		A2	4.9140	$203.36

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31720	Clearance of airways	N		A2	0.7510	$31.09
31730	Intro, windpipe wire/tube	Y		A2	4.9140	$203.36
31750	Repair of windpipe	Y		A2	28.7470	$1,189.67
31755	Repair of windpipe	Y		A2	25.5540	$1,057.52
31820	Closure of windpipe lesion	Y		A2	12.3090	$509.40
31825	Repair of windpipe defect	Y		A2	17.2680	$714.63
31830	Revise windpipe scar	Y		A2	17.2680	$714.63
32400	Needle biopsy chest lining	Y		A2	8.6130	$356.45
32405	Biopsy, lung or mediastinum	Y		A2	8.6130	$356.45
32420	Puncture/clear lung	Y		A2	5.2400	$216.86
32421	Thoracentesis for aspiration	Y		A2	5.2400	$216.86
32422	Thoracentesis w/tube insert	Y		G2	5.2300	$216.45
32550	Insert pleural cath	Y		G2	28.9270	$1,197.13
32960	Therapeutic pneumothorax	Y		G2	5.2300	$216.45
32998	Perq rf ablate tx, pul tumor	Y		G2	44.9590	$1,860.58
33010	Drainage of heart sac	Y		A2	5.2400	$216.86
33011	Repeat drainage of heart sac	Y		A2	5.2400	$216.86
33206	Insertion of heart pacemaker	Y		J8	162.3420	$6,718.36
33207	Insertion of heart pacemaker	Y		J8	162.3420	$6,718.36
33208	Insertion of heart pacemaker	Y		J8	202.7070	$8,388.81
33210	Insertion of heart electrode	Y	CH	G2	48.3950	$2,002.77
33211	Insertion of heart electrode	Y	CH	G2	48.3950	$2,002.77
33212	Insertion of pulse generator	Y		H8	127.9190	$5,293.78
33213	Insertion of pulse generator	Y		H8	150.2000	$6,215.87
33214	Upgrade of pacemaker system	Y		J8	202.7070	$8,388.81
33215	Reposition pacing-defib lead	Y		G2	21.7430	$899.80
33216	Insert lead pace-defib, one	Y	CH	G2	48.3950	$2,002.77
33217	Insert lead pace-defib, dual	Y	CH	G2	48.3950	$2,002.77
33218	Repair lead pace-defib, one	Y		G2	21.7430	$899.80
33220	Repair lead pace-defib, dual	Y		G2	21.7430	$899.80
33222	Revise pocket, pacemaker	Y		A2	13.0620	$540.56
33223	Revise pocket, pacing-defib	Y		A2	13.0620	$540.56
33224	Insert pacing lead & connect	Y		J8	184.8640	$7,650.43
33225	L ventric pacing lead add-on	Y		J8	184.8640	$7,650.43
33226	Reposition l ventric lead	Y		G2	21.7430	$899.80
33233	Removal of pacemaker system	Y		A2	16.1270	$667.39
33234	Removal of pacemaker system	Y		G2	21.7430	$899.80
33235	Removal pacemaker electrode	Y		G2	21.7430	$899.80
33240	Insert pulse generator	Y		J8	497.1610	$20,574.52
33241	Remove pulse generator	Y		G2	21.7430	$899.80

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33249	Eltrd/insert pace-defib	Y		J8	616.1790	$25,499.96
33282	Implant pat-active ht record	N		J8	100.8680	$4,174.30
33284	Remove pat-active ht record	Y		G2	7.7890	$322.34
33508	Endoscopic vein harvest	N		N1		
34490	Removal of vein clot	Y	CH	G2	39.2450	$1,624.13
35188	Repair blood vessel lesion	Y		A2	27.0460	$1,119.28
35207	Repair blood vessel lesion	Y		A2	27.0460	$1,119.28
35473	Repair arterial blockage	Y		G2	47.0760	$1,948.18
35476	Repair venous blockage	Y		G2	47.0760	$1,948.18
35492	Atherectomy, percutaneous	Y		G2	86.8140	$3,592.69
35572	Harvest femoropopliteal vein	N		N1		
35761	Exploration of artery/vein	Y		G2	29.7800	$1,232.40
35875	Removal of clot in graft	Y		A2	35.4010	$1,465.03
35876	Removal of clot in graft	Y		A2	35.4010	$1,465.03
36000	Place needle in vein	N		N1		
36002	Pseudoaneurysm injection trt	N		G2	2.2920	$94.83
36005	Injection ext venography	N		N1		
36010	Place catheter in vein	N		N1		
36011	Place catheter in vein	N		N1		
36012	Place catheter in vein	N		N1		
36013	Place catheter in artery	N		N1		
36014	Place catheter in artery	N		N1		
36015	Place catheter in artery	N		N1		
36100	Establish access to artery	N		N1		
36120	Establish access to artery	N		N1		
36140	Establish access to artery	N		N1		
36145	Artery to vein shunt	N		N1		
36160	Establish access to aorta	N		N1		
36200	Place catheter in aorta	N		N1		
36215	Place catheter in artery	N		N1		
36216	Place catheter in artery	N		N1		
36217	Place catheter in artery	N		N1		
36218	Place catheter in artery	N		N1		
36245	Place catheter in artery	N		N1		
36246	Place catheter in artery	N		N1		
36247	Place catheter in artery	N		N1		
36248	Place catheter in artery	N		N1		
36260	Insertion of infusion pump	Y		A2	20.4280	$845.40
36261	Revision of infusion pump	Y		A2	16.1270	$667.39
36262	Removal of infusion pump	Y		A2	14.7950	$612.29

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36400	Bl draw < 3 yrs fem/jugular	N		N1		
36405	Bl draw < 3 yrs scalp vein	N		N1		
36406	Bl draw < 3 yrs other vein	N		N1		
36410	Non-routine bl draw > 3 yrs	N		N1		
36416	Capillary blood draw	N		N1		
36420	Vein access cutdown < 1 yr	N		G2	0.2240	$9.27
36425	Vein access cutdown > 1 yr	N		R2	0.2240	$9.27
36430	Blood transfusion service	N		P3	0.7480	$30.94
36440	Bl push transfuse, 2 yr or <	N		R2	3.3100	$136.99
36450	Bl exchange/transfuse, nb	N		R2	3.3100	$136.99
36455	Bl exchange/transfuse non-nb	N	CH	G2	3.3100	$136.99
36468	Injection(s), spider veins	Y		R2	0.8130	$33.63
36469	Injection(s), spider veins	Y		R2	0.8130	$33.63
36470	Injection therapy of vein	Y		P2	0.8130	$33.63
36471	Injection therapy of veins	Y		P2	0.8130	$33.63
36475	Endovenous rf, 1st vein	Y		A2	36.8090	$1,523.31
36476	Endovenous rf, vein add-on	Y		A2	29.0040	$1,200.30
36478	Endovenous laser, 1st vein	Y		A2	29.0040	$1,200.30
36479	Endovenous laser vein addon	Y		A2	29.0040	$1,200.30
36481	Insertion of catheter, vein	N		N1		
36500	Insertion of catheter, vein	N		N1		
36510	Insertion of catheter, vein	N		N1		
36511	Apheresis wbc	N		G2	11.4300	$473.04
36512	Apheresis rbc	N		G2	11.4300	$473.04
36513	Apheresis platelets	N		G2	11.4300	$473.04
36514	Apheresis plasma	N		G2	11.4300	$473.04
36515	Apheresis, adsorp/reinfuse	N	CH	P2	29.9960	$1,241.35
36516	Apheresis, selective	N	CH	P2	29.9960	$1,241.35
36522	Photopheresis	N		G2	29.9960	$1,241.35
36555	Insert non-tunnel cv cath	Y		A2	9.3560	$387.18
36556	Insert non-tunnel cv cath	Y		A2	9.3560	$387.18
36557	Insert tunneled cv cath	Y		A2	17.3380	$717.52
36558	Insert tunneled cv cath	Y		A2	17.3380	$717.52
36560	Insert tunneled cv cath	Y		A2	20.4280	$845.40
36561	Insert tunneled cv cath	Y		A2	20.4280	$845.40
36563	Insert tunneled cv cath	Y		A2	20.4280	$845.40
36565	Insert tunneled cv cath	Y		A2	20.4280	$845.40
36566	Insert tunneled cv cath	Y	CH	A2	20.4280	$845.40
36568	Insert picc cath	Y		A2	9.3560	$387.18
36569	Insert picc cath	Y		A2	9.3560	$387.18

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36570	Insert picvad cath	Y		A2	18.0920	$748.73
36571	Insert picvad cath	Y		A2	18.0920	$748.73
36575	Repair tunneled cv cath	Y		A2	7.4970	$310.27
36576	Repair tunneled cv cath	Y		A2	10.6880	$442.29
36578	Replace tunneled cv cath	Y		A2	17.3380	$717.52
36580	Replace cvad cath	Y		A2	9.3560	$387.18
36581	Replace tunneled cv cath	Y		A2	17.3380	$717.52
36582	Replace tunneled cv cath	Y		A2	20.4280	$845.40
36583	Replace tunneled cv cath	Y		A2	20.4280	$845.40
36584	Replace picc cath	Y		A2	9.3560	$387.18
36585	Replace picvad cath	Y		A2	18.0920	$748.73
36589	Removal tunneled cv cath	Y		A2	6.1660	$255.17
36590	Removal tunneled cv cath	Y		A2	9.3560	$387.18
36591	Draw blood off venous device	N		N1		
36592	Collect blood from picc	N		N1		
36593	Declot vascular device	Y		P3	0.5610	$23.20
36595	Mech remov tunneled cv cath	Y		G2	24.1660	$1,000.07
36596	Mech remov tunneled cv cath	Y		G2	10.8640	$449.60
36597	Reposition venous catheter	Y		G2	10.8640	$449.60
36598	Inj w/fluor, eval cv device	Y		P3	1.8070	$74.77
36600	Withdrawal of arterial blood	N		N1		
36620	Insertion catheter, artery	N		N1		
36625	Insertion catheter, artery	N		N1		
36640	Insertion catheter, artery	Y		A2	18.3430	$759.09
36680	Insert needle, bone cavity	Y		G2	1.4960	$61.91
36800	Insertion of cannula	Y		A2	20.8990	$864.90
36810	Insertion of cannula	Y		A2	20.8990	$864.90
36815	Insertion of cannula	Y		A2	20.8990	$864.90
36818	Av fuse, uppr arm, cephalic	Y		A2	25.6320	$1,060.77
36819	Av fuse, uppr arm, basilic	Y		A2	25.6320	$1,060.77
36820	Av fusion/forearm vein	Y		A2	25.6320	$1,060.77
36821	Av fusion direct any site	Y		A2	25.6320	$1,060.77
36825	Artery-vein autograft	Y		A2	27.0460	$1,119.28
36830	Artery-vein nonautograft	Y		A2	27.0460	$1,119.28
36831	Open thrombect av fistula	Y		A2	35.4010	$1,465.03
36832	Av fistula revision, open	Y		A2	27.0460	$1,119.28
36833	Av fistula revision	Y		A2	27.0460	$1,119.28
36834	Repair a-v aneurysm	Y		A2	25.6320	$1,060.77
36835	Artery to vein shunt	Y		A2	22.3140	$923.42
36860	External cannula declotting	Y		A2	2.6960	$111.56

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36861	Cannula declotting	Y		A2	20.8990	$864.90
36870	Percut thrombect av fistula	Y		A2	37.9750	$1,571.56
37184	Prim art mech thrombectomy	Y		G2	39.2450	$1,624.13
37185	Prim art m-thrombect add-on	Y		G2	39.2450	$1,624.13
37186	Sec art m-thrombect add-on	Y		G2	39.2450	$1,624.13
37187	Venous mech thrombectomy	Y		G2	39.2450	$1,624.13
37188	Venous m-thrombectomy add-on	Y		G2	39.2450	$1,624.13
37200	Transcatheter biopsy	Y		G2	28.8370	$1,193.39
37203	Transcatheter retrieval	Y		G2	28.8370	$1,193.39
37250	Iv us first vessel add-on	N		N1		
37251	Iv us each add vessel add-on	N		N1		
37500	Endoscopy ligate perf veins	Y		A2	27.0410	$1,119.05
37607	Ligation of a-v fistula	Y		A2	19.2360	$796.04
37609	Temporal artery procedure	Y		A2	12.9940	$537.76
37650	Revision of major vein	Y		A2	18.4810	$764.83
37700	Revise leg vein	Y		A2	18.4810	$764.83
37718	Ligate/strip short leg vein	Y		A2	19.2360	$796.04
37722	Ligate/strip long leg vein	Y		A2	27.0410	$1,119.05
37735	Removal of leg veins/lesion	Y		A2	27.0410	$1,119.05
37760	Ligation, leg veins, open	Y		A2	19.2360	$796.04
37765	Phleb veins extrem 10-20	Y		R2	26.4520	$1,094.68
37766	Phleb veins extrem 20+	Y		R2	26.4520	$1,094.68
37780	Revision of leg vein	Y		A2	19.2360	$796.04
37785	Ligate/divide/excise vein	Y		A2	19.2360	$796.04
37790	Penile venous occlusion	Y		A2	23.3460	$966.15
38200	Injection for spleen x-ray	N		N1		
38204	Bl donor search management	N		N1		
38205	Harvest allogenic stem cells	N		G2	11.4300	$473.04
38206	Harvest auto stem cells	N		G2	11.4300	$473.04
38220	Bone marrow aspiration	Y		P3	2.3050	$95.40
38221	Bone marrow biopsy	Y		P3	2.4070	$99.59
38230	Bone marrow collection	N		G2	29.9960	$1,241.35
38241	Bone marrow/stem transplant	N		G2	29.9960	$1,241.35
38242	Lymphocyte infuse transplant	N		R2	11.4300	$473.04
38300	Drainage, lymph node lesion	Y		A2	10.1680	$420.81
38305	Drainage, lymph node lesion	Y		A2	14.8020	$612.58
38308	Incision of lymph channels	Y		A2	16.8390	$696.87
38500	Biopsy/removal, lymph nodes	Y		A2	16.8390	$696.87
38505	Needle biopsy, lymph nodes	Y		A2	6.4280	$266.00
38510	Biopsy/removal, lymph nodes	Y		A2	16.8390	$696.87

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38520	Biopsy/removal, lymph nodes	Y		A2	16.8390	$696.87
38525	Biopsy/removal, lymph nodes	Y		A2	16.8390	$696.87
38530	Biopsy/removal, lymph nodes	Y		A2	16.8390	$696.87
38542	Explore deep node(s), neck	Y		A2	28.2440	$1,168.86
38550	Removal, neck/armpit lesion	Y		A2	17.5930	$728.08
38555	Removal, neck/armpit lesion	Y		A2	19.0070	$786.60
38570	Laparoscopy, lymph node biop	Y		A2	38.3990	$1,589.09
38571	Laparoscopy, lymphadenectomy	Y		A2	50.7820	$2,101.58
38572	Laparoscopy, lymphadenectomy	Y		A2	38.3990	$1,589.09
38700	Removal of lymph nodes, neck	Y		G2	23.1680	$958.76
38740	Remove armpit lymph nodes	Y		A2	28.2440	$1,168.86
38745	Remove armpit lymph nodes	Y		A2	30.4120	$1,258.58
38760	Remove groin lymph nodes	Y		A2	16.8390	$696.87
38790	Inject for lymphatic x-ray	N		N1		
38792	Identify sentinel node	N		N1		
38794	Access thoracic lymph duct	N		N1		
40490	Biopsy of lip	Y		P3	1.5260	$63.17
40500	Partial excision of lip	Y		A2	13.6410	$564.51
40510	Partial excision of lip	Y		A2	17.2680	$714.63
40520	Partial excision of lip	Y		A2	13.6410	$564.51
40525	Reconstruct lip with flap	Y		A2	17.2680	$714.63
40527	Reconstruct lip with flap	Y		A2	17.2680	$714.63
40530	Partial removal of lip	Y		A2	17.2680	$714.63
40650	Repair lip	Y		A2	9.2490	$382.75
40652	Repair lip	Y		A2	9.2490	$382.75
40654	Repair lip	Y		A2	9.2490	$382.75
40700	Repair cleft lip/nasal	Y		A2	32.0230	$1,325.24
40701	Repair cleft lip/nasal	Y		A2	32.0230	$1,325.24
40702	Repair cleft lip/nasal	Y		R2	40.5970	$1,680.05
40720	Repair cleft lip/nasal	Y		A2	32.0230	$1,325.24
40761	Repair cleft lip/nasal	Y		A2	26.3080	$1,088.73
40800	Drainage of mouth lesion	Y		P2	1.3920	$57.59
40801	Drainage of mouth lesion	Y		A2	9.0350	$373.90
40804	Removal, foreign body, mouth	N		P2	0.6320	$26.16
40805	Removal, foreign body, mouth	Y		P3	3.8630	$159.85
40806	Incision of lip fold	Y		P3	1.8070	$74.77
40808	Biopsy of mouth lesion	Y	CH	P3	2.6400	$109.25
40810	Excision of mouth lesion	Y		P3	2.7260	$112.80
40812	Excise/repair mouth lesion	Y		P3	3.4030	$140.84
40814	Excise/repair mouth lesion	Y		A2	13.6410	$564.51

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40816	Excision of mouth lesion	Y		A2	17.2680	$714.63
40818	Excise oral mucosa for graft	Y		A2	3.3150	$137.20
40819	Excise lip or cheek fold	Y		A2	7.7040	$318.80
40820	Treatment of mouth lesion	Y		P3	3.9410	$163.08
40830	Repair mouth laceration	Y		G2	3.0790	$127.41
40831	Repair mouth laceration	Y		A2	7.7040	$318.80
40840	Reconstruction of mouth	Y		A2	17.2680	$714.63
40842	Reconstruction of mouth	Y		A2	18.0220	$745.84
40843	Reconstruction of mouth	Y		A2	18.0220	$745.84
40844	Reconstruction of mouth	Y		A2	28.7470	$1,189.67
40845	Reconstruction of mouth	Y		A2	28.7470	$1,189.67
41000	Drainage of mouth lesion	Y		P3	1.9470	$80.57
41005	Drainage of mouth lesion	Y		A2	3.3150	$137.20
41006	Drainage of mouth lesion	Y		A2	15.9370	$659.53
41007	Drainage of mouth lesion	Y		A2	12.3090	$509.40
41008	Drainage of mouth lesion	Y		A2	12.3090	$509.40
41009	Drainage of mouth lesion	Y		A2	3.3150	$137.20
41010	Incision of tongue fold	Y		A2	7.7040	$318.80
41015	Drainage of mouth lesion	Y		A2	3.3150	$137.20
41016	Drainage of mouth lesion	Y		A2	7.7040	$318.80
41017	Drainage of mouth lesion	Y		A2	7.7040	$318.80
41018	Drainage of mouth lesion	Y		A2	7.7040	$318.80
41019	Place needles h&n for rt	Y		G2	24.0260	$994.28
41100	Biopsy of tongue	Y		P3	2.0480	$84.76
41105	Biopsy of tongue	Y		P3	2.0170	$83.47
41108	Biopsy of floor of mouth	Y		P3	1.8850	$77.99
41110	Excision of tongue lesion	Y		P3	2.7260	$112.80
41112	Excision of tongue lesion	Y		A2	13.6410	$564.51
41113	Excision of tongue lesion	Y		A2	13.6410	$564.51
41114	Excision of tongue lesion	Y		A2	17.2680	$714.63
41115	Excision of tongue fold	Y		P3	3.1770	$131.49
41116	Excision of mouth lesion	Y		A2	12.3090	$509.40
41120	Partial removal of tongue	Y		A2	20.4620	$846.79
41250	Repair tongue laceration	Y		A2	2.3290	$96.37
41251	Repair tongue laceration	Y		A2	3.3150	$137.20
41252	Repair tongue laceration	Y		A2	9.0350	$373.90
41500	Fixation of tongue	Y		A2	15.9370	$659.53
41510	Tongue to lip surgery	Y		A2	12.3090	$509.40
41520	Reconstruction, tongue fold	Y		A2	9.0350	$373.90
41800	Drainage of gum lesion	Y		A2	1.7380	$71.93

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41805	Removal foreign body, gum	Y		P3	3.4270	$141.81
41806	Removal foreign body,jawbone	Y		P3	4.1740	$172.74
41820	Excision, gum, each quadrant	Y		R2	7.5590	$312.82
41821	Excision of gum flap	Y		G2	7.5590	$312.82
41822	Excision of gum lesion	Y		P3	3.4420	$142.45
41823	Excision of gum lesion	Y		P3	4.9760	$205.94
41825	Excision of gum lesion	Y		P3	2.7720	$114.73
41826	Excision of gum lesion	Y		P3	3.4890	$144.38
41827	Excision of gum lesion	Y		A2	17.2680	$714.63
41828	Excision of gum lesion	Y		P3	3.1230	$129.24
41830	Removal of gum tissue	Y		P3	4.4550	$184.35
41850	Treatment of gum lesion	Y		R2	16.7710	$694.03
41870	Gum graft	Y		G2	24.0260	$994.28
41872	Repair gum	Y		P3	4.4780	$185.31
41874	Repair tooth socket	Y		P3	4.2910	$177.58
42000	Drainage mouth roof lesion	Y		A2	3.3150	$137.20
42100	Biopsy roof of mouth	Y		P3	1.7370	$71.87
42104	Excision lesion, mouth roof	Y		P3	2.5930	$107.32
42106	Excision lesion, mouth roof	Y		P3	3.2550	$134.72
42107	Excision lesion, mouth roof	Y		A2	17.2680	$714.63
42120	Remove palate/lesion	Y		A2	27.7220	$1,147.24
42140	Excision of uvula	Y		A2	9.0350	$373.90
42145	Repair palate, pharynx/uvula	Y		A2	20.4620	$846.79
42160	Treatment mouth roof lesion	Y		P3	3.0760	$127.30
42180	Repair palate	Y		A2	3.3150	$137.20
42182	Repair palate	Y		A2	25.5540	$1,057.52
42200	Reconstruct cleft palate	Y		A2	28.7470	$1,189.67
42205	Reconstruct cleft palate	Y		A2	28.7470	$1,189.67
42210	Reconstruct cleft palate	Y		A2	28.7470	$1,189.67
42215	Reconstruct cleft palate	Y		A2	32.0230	$1,325.24
42220	Reconstruct cleft palate	Y		A2	28.7470	$1,189.67
42226	Lengthening of palate	Y		A2	28.7470	$1,189.67
42235	Repair palate	Y		A2	16.8340	$696.66
42260	Repair nose to lip fistula	Y		A2	19.4370	$804.36
42280	Preparation, palate mold	Y		P3	1.6900	$69.94
42281	Insertion, palate prosthesis	Y		G2	16.7710	$694.03
42300	Drainage of salivary gland	Y		A2	12.3090	$509.40
42305	Drainage of salivary gland	Y		A2	13.6410	$564.51
42310	Drainage of salivary gland	Y		A2	3.3150	$137.20
42320	Drainage of salivary gland	Y		A2	3.3150	$137.20

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42330	Removal of salivary stone	Y		P3	2.6090	$107.97
42335	Removal of salivary stone	Y		P3	4.3380	$179.51
42340	Removal of salivary stone	Y		A2	13.6410	$564.51
42400	Biopsy of salivary gland	Y		P3	1.4800	$61.23
42405	Biopsy of salivary gland	Y		A2	13.6410	$564.51
42408	Excision of salivary cyst	Y		A2	14.3950	$595.72
42409	Drainage of salivary cyst	Y		A2	14.3950	$595.72
42410	Excise parotid gland/lesion	Y		A2	26.3080	$1,088.73
42415	Excise parotid gland/lesion	Y		A2	32.0230	$1,325.24
42420	Excise parotid gland/lesion	Y		A2	32.0230	$1,325.24
42425	Excise parotid gland/lesion	Y		A2	32.0230	$1,325.24
42440	Excise submaxillary gland	Y		A2	26.3080	$1,088.73
42450	Excise sublingual gland	Y		A2	17.2680	$714.63
42500	Repair salivary duct	Y		A2	18.0220	$745.84
42505	Repair salivary duct	Y		A2	27.7220	$1,147.24
42507	Parotid duct diversion	Y		A2	26.3080	$1,088.73
42508	Parotid duct diversion	Y		A2	27.7220	$1,147.24
42509	Parotid duct diversion	Y		A2	27.7220	$1,147.24
42510	Parotid duct diversion	Y		A2	27.7220	$1,147.24
42550	Injection for salivary x-ray	N		N1		
42600	Closure of salivary fistula	Y		A2	12.3090	$509.40
42650	Dilation of salivary duct	Y		P3	0.9660	$39.96
42660	Dilation of salivary duct	Y		P3	1.1210	$46.41
42665	Ligation of salivary duct	Y		A2	23.7370	$982.35
42700	Drainage of tonsil abscess	Y		A2	3.3150	$137.20
42720	Drainage of throat abscess	Y		A2	12.3090	$509.40
42725	Drainage of throat abscess	Y		A2	25.5540	$1,057.52
42800	Biopsy of throat	Y		P3	1.8690	$77.35
42802	Biopsy of throat	Y		A2	12.3090	$509.40
42804	Biopsy of upper nose/throat	Y		A2	12.3090	$509.40
42806	Biopsy of upper nose/throat	Y		A2	17.2680	$714.63
42808	Excise pharynx lesion	Y		A2	13.6410	$564.51
42809	Remove pharynx foreign body	N		G2	0.6320	$26.16
42810	Excision of neck cyst	Y		A2	18.0220	$745.84
42815	Excision of neck cyst	Y		A2	28.7470	$1,189.67
42820	Remove tonsils and adenoids	Y		A2	18.0220	$745.84
42821	Remove tonsils and adenoids	Y		A2	20.4620	$846.79
42825	Removal of tonsils	Y		A2	19.4370	$804.36
42826	Removal of tonsils	Y		A2	19.4370	$804.36
42830	Removal of adenoids	Y		A2	19.4370	$804.36

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42831	Removal of adenoids	Y		A2	19.4370	$804.36
42835	Removal of adenoids	Y		A2	19.4370	$804.36
42836	Removal of adenoids	Y		A2	19.4370	$804.36
42860	Excision of tonsil tags	Y		A2	18.0220	$745.84
42870	Excision of lingual tonsil	Y		A2	18.0220	$745.84
42890	Partial removal of pharynx	Y		A2	32.0230	$1,325.24
42892	Revision of pharyngeal walls	Y		A2	32.0230	$1,325.24
42900	Repair throat wound	Y		A2	7.7040	$318.80
42950	Reconstruction of throat	Y		A2	17.2680	$714.63
42955	Surgical opening of throat	Y		A2	17.2680	$714.63
42960	Control throat bleeding	Y		A2	1.4070	$58.22
42962	Control throat bleeding	Y		A2	25.5540	$1,057.52
42970	Control nose/throat bleeding	Y		R2	1.1060	$45.75
42972	Control nose/throat bleeding	Y		A2	14.3950	$595.72
43030	Throat muscle surgery	Y		G2	16.7710	$694.03
43200	Esophagus endoscopy	Y		A2	8.1720	$338.18
43201	Esoph scope w/submucous inj	Y		A2	8.1720	$338.18
43202	Esophagus endoscopy, biopsy	Y		A2	8.1720	$338.18
43204	Esoph scope w/sclerosis inj	Y		A2	8.1720	$338.18
43205	Esophagus endoscopy/ligation	Y		A2	8.1720	$338.18
43215	Esophagus endoscopy	Y		A2	8.1720	$338.18
43216	Esophagus endoscopy/lesion	Y		A2	8.1720	$338.18
43217	Esophagus endoscopy	Y		A2	8.1720	$338.18
43219	Esophagus endoscopy	Y		A2	16.4960	$682.66
43220	Esoph endoscopy, dilation	Y		A2	8.1720	$338.18
43226	Esoph endoscopy, dilation	Y		A2	8.1720	$338.18
43227	Esoph endoscopy, repair	Y		A2	9.5030	$393.29
43228	Esoph endoscopy, ablation	Y		A2	18.1580	$751.46
43231	Esoph endoscopy w/us exam	Y		A2	9.5030	$393.29
43232	Esoph endoscopy w/us fn bx	Y		A2	9.5030	$393.29
43234	Upper gi endoscopy, exam	Y		A2	8.1720	$338.18
43235	Uppr gi endoscopy, diagnosis	Y		A2	8.1720	$338.18
43236	Uppr gi scope w/submuc inj	Y		A2	9.5030	$393.29
43237	Endoscopic us exam, esoph	Y		A2	9.5030	$393.29
43238	Uppr gi endoscopy w/us fn bx	Y		A2	9.5030	$393.29
43239	Upper gi endoscopy, biopsy	Y		A2	9.5030	$393.29
43240	Esoph endoscope w/drain cyst	Y		A2	9.5030	$393.29
43241	Upper gi endoscopy with tube	Y		A2	9.5030	$393.29
43242	Uppr gi endoscopy w/us fn bx	Y		A2	9.5030	$393.29
43243	Upper gi endoscopy & inject	Y		A2	9.5030	$393.29

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43244	Upper gi endoscopy/ligation	Y		A2	9.5030	$393.29
43245	Uppr gi scope dilate strictr	Y		A2	9.5030	$393.29
43246	Place gastrostomy tube	Y		A2	9.5030	$393.29
43247	Operative upper gi endoscopy	Y		A2	9.5030	$393.29
43248	Uppr gi endoscopy/guide wire	Y		A2	9.5030	$393.29
43249	Esoph endoscopy, dilation	Y		A2	9.5030	$393.29
43250	Upper gi endoscopy/tumor	Y		A2	9.5030	$393.29
43251	Operative upper gi endoscopy	Y		A2	9.5030	$393.29
43255	Operative upper gi endoscopy	Y		A2	9.5030	$393.29
43256	Uppr gi endoscopy w/stent	Y		A2	18.5810	$768.97
43257	Uppr gi scope w/thrml txmnt	Y		A2	18.9120	$782.67
43258	Operative upper gi endoscopy	Y		A2	10.2580	$424.50
43259	Endoscopic ultrasound exam	Y		A2	10.2580	$424.50
43260	Endo cholangiopancreatograph	Y		A2	15.8840	$657.33
43261	Endo cholangiopancreatograph	Y		A2	15.8840	$657.33
43262	Endo cholangiopancreatograph	Y		A2	15.8840	$657.33
43263	Endo cholangiopancreatograph	Y		A2	15.8840	$657.33
43264	Endo cholangiopancreatograph	Y		A2	15.8840	$657.33
43265	Endo cholangiopancreatograph	Y		A2	15.8840	$657.33
43267	Endo cholangiopancreatograph	Y		A2	15.8840	$657.33
43268	Endo cholangiopancreatograph	Y		A2	17.8270	$737.76
43269	Endo cholangiopancreatograph	Y		A2	17.8270	$737.76
43271	Endo cholangiopancreatograph	Y		A2	15.8840	$657.33
43272	Endo cholangiopancreatograph	Y		A2	15.8840	$657.33
43450	Dilate esophagus	Y		A2	7.0890	$293.35
43453	Dilate esophagus	Y		A2	7.0890	$293.35
43456	Dilate esophagus	Y		A2	7.1170	$294.52
43458	Dilate esophagus	Y		A2	8.2000	$339.36
43600	Biopsy of stomach	Y		A2	8.1720	$338.18
43653	Laparoscopy, gastrostomy	Y		A2	38.3990	$1,589.09
43760	Change gastrostomy tube	Y		A2	3.9500	$163.48
43761	Reposition gastrostomy tube	Y		A2	8.1720	$338.18
43870	Repair stomach opening	Y		A2	8.1720	$338.18
43886	Revise gastric port, open	Y		G2	20.2870	$839.55
43887	Remove gastric port, open	Y		G2	4.6330	$191.73
43888	Change gastric port, open	Y		G2	20.2870	$839.55
44100	Biopsy of bowel	Y		A2	8.1720	$338.18
44312	Revision of ileostomy	Y		A2	14.0680	$582.17
44340	Revision of colostomy	Y		A2	16.1530	$668.48
44360	Small bowel endoscopy	Y		A2	9.9150	$410.34

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44361	Small bowel endoscopy/biopsy	Y		A2	9.9150	$410.34
44363	Small bowel endoscopy	Y		A2	9.9150	$410.34
44364	Small bowel endoscopy	Y		A2	9.9150	$410.34
44365	Small bowel endoscopy	Y		A2	9.9150	$410.34
44366	Small bowel endoscopy	Y		A2	9.9150	$410.34
44369	Small bowel endoscopy	Y		A2	9.9150	$410.34
44370	Small bowel endoscopy/stent	Y		A2	28.3500	$1,173.23
44372	Small bowel endoscopy	Y		A2	9.9150	$410.34
44373	Small bowel endoscopy	Y		A2	9.9150	$410.34
44376	Small bowel endoscopy	Y		A2	9.9150	$410.34
44377	Small bowel endoscopy/biopsy	Y		A2	9.9150	$410.34
44378	Small bowel endoscopy	Y		A2	9.9150	$410.34
44379	S bowel endoscope w/stent	Y		A2	28.3500	$1,173.23
44380	Small bowel endoscopy	Y		A2	8.5840	$355.23
44382	Small bowel endoscopy	Y		A2	8.5840	$355.23
44383	Ileoscopy w/stent	Y		A2	28.3500	$1,173.23
44385	Endoscopy of bowel pouch	Y		A2	8.3340	$344.90
44386	Endoscopy, bowel pouch/biop	Y		A2	8.3340	$344.90
44388	Colonoscopy	Y		A2	8.3340	$344.90
44389	Colonoscopy with biopsy	Y		A2	8.3340	$344.90
44390	Colonoscopy for foreign body	Y		A2	8.3340	$344.90
44391	Colonoscopy for bleeding	Y		A2	8.3340	$344.90
44392	Colonoscopy & polypectomy	Y		A2	8.3340	$344.90
44393	Colonoscopy, lesion removal	Y		A2	8.3340	$344.90
44394	Colonoscopy w/snare	Y		A2	8.3340	$344.90
44397	Colonoscopy w/stent	Y		A2	16.4960	$682.66
44500	Intro, gastrointestinal tube	Y		G2	4.4840	$185.56
44701	Intraop colon lavage add-on	N		N1		
45000	Drainage of pelvic abscess	Y		A2	9.6500	$399.35
45005	Drainage of rectal abscess	Y		A2	11.2280	$464.66
45020	Drainage of rectal abscess	Y		A2	11.2280	$464.66
45100	Biopsy of rectum	Y		A2	15.3060	$633.44
45108	Removal of anorectal lesion	Y		A2	16.6380	$688.55
45150	Excision of rectal stricture	Y		A2	16.6380	$688.55
45160	Excision of rectal lesion	Y		A2	16.6380	$688.55
45170	Excision of rectal lesion	Y		A2	16.6380	$688.55
45190	Destruction, rectal tumor	Y		A2	27.1610	$1,124.02
45300	Proctosigmoidoscopy dx	Y		P3	1.4490	$59.95
45303	Proctosigmoidoscopy dilate	Y		P2	8.9430	$370.11
45305	Proctosigmoidoscopy w/bx	Y		A2	8.3960	$347.44

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45307	Proctosigmoidoscopy fb	Y		A2	15.5760	$644.59
45308	Proctosigmoidoscopy removal	Y		A2	8.3960	$347.44
45309	Proctosigmoidoscopy removal	Y		A2	8.3960	$347.44
45315	Proctosigmoidoscopy removal	Y		A2	8.3960	$347.44
45317	Proctosigmoidoscopy bleed	Y		A2	8.3960	$347.44
45320	Proctosigmoidoscopy ablate	Y		A2	15.5760	$644.59
45321	Proctosigmoidoscopy volvul	Y		A2	15.5760	$644.59
45327	Proctosigmoidoscopy w/stent	Y		A2	16.4960	$682.66
45330	Diagnostic sigmoidoscopy	Y		P3	1.9390	$80.25
45331	Sigmoidoscopy and biopsy	Y		A2	6.2340	$258.00
45332	Sigmoidoscopy w/fb removal	Y		A2	6.2340	$258.00
45333	Sigmoidoscopy & polypectomy	Y		A2	8.3960	$347.44
45334	Sigmoidoscopy for bleeding	Y		A2	8.3960	$347.44
45335	Sigmoidoscopy w/submuc inj	Y		A2	6.2340	$258.00
45337	Sigmoidoscopy & decompress	Y		A2	6.2340	$258.00
45338	Sigmoidoscopy w/tumr remove	Y		A2	8.3960	$347.44
45339	Sigmoidoscopy w/ablate tumr	Y		A2	8.3960	$347.44
45340	Sig w/balloon dilation	Y		A2	8.3960	$347.44
45341	Sigmoidoscopy w/ultrasound	Y		A2	8.3960	$347.44
45342	Sigmoidoscopy w/us guide bx	Y		A2	8.3960	$347.44
45345	Sigmoidoscopy w/stent	Y		A2	16.4960	$682.66
45355	Surgical colonoscopy	Y		A2	8.3340	$344.90
45378	Diagnostic colonoscopy	Y		A2	9.6660	$400.00
45379	Colonoscopy w/fb removal	Y		A2	9.6660	$400.00
45380	Colonoscopy and biopsy	Y		A2	9.6660	$400.00
45381	Colonoscopy, submucous inj	Y		A2	9.6660	$400.00
45382	Colonoscopy/control bleeding	Y		A2	9.6660	$400.00
45383	Lesion removal colonoscopy	Y		A2	9.6660	$400.00
45384	Lesion remove colonoscopy	Y		A2	9.6660	$400.00
45385	Lesion removal colonoscopy	Y		A2	9.6660	$400.00
45386	Colonoscopy dilate stricture	Y		A2	9.6660	$400.00
45387	Colonoscopy w/stent	Y		A2	16.4960	$682.66
45391	Colonoscopy w/endoscope us	Y		A2	9.6660	$400.00
45392	Colonoscopy w/endoscopic fnb	Y		A2	9.6660	$400.00
45500	Repair of rectum	Y		A2	16.6380	$688.55
45505	Repair of rectum	Y		A2	20.4700	$847.14
45520	Treatment of rectal prolapse	Y		P2	0.8130	$33.63
45560	Repair of rectocele	Y		A2	20.4700	$847.14
45900	Reduction of rectal prolapse	Y		A2	6.4870	$268.45
45905	Dilation of anal sphincter	Y		A2	15.3060	$633.44

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45910	Dilation of rectal narrowing	Y		A2	15.3060	$633.44
45915	Remove rectal obstruction	Y		A2	9.6500	$399.35
45990	Surg dx exam, anorectal	Y		A2	15.0600	$623.24
46020	Placement of seton	Y		A2	17.3920	$719.76
46030	Removal of rectal marker	Y		A2	6.4870	$268.45
46040	Incision of rectal abscess	Y		A2	17.3920	$719.76
46045	Incision of rectal abscess	Y		A2	16.6380	$688.55
46050	Incision of anal abscess	Y		A2	9.6500	$399.35
46060	Incision of rectal abscess	Y		A2	16.6380	$688.55
46070	Incision of anal septum	Y		G2	11.9450	$494.33
46080	Incision of anal sphincter	Y		A2	17.3920	$719.76
46083	Incise external hemorrhoid	Y	CH	P3	1.8850	$77.99
46200	Removal of anal fissure	Y		A2	16.6380	$688.55
46210	Removal of anal crypt	Y		A2	16.6380	$688.55
46211	Removal of anal crypts	Y		A2	16.6380	$688.55
46220	Removal of anal tag	Y		A2	15.3060	$633.44
46221	Ligation of hemorrhoid(s)	Y		P3	2.7020	$111.83
46230	Removal of anal tags	Y		A2	15.3060	$633.44
46250	Hemorrhoidectomy	Y		A2	17.3920	$719.76
46255	Hemorrhoidectomy	Y		A2	17.3920	$719.76
46257	Remove hemorrhoids & fissure	Y		A2	17.3920	$719.76
46258	Remove hemorrhoids & fistula	Y		A2	17.3920	$719.76
46260	Hemorrhoidectomy	Y		A2	17.3920	$719.76
46261	Remove hemorrhoids & fissure	Y		A2	18.8060	$778.27
46262	Remove hemorrhoids & fistula	Y		A2	18.8060	$778.27
46270	Removal of anal fistula	Y		A2	17.3920	$719.76
46275	Removal of anal fistula	Y		A2	17.3920	$719.76
46280	Removal of anal fistula	Y		A2	18.8060	$778.27
46285	Removal of anal fistula	Y		A2	15.3060	$633.44
46288	Repair anal fistula	Y		A2	18.8060	$778.27
46320	Removal of hemorrhoid clot	Y		P3	1.8300	$75.74
46500	Injection into hemorrhoid(s)	Y		P3	2.5310	$104.74
46505	Chemodenervation anal musc	Y		G2	11.9450	$494.33
46600	Diagnostic anoscopy	N		P2	0.6320	$26.16
46604	Anoscopy and dilation	Y		P2	8.9430	$370.11
46606	Anoscopy and biopsy	Y		P3	3.0370	$125.69
46608	Anoscopy, remove for body	Y		A2	8.3960	$347.44
46610	Anoscopy, remove lesion	Y		A2	15.5760	$644.59
46611	Anoscopy	Y		A2	8.3960	$347.44
46612	Anoscopy, remove lesions	Y		A2	15.5760	$644.59

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46614	Anoscopy, control bleeding	Y		P3	1.5810	$65.42
46615	Anoscopy	Y		A2	16.9080	$699.70
46700	Repair of anal stricture	Y		A2	17.3920	$719.76
46706	Repr of anal fistula w/glue	Y		A2	19.1390	$792.04
46750	Repair of anal sphincter	Y		A2	21.2240	$878.35
46753	Reconstruction of anus	Y		A2	17.3920	$719.76
46754	Removal of suture from anus	Y		A2	16.6380	$688.55
46760	Repair of anal sphincter	Y		A2	20.4700	$847.14
46761	Repair of anal sphincter	Y		A2	21.2240	$878.35
46762	Implant artificial sphincter	Y		A2	26.9390	$1,114.86
46900	Destruction, anal lesion(s)	Y		P2	2.6390	$109.23
46910	Destruction, anal lesion(s)	Y		P3	2.8660	$118.60
46916	Cryosurgery, anal lesion(s)	Y		P2	1.4750	$61.05
46917	Laser surgery, anal lesions	Y		A2	13.9800	$578.55
46922	Excision of anal lesion(s)	Y		A2	13.9800	$578.55
46924	Destruction, anal lesion(s)	Y		A2	13.9800	$578.55
46934	Destruction of hemorrhoids	Y		P3	4.3610	$180.48
46935	Destruction of hemorrhoids	Y		P3	2.9130	$120.53
46936	Destruction of hemorrhoids	Y		P3	4.7040	$194.66
46937	Cryotherapy of rectal lesion	Y		A2	16.6380	$688.55
46938	Cryotherapy of rectal lesion	Y		A2	20.4700	$847.14
46940	Treatment of anal fissure	Y		P3	2.0480	$84.76
46942	Treatment of anal fissure	Y		P3	1.9940	$82.50
46945	Ligation of hemorrhoids	Y		P3	3.4270	$141.81
46946	Ligation of hemorrhoids	Y		A2	9.8960	$409.55
46947	Hemorrhoidopexy by stapling	Y		A2	26.9390	$1,114.86
47000	Needle biopsy of liver	Y		A2	8.6130	$356.45
47001	Needle biopsy, liver add-on	N		N1		
47382	Percut ablate liver rf	Y		G2	44.9590	$1,860.58
47500	Injection for liver x-rays	N		N1		
47505	Injection for liver x-rays	N		N1		
47510	Insert catheter, bile duct	Y		A2	19.9360	$825.05
47511	Insert bile duct drain	Y		A2	29.3620	$1,215.10
47525	Change bile duct catheter	Y		A2	11.4850	$475.29
47530	Revise/reinsert bile tube	Y		A2	11.4850	$475.29
47552	Biliary endoscopy thru skin	Y		A2	19.9360	$825.05
47553	Biliary endoscopy thru skin	Y		A2	20.6910	$856.26
47554	Biliary endoscopy thru skin	Y		A2	20.6910	$856.26
47555	Biliary endoscopy thru skin	Y		A2	20.6910	$856.26
47556	Biliary endoscopy thru skin	Y		A2	29.3620	$1,215.10

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47560	Laparoscopy w/cholangio	Y		A2	24.3200	$1,006.44
47561	Laparo w/cholangio/biopsy	Y		A2	24.3200	$1,006.44
47562	Laparoscopic cholecystectomy	Y		G2	45.2410	$1,872.25
47563	Laparo cholecystectomy/graph	Y		G2	45.2410	$1,872.25
47564	Laparo cholecystectomy/explr	Y		G2	45.2410	$1,872.25
47630	Remove bile duct stone	Y		A2	20.6910	$856.26
48102	Needle biopsy, pancreas	Y		A2	8.6130	$356.45
49080	Puncture, peritoneal cavity	Y		A2	5.2400	$216.86
49081	Removal of abdominal fluid	Y		A2	5.2400	$216.86
49180	Biopsy, abdominal mass	Y		A2	8.6130	$356.45
49250	Excision of umbilicus	Y		A2	18.7700	$776.76
49320	Diag laparo separate proc	Y		A2	24.3200	$1,006.44
49321	Laparoscopy, biopsy	Y		A2	25.7330	$1,064.95
49322	Laparoscopy, aspiration	Y		A2	25.7330	$1,064.95
49324	Lap insertion perm ip cath	Y	CH	G2	36.6200	$1,515.47
49325	Lap revision,perm ip cath	Y	CH	G2	36.6200	$1,515.47
49326	Lap w/omentopexy add-on	Y	CH	G2	36.6200	$1,515.47
49400	Air injection into abdomen	N		N1		
49402	Remove foreign body, adbomen	Y		A2	16.6010	$687.03
49419	Insrt abdom cath for chemotx	Y		A2	18.8140	$778.59
49420	Insert abdom drain, temp	Y		A2	18.3880	$760.95
49421	Insert abdom drain, perm	Y		A2	18.3880	$760.95
49422	Remove perm cannula/catheter	Y		A2	14.7950	$612.29
49423	Exchange drainage catheter	Y		G2	15.1220	$625.81
49424	Assess cyst, contrast inject	N		N1		
49426	Revise abdomen-venous shunt	Y		A2	16.6010	$687.03
49427	Injection, abdominal shunt	N		N1		
49429	Removal of shunt	Y		G2	21.7430	$899.80
49440	Place gastrostomy tube perc	Y		G2	8.4960	$351.59
49441	Place duod/jej tube perc	Y		G2	8.4960	$351.59
49446	Change g-tube to g-j perc	Y		G2	8.4960	$351.59
49450	Replace g/c tube perc	Y		G2	4.4840	$185.56
49451	Replace duod/jej tube perc	Y		G2	4.4840	$185.56
49452	Replace g-j tube perc	Y		G2	4.4840	$185.56
49460	Fix g/colon tube w/device	Y		G2	4.4840	$185.56
49465	Fluoro exam of g/colon tube	N		N1		
49495	Rpr ing hernia baby, reduc	Y		A2	22.8770	$946.75
49496	Rpr ing hernia baby, blocked	Y		A2	22.8770	$946.75
49500	Rpr ing hernia, init, reduce	Y		A2	22.8770	$946.75
49501	Rpr ing hernia, init blocked	Y		A2	31.2320	$1,292.49

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49505	Prp i/hern init reduc >5 yr	Y		A2	22.8770	$946.75
49507	Prp i/hern init block >5 yr	Y		A2	31.2320	$1,292.49
49520	Rerepair ing hernia, reduce	Y		A2	27.1780	$1,124.74
49521	Rerepair ing hernia, blocked	Y		A2	31.2320	$1,292.49
49525	Repair ing hernia, sliding	Y		A2	22.8770	$946.75
49540	Repair lumbar hernia	Y		A2	20.7090	$857.02
49550	Rpr rem hernia, init, reduce	Y		A2	23.9030	$989.18
49553	Rpr fem hernia, init blocked	Y		A2	31.2320	$1,292.49
49555	Rerepair fem hernia, reduce	Y		A2	23.9030	$989.18
49557	Rerepair fem hernia, blocked	Y		A2	31.2320	$1,292.49
49560	Rpr ventral hern init, reduc	Y		A2	22.8770	$946.75
49561	Rpr ventral hern init, block	Y		A2	31.2320	$1,292.49
49565	Rerepair ventrl hern, reduce	Y		A2	22.8770	$946.75
49566	Rerepair ventrl hern, block	Y		A2	31.2320	$1,292.49
49568	Hernia repair w/mesh	Y		A2	27.1780	$1,124.74
49570	Rpr epigastric hern, reduce	Y		A2	22.8770	$946.75
49572	Rpr epigastric hern, blocked	Y		A2	31.2320	$1,292.49
49580	Rpr umbil hern, reduc < 5 yr	Y		A2	22.8770	$946.75
49582	Rpr umbil hern, block < 5 yr	Y		A2	31.2320	$1,292.49
49585	Rpr umbil hern, reduc > 5 yr	Y		A2	22.8770	$946.75
49587	Rpr umbil hern, block > 5 yr	Y		A2	31.2320	$1,292.49
49590	Repair spigelian hernia	Y		A2	21.4630	$888.23
49600	Repair umbilical lesion	Y		A2	22.8770	$946.75
49650	Laparo hernia repair initial	Y		A2	30.0440	$1,243.34
49651	Laparo hernia repair recur	Y		A2	34.3450	$1,421.34
50200	Biopsy of kidney	Y		A2	8.6130	$356.45
50382	Change ureter stent, percut	Y		G2	25.0470	$1,036.54
50384	Remove ureter stent, percut	Y		G2	18.4850	$764.97
50385	Change stent via transureth	Y		G2	18.4850	$764.97
50386	Remove stent via transureth	Y		G2	6.9910	$289.33
50387	Change ext/int ureter stent	Y		G2	15.1220	$625.81
50389	Remove renal tube w/fluoro	Y		G2	6.9910	$289.33
50390	Drainage of kidney lesion	Y		A2	8.6130	$356.45
50391	Instll rx agnt into rnal tub	Y		P2	1.0140	$41.98
50392	Insert kidney drain	Y		A2	13.1660	$544.88
50393	Insert ureteral tube	Y		A2	16.4470	$680.66
50394	Injection for kidney x-ray	N		N1		
50395	Create passage to kidney	Y		A2	13.1660	$544.88
50396	Measure kidney pressure	Y		A2	2.6250	$108.65
50398	Change kidney tube	Y		A2	11.4850	$475.29

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HCPCS Code	Short Descriptor	Subject to Multiple Procedure Discounting	Comment Indicator	Payment Indicator	CY 2009 Second Year Transition Payment Weight	CY 2009 Second Year Transition Payment
50551	Kidney endoscopy	Y		A2	7.4200	$307.05
50553	Kidney endoscopy	Y		A2	16.4470	$680.66
50555	Kidney endoscopy & biopsy	Y		A2	7.4200	$307.05
50557	Kidney endoscopy & treatment	Y		A2	16.4470	$680.66
50561	Kidney endoscopy & treatment	Y		A2	16.4470	$680.66
50562	Renal scope w/tumor resect	Y		G2	6.9910	$289.33
50570	Kidney endoscopy	Y		G2	6.9910	$289.33
50572	Kidney endoscopy	Y		G2	6.9910	$289.33
50574	Kidney endoscopy & biopsy	Y		G2	6.9910	$289.33
50575	Kidney endoscopy	Y		G2	35.5230	$1,470.08
50576	Kidney endoscopy & treatment	Y		G2	18.4850	$764.97
50580	Kidney endoscopy & treatment	Y		G2	18.4850	$764.97
50590	Fragmenting of kidney stone	Y		G2	41.4110	$1,713.74
50592	Perc rf ablate renal tumor	Y		G2	44.9590	$1,860.58
50684	Injection for ureter x-ray	N		N1		
50686	Measure ureter pressure	Y	CH	P3	0.6700	$27.72
50688	Change of ureter tube/stent	Y		A2	11.4850	$475.29
50690	Injection for ureter x-ray	N		N1		
50947	Laparo new ureter/bladder	Y		A2	38.3990	$1,589.09
50948	Laparo new ureter/bladder	Y		A2	38.3990	$1,589.09
50951	Endoscopy of ureter	Y		A2	7.4200	$307.05
50953	Endoscopy of ureter	Y		A2	7.4200	$307.05
50955	Ureter endoscopy & biopsy	Y		A2	16.4470	$680.66
50957	Ureter endoscopy & treatment	Y		A2	16.4470	$680.66
50961	Ureter endoscopy & treatment	Y		A2	16.4470	$680.66
50970	Ureter endoscopy	Y		A2	7.4200	$307.05
50972	Ureter endoscopy & catheter	Y		A2	7.4200	$307.05
50974	Ureter endoscopy & biopsy	Y		A2	13.1660	$544.88
50976	Ureter endoscopy & treatment	Y		A2	13.1660	$544.88
50980	Ureter endoscopy & treatment	Y		A2	16.4470	$680.66
51020	Incise & treat bladder	Y		A2	19.9470	$825.49
51030	Incise & treat bladder	Y		A2	19.9470	$825.49
51040	Incise & drain bladder	Y		A2	19.9470	$825.49
51045	Incise bladder/drain ureter	Y		A2	8.2000	$339.35
51050	Removal of bladder stone	Y		A2	19.9470	$825.49
51065	Remove ureter calculus	Y		A2	19.9470	$825.49
51080	Drainage of bladder abscess	Y		A2	13.4710	$557.47
51100	Drain bladder by needle	Y		P3	0.6930	$28.68
51101	Drain bladder by trocar/cath	Y		P2	1.0140	$41.98
51102	Drain bl w/cath insertion	Y		A2	13.8050	$571.32

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51500	Removal of bladder cyst	Y		A2	22.8770	$946.75
51520	Removal of bladder lesion	Y		A2	19.9470	$825.49
51600	Injection for bladder x-ray	N		N1		
51605	Preparation for bladder xray	N		N1		
51610	Injection for bladder x-ray	N		N1		
51700	Irrigation of bladder	Y		P3	1.1840	$48.99
51701	Insert bladder catheter	N		P2	0.6320	$26.16
51702	Insert temp bladder cath	N		P2	0.6320	$26.16
51703	Insert bladder cath, complex	Y		P2	1.0140	$41.98
51705	Change of bladder tube	Y		P3	1.6280	$67.36
51710	Change of bladder tube	Y		A2	11.4850	$475.29
51715	Endoscopic injection/implant	Y		A2	20.9080	$865.24
51720	Treatment of bladder lesion	Y		P3	1.2850	$53.18
51725	Simple cystometrogram	Y		P2	3.0730	$127.15
51726	Complex cystometrogram	Y		A2	4.0050	$165.73
51736	Urine flow measurement	Y		P3	0.4830	$19.98
51741	Electro-uroflowmetry, first	Y		P3	0.5690	$23.53
51772	Urethra pressure profile	Y		A2	2.6250	$108.65
51784	Anal/urinary muscle study	Y		P2	1.0140	$41.98
51785	Anal/urinary muscle study	Y		A2	1.8650	$77.16
51792	Urinary reflex study	Y		P2	1.0140	$41.98
51795	Urine voiding pressure study	Y		P2	2.1520	$89.05
51797	Intraabdominal pressure test	Y		P2	2.1520	$89.05
51798	Us urine capacity measure	N		P3	0.4130	$17.08
51880	Repair of bladder opening	Y		A2	16.4470	$680.66
51992	Laparo sling operation	Y		A2	31.0690	$1,285.77
52000	Cystoscopy	Y		A2	7.4200	$307.05
52001	Cystoscopy, removal of clots	Y		A2	13.9470	$577.18
52005	Cystoscopy & ureter catheter	Y		A2	14.4980	$599.98
52007	Cystoscopy and biopsy	Y		A2	17.7790	$735.76
52010	Cystoscopy & duct catheter	Y		A2	8.2000	$339.35
52204	Cystoscopy w/biopsy(s)	Y		A2	14.4980	$599.98
52214	Cystoscopy and treatment	Y		A2	17.7790	$735.76
52224	Cystoscopy and treatment	Y		A2	17.7790	$735.76
52234	Cystoscopy and treatment	Y		A2	17.7790	$735.76
52235	Cystoscopy and treatment	Y		A2	18.5330	$766.97
52240	Cystoscopy and treatment	Y		A2	18.5330	$766.97
52250	Cystoscopy and radiotracer	Y		A2	19.9470	$825.49
52260	Cystoscopy and treatment	Y		A2	14.4980	$599.98
52265	Cystoscopy and treatment	Y		P2	6.9910	$289.33

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52270	Cystoscopy & revise urethra	Y		A2	14.4980	$599.98
52275	Cystoscopy & revise urethra	Y		A2	17.7790	$735.76
52276	Cystoscopy and treatment	Y		A2	18.5330	$766.97
52277	Cystoscopy and treatment	Y		A2	17.7790	$735.76
52281	Cystoscopy and treatment	Y		A2	14.4980	$599.98
52282	Cystoscopy, implant stent	Y		A2	33.5400	$1,388.00
52283	Cystoscopy and treatment	Y		A2	17.7790	$735.76
52285	Cystoscopy and treatment	Y		A2	14.4980	$599.98
52290	Cystoscopy and treatment	Y		A2	14.4980	$599.98
52300	Cystoscopy and treatment	Y		A2	17.7790	$735.76
52301	Cystoscopy and treatment	Y		A2	18.5330	$766.97
52305	Cystoscopy and treatment	Y		A2	17.7790	$735.76
52310	Cystoscopy and treatment	Y		A2	13.9470	$577.18
52315	Cystoscopy and treatment	Y		A2	17.7790	$735.76
52317	Remove bladder stone	Y		A2	16.4470	$680.66
52318	Remove bladder stone	Y		A2	17.7790	$735.76
52320	Cystoscopy and treatment	Y		A2	20.9720	$867.92
52325	Cystoscopy, stone removal	Y		A2	19.9470	$825.49
52327	Cystoscopy, inject material	Y		A2	23.0170	$952.53
52330	Cystoscopy and treatment	Y		A2	17.7790	$735.76
52332	Cystoscopy and treatment	Y		A2	17.7790	$735.76
52334	Create passage to kidney	Y		A2	18.5330	$766.97
52341	Cysto w/ureter stricture tx	Y		A2	18.5330	$766.97
52342	Cysto w/up stricture tx	Y		A2	18.5330	$766.97
52343	Cysto w/renal stricture tx	Y		A2	18.5330	$766.97
52344	Cysto/uretero, stricture tx	Y		A2	18.5330	$766.97
52345	Cysto/uretero w/up stricture	Y		A2	18.5330	$766.97
52346	Cystouretero w/renal strict	Y		A2	18.5330	$766.97
52351	Cystouretero & or pyeloscope	Y		A2	18.5330	$766.97
52352	Cystouretero w/stone remove	Y		A2	19.9470	$825.49
52353	Cystouretero w/lithotripsy	Y		A2	25.1850	$1,042.26
52354	Cystouretero w/biopsy	Y		A2	19.9470	$825.49
52355	Cystouretero w/excise tumor	Y		A2	19.9470	$825.49
52400	Cystouretero w/congen repr	Y		A2	18.5330	$766.97
52402	Cystourethro cut ejacul duct	Y		A2	18.5330	$766.97
52450	Incision of prostate	Y		A2	18.5330	$766.97
52500	Revision of bladder neck	Y		A2	18.5330	$766.97
52601	Prostatectomy (turp)	Y		A2	25.1850	$1,042.26
52606	Control postop bleeding	Y		A2	16.4470	$680.66
52612	Prostatectomy, first stage	Y		A2	23.0170	$952.53

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52614	Prostatectomy, second stage	Y		A2	21.6850	$897.43
52620	Remove residual prostate	Y		A2	21.6850	$897.43
52630	Remove prostate regrowth	Y		A2	23.0170	$952.53
52640	Relieve bladder contracture	Y		A2	17.7790	$735.76
52647	Laser surgery of prostate	Y		A2	38.1680	$1,579.54
52648	Laser surgery of prostate	Y		A2	38.1680	$1,579.54
52700	Drainage of prostate abscess	Y		A2	17.7790	$735.76
53000	Incision of urethra	Y		A2	13.7170	$567.67
53010	Incision of urethra	Y		A2	13.7170	$567.67
53020	Incision of urethra	Y		A2	13.7170	$567.67
53025	Incision of urethra	Y		R2	19.5860	$810.56
53040	Drainage of urethra abscess	Y		A2	15.0490	$622.77
53060	Drainage of urethra abscess	Y		P3	1.5650	$64.78
53080	Drainage of urinary leakage	Y		A2	15.8030	$653.98
53085	Drainage of urinary leakage	Y		G2	19.5860	$810.56
53200	Biopsy of urethra	Y		A2	13.7170	$567.67
53210	Removal of urethra	Y		A2	23.3470	$966.19
53215	Removal of urethra	Y		A2	18.2420	$754.93
53220	Treatment of urethra lesion	Y		A2	20.1530	$834.03
53230	Removal of urethra lesion	Y		A2	20.1530	$834.03
53235	Removal of urethra lesion	Y		A2	15.8030	$653.98
53240	Surgery for urethra pouch	Y		A2	20.1530	$834.03
53250	Removal of urethra gland	Y		A2	15.0490	$622.77
53260	Treatment of urethra lesion	Y		A2	15.0490	$622.77
53265	Treatment of urethra lesion	Y		A2	15.0490	$622.77
53270	Removal of urethra gland	Y		A2	15.0490	$622.77
53275	Repair of urethra defect	Y		A2	15.0490	$622.77
53400	Revise urethra, stage 1	Y		A2	20.9080	$865.24
53405	Revise urethra, stage 2	Y		A2	20.1530	$834.03
53410	Reconstruction of urethra	Y		A2	20.1530	$834.03
53420	Reconstruct urethra, stage 1	Y		A2	20.9080	$865.24
53425	Reconstruct urethra, stage 2	Y		A2	20.1530	$834.03
53430	Reconstruction of urethra	Y		A2	20.1530	$834.03
53431	Reconstruct urethra/bladder	Y		A2	20.1530	$834.03
53440	Male sling procedure	N		H8	111.6410	$4,620.14
53442	Remove/revise male sling	Y		A2	18.8220	$778.93
53444	Insert tandem cuff	N		H8	111.6410	$4,620.14
53445	Insert uro/ves nck sphincter	N		H8	181.2270	$7,499.90
53446	Remove uro sphincter	Y		A2	18.8220	$778.93
53447	Remove/replace ur sphincter	N		H8	181.2270	$7,499.90

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53449	Repair uro sphincter	Y		A2	18.8220	$778.93
53450	Revision of urethra	Y		A2	18.8220	$778.93
53460	Revision of urethra	Y		A2	13.7170	$567.67
53502	Repair of urethra injury	Y		A2	15.0490	$622.77
53505	Repair of urethra injury	Y		A2	20.1530	$834.03
53510	Repair of urethra injury	Y		A2	15.0490	$622.77
53515	Repair of urethra injury	Y		A2	20.1530	$834.03
53520	Repair of urethra defect	Y		A2	20.1530	$834.03
53600	Dilate urethra stricture	Y		P3	0.8960	$37.06
53601	Dilate urethra stricture	Y		P2	1.0140	$41.98
53605	Dilate urethra stricture	Y		A2	14.4980	$599.98
53620	Dilate urethra stricture	Y		P3	1.3780	$57.04
53621	Dilate urethra stricture	Y		P3	1.4560	$60.27
53660	Dilation of urethra	Y		P2	1.0140	$41.98
53661	Dilation of urethra	Y		P2	1.0140	$41.98
53665	Dilation of urethra	Y		A2	13.7170	$567.67
53850	Prostatic microwave thermotx	Y		P2	44.7800	$1,853.15
53852	Prostatic rf thermotx	Y		P2	44.7800	$1,853.15
53853	Prostatic water thermother	Y		P2	25.0470	$1,036.54
54000	Slitting of prepuce	Y		A2	15.0490	$622.77
54001	Slitting of prepuce	Y		A2	15.0490	$622.77
54015	Drain penis lesion	Y		A2	16.9700	$702.30
54050	Destruction, penis lesion(s)	Y		P2	0.8130	$33.63
54055	Destruction, penis lesion(s)	Y		P3	1.4640	$60.59
54056	Cryosurgery, penis lesion(s)	Y		P2	0.8130	$33.63
54057	Laser surg, penis lesion(s)	Y		A2	13.9800	$578.55
54060	Excision of penis lesion(s)	Y		A2	13.9800	$578.55
54065	Destruction, penis lesion(s)	Y		A2	13.9800	$578.55
54100	Biopsy of penis	Y		A2	11.6630	$482.66
54105	Biopsy of penis	Y		A2	14.5290	$601.28
54110	Treatment of penis lesion	Y		A2	22.5920	$934.94
54111	Treat penis lesion, graft	Y		A2	22.5920	$934.94
54112	Treat penis lesion, graft	Y		A2	22.5920	$934.94
54115	Treatment of penis lesion	Y		A2	13.4710	$557.47
54120	Partial removal of penis	Y		A2	22.5920	$934.94
54150	Circumcision w/regionl block	Y		A2	15.0800	$624.08
54160	Circumcision, neonate	Y		A2	16.4120	$679.18
54161	Circum 28 days or older	Y		A2	16.4120	$679.18
54162	Lysis penil circumic lesion	Y		A2	16.4120	$679.18
54163	Repair of circumcision	Y		A2	16.4120	$679.18

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54164	Frenulotomy of penis	Y		A2	16.4120	$679.18
54200	Treatment of penis lesion	Y		P3	1.5260	$63.17
54205	Treatment of penis lesion	Y		A2	24.7600	$1,024.67
54220	Treatment of penis lesion	Y		A2	2.6250	$108.65
54230	Prepare penis study	N		N1		
54231	Dynamic cavernosometry	Y		P3	1.4100	$58.33
54235	Penile injection	Y		P3	1.0050	$41.57
54240	Penis study	Y		P3	0.7400	$30.62
54250	Penis study	Y		P3	0.2570	$10.64
54300	Revision of penis	Y		A2	23.3460	$966.15
54304	Revision of penis	Y		A2	23.3460	$966.15
54308	Reconstruction of urethra	Y		A2	23.3460	$966.15
54312	Reconstruction of urethra	Y		A2	23.3460	$966.15
54316	Reconstruction of urethra	Y		A2	23.3460	$966.15
54318	Reconstruction of urethra	Y		A2	23.3460	$966.15
54322	Reconstruction of urethra	Y		A2	23.3460	$966.15
54324	Reconstruction of urethra	Y		A2	23.3460	$966.15
54326	Reconstruction of urethra	Y		A2	23.3460	$966.15
54328	Revise penis/urethra	Y		A2	23.3460	$966.15
54340	Secondary urethral surgery	Y		A2	23.3460	$966.15
54344	Secondary urethral surgery	Y		A2	23.3460	$966.15
54348	Secondary urethral surgery	Y		A2	23.3460	$966.15
54352	Reconstruct urethra/penis	Y		A2	23.3460	$966.15
54360	Penis plastic surgery	Y		A2	23.3460	$966.15
54380	Repair penis	Y		A2	23.3460	$966.15
54385	Repair penis	Y		A2	23.3460	$966.15
54400	Insert semi-rigid prosthesis	N		H8	112.3950	$4,651.35
54401	Insert self-contd prosthesis	N		H8	183.3130	$7,586.21
54405	Insert multi-comp penis pros	N		H8	183.3130	$7,586.21
54406	Remove muti-comp penis pros	Y		A2	23.3460	$966.15
54408	Repair multi-comp penis pros	Y		A2	23.3460	$966.15
54410	Remove/replace penis prosth	N		H8	183.3130	$7,586.21
54415	Remove self-contd penis pros	Y		A2	23.3460	$966.15
54416	Remv/repl penis contain pros	N		H8	183.3130	$7,586.21
54420	Revision of penis	Y		A2	24.7600	$1,024.67
54435	Revision of penis	Y		A2	24.7600	$1,024.67
54440	Repair of penis	Y		A2	24.7600	$1,024.67
54450	Preputial stretching	Y		A2	4.0050	$165.73
54500	Biopsy of testis	Y		A2	10.5200	$435.35
54505	Biopsy of testis	Y		A2	15.0800	$624.08

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54512	Excise lesion testis	Y		A2	16.4120	$679.18
54520	Removal of testis	Y		A2	17.1660	$710.39
54522	Orchiectomy, partial	Y		A2	17.1660	$710.39
54530	Removal of testis	Y		A2	22.8770	$946.75
54550	Exploration for testis	Y		A2	22.8770	$946.75
54560	Exploration for testis	Y		G2	22.3120	$923.38
54600	Reduce testis torsion	Y		A2	18.5800	$768.91
54620	Suspension of testis	Y		A2	17.1660	$710.39
54640	Suspension of testis	Y		A2	22.8770	$946.75
54660	Revision of testis	Y		A2	16.4120	$679.18
54670	Repair testis injury	Y		A2	17.1660	$710.39
54680	Relocation of testis(es)	Y		A2	17.1660	$710.39
54690	Laparoscopy, orchiectomy	Y		A2	38.3990	$1,589.09
54692	Laparoscopy, orchiopexy	Y		G2	70.0090	$2,897.24
54700	Drainage of scrotum	Y		A2	16.4120	$679.18
54800	Biopsy of epididymis	Y		A2	3.7050	$153.33
54830	Remove epididymis lesion	Y		A2	17.1660	$710.39
54840	Remove epididymis lesion	Y		A2	18.5800	$768.91
54860	Removal of epididymis	Y		A2	17.1660	$710.39
54861	Removal of epididymis	Y		A2	18.5800	$768.91
54865	Explore epididymis	Y		A2	15.0800	$624.08
54900	Fusion of spermatic ducts	Y		A2	18.5800	$768.91
54901	Fusion of spermatic ducts	Y		A2	18.5800	$768.91
55000	Drainage of hydrocele	Y		P3	1.4880	$61.56
55040	Removal of hydrocele	Y		A2	21.4630	$888.23
55041	Removal of hydroceles	Y		A2	23.9030	$989.18
55060	Repair of hydrocele	Y		A2	18.5800	$768.91
55100	Drainage of scrotum abscess	Y		A2	10.1680	$420.81
55110	Explore scrotum	Y		A2	16.4120	$679.18
55120	Removal of scrotum lesion	Y		A2	16.4120	$679.18
55150	Removal of scrotum	Y		A2	15.0800	$624.08
55175	Revision of scrotum	Y		A2	15.0800	$624.08
55180	Revision of scrotum	Y		A2	16.4120	$679.18
55200	Incision of sperm duct	Y		A2	16.4120	$679.18
55250	Removal of sperm duct(s)	Y		A2	16.4120	$679.18
55300	Prepare, sperm duct x-ray	N		N1		
55400	Repair of sperm duct	Y		A2	15.0800	$624.08
55450	Ligation of sperm duct	Y		P3	4.7740	$197.56
55500	Removal of hydrocele	Y		A2	17.1660	$710.39
55520	Removal of sperm cord lesion	Y		A2	18.5800	$768.91

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55530	Revise spermatic cord veins	Y		A2	18.5800	$768.91
55535	Revise spermatic cord veins	Y		A2	22.8770	$946.75
55540	Revise hernia & sperm veins	Y		A2	23.9030	$989.18
55550	Laparo ligate spermatic vein	Y		A2	38.3990	$1,589.09
55600	Incise sperm duct pouch	Y		R2	22.3120	$923.38
55680	Remove sperm pouch lesion	Y		A2	15.0800	$624.08
55700	Biopsy of prostate	Y		A2	9.8330	$406.91
55705	Biopsy of prostate	Y		A2	9.8330	$406.91
55720	Drainage of prostate abscess	Y		A2	16.4470	$680.66
55725	Drainage of prostate abscess	Y		A2	17.7790	$735.76
55860	Surgical exposure, prostate	Y		G2	19.7630	$817.86
55870	Electroejaculation	Y		P3	1.7440	$72.19
55873	Cryoablate prostate	Y		H8	152.5200	$6,311.88
55875	Transperi needle place, pros	N		A2	33.5400	$1,388.00
55876*	Place rt device/marker, pros	N		P3	1.6040	$66.39
55920	Place needles pelvic for rt	Y		G2	22.6920	$939.08
56405	I & d of vulva/perineum	Y		P3	0.9500	$39.32
56420	Drainage of gland abscess	Y		P2	1.3850	$57.33
56440	Surgery for vulva lesion	Y		A2	14.9520	$618.77
56441	Lysis of labial lesion(s)	Y		A2	13.6200	$563.66
56442	Hymenotomy	Y		A2	13.6200	$563.66
56501	Destroy, vulva lesions, sim	Y		P3	1.3080	$54.14
56515	Destroy vulva lesion/s compl	Y		A2	16.0660	$664.86
56605	Biopsy of vulva/perineum	Y		P3	0.7550	$31.26
56606	Biopsy of vulva/perineum	Y		P3	0.3120	$12.89
56620	Partial removal of vulva	Y		A2	18.1450	$750.92
56625	Complete removal of vulva	Y		A2	21.4210	$886.49
56700	Partial removal of hymen	Y		A2	13.6200	$563.66
56740	Remove vagina gland lesion	Y		A2	15.7060	$649.98
56800	Repair of vagina	Y		A2	15.7060	$649.98
56805	Repair clitoris	Y		G2	19.3930	$802.56
56810	Repair of perineum	Y		A2	18.1450	$750.92
56820	Exam of vulva w/scope	Y		P3	0.9580	$39.64
56821	Exam/biopsy of vulva w/scope	Y	CH	P3	1.2460	$51.57
57000	Exploration of vagina	Y		A2	13.6200	$563.66
57010	Drainage of pelvic abscess	Y		A2	14.9520	$618.77
57020	Drainage of pelvic fluid	Y		A2	7.9100	$327.36
57022	I & d vaginal hematoma, pp	Y		G2	12.4890	$516.84
57023	I & d vag hematoma, non-ob	Y		A2	13.4710	$557.47
57061	Destroy vag lesions, simple	Y		P3	1.2150	$50.28

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57065	Destroy vag lesions, complex	Y		A2	13.6200	$563.66
57100	Biopsy of vagina	Y		P3	0.7710	$31.91
57105	Biopsy of vagina	Y		A2	14.9520	$618.77
57130	Remove vagina lesion	Y		A2	14.9520	$618.77
57135	Remove vagina lesion	Y		A2	14.9520	$618.77
57150	Treat vagina infection	Y		P3	0.5610	$23.20
57155	Insert uteri tandems/ovoids	Y		A2	7.9100	$327.36
57160	Insert pessary/other device	Y		P3	0.8100	$33.52
57170	Fitting of diaphragm/cap	Y		P2	0.1780	$7.36
57180	Treat vaginal bleeding	Y		A2	2.7910	$115.49
57200	Repair of vagina	Y		A2	13.6200	$563.66
57210	Repair vagina/perineum	Y		A2	14.9520	$618.77
57220	Revision of urethra	Y		A2	27.2850	$1,129.16
57230	Repair of urethral lesion	Y		A2	22.5470	$933.09
57240	Repair bladder & vagina	Y		A2	24.9860	$1,034.03
57250	Repair rectum & vagina	Y		A2	24.9860	$1,034.03
57260	Repair of vagina	Y		A2	24.9860	$1,034.03
57265	Extensive repair of vagina	Y		A2	33.0000	$1,365.67
57267	Insert mesh/pelvic flr addon	Y		A2	28.2620	$1,169.60
57268	Repair of bowel bulge	Y		A2	22.5470	$933.09
57287	Revise/remove sling repair	Y		G2	33.0750	$1,368.77
57288	Repair bladder defect	Y		A2	29.7240	$1,230.10
57289	Repair bladder & vagina	Y		A2	24.9860	$1,034.03
57291	Construction of vagina	Y		A2	24.9860	$1,034.03
57300	Repair rectum-vagina fistula	Y		A2	22.5470	$933.09
57320	Repair bladder-vagina lesion	Y		G2	33.0750	$1,368.77
57400	Dilation of vagina	Y		A2	14.9520	$618.77
57410	Pelvic examination	Y		A2	14.9520	$618.77
57415	Remove vaginal foreign body	Y		A2	14.9520	$618.77
57420	Exam of vagina w/scope	Y		P3	0.9890	$40.93
57421	Exam/biopsy of vag w/scope	Y		P3	1.3010	$53.82
57452	Exam of cervix w/scope	Y		P3	0.9420	$39.00
57454	Bx/curett of cervix w/scope	Y		P3	1.1450	$47.38
57455	Biopsy of cervix w/scope	Y		P3	1.2150	$50.28
57456	Endocerv curettage w/scope	Y		P3	1.1760	$48.67
57460	Bx of cervix w/scope, leep	Y		P3	3.6680	$151.80
57461	Conz of cervix w/scope, leep	Y		P3	3.8940	$161.14
57500	Biopsy of cervix	Y		P3	1.6820	$69.61
57505	Endocervical curettage	Y		P3	1.0670	$44.15
57510	Cauterization of cervix	Y		P3	1.0750	$44.48

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57511	Cryocautery of cervix	Y	CH	P3	1.3010	$53.82
57513	Laser surgery of cervix	Y		A2	14.9520	$618.77
57520	Conization of cervix	Y		A2	14.9520	$618.77
57522	Conization of cervix	Y		A2	14.9520	$618.77
57530	Removal of cervix	Y		A2	22.5470	$933.09
57550	Removal of residual cervix	Y		A2	22.5470	$933.09
57556	Remove cervix, repair bowel	Y		A2	29.7240	$1,230.10
57558	D&c of cervical stump	Y		A2	15.7060	$649.98
57700	Revision of cervix	Y		A2	13.6200	$563.66
57720	Revision of cervix	Y		A2	15.7060	$649.98
57800	Dilation of cervical canal	Y		P3	0.5760	$23.85
58100	Biopsy of uterus lining	Y		P3	0.9340	$38.67
58110	Bx done w/colposcopy add-on	N		N1		
58120	Dilation and curettage	Y		A2	14.9520	$618.77
58145	Myomectomy vag method	Y		A2	24.9860	$1,034.03
58301	Remove intrauterine device	Y		P3	0.8720	$36.10
58321	Artificial insemination	Y		P3	0.8250	$34.16
58322	Artificial insemination	Y		P3	0.8410	$34.81
58323	Sperm washing	Y		P3	0.1950	$8.06
58340	Catheter for hysterography	N		N1		
58345	Reopen fallopian tube	Y		R2	19.3930	$802.56
58346	Insert heyman uteri capsule	Y		A2	14.9520	$618.77
58350	Reopen fallopian tube	Y		A2	22.5470	$933.09
58353	Endometr ablate, thermal	Y		A2	28.2620	$1,169.60
58356	Endometrial cryoablation	Y	CH	P3	37.5210	$1,552.77
58545	Laparoscopic myomectomy	Y		A2	34.0880	$1,410.70
58546	Laparo-myomectomy, complex	Y		A2	38.3990	$1,589.09
58550	Laparo-asst vag hysterectomy	Y		A2	50.7820	$2,101.58
58552	Laparo-vag hyst incl t/o	Y		G2	45.2410	$1,872.25
58555	Hysteroscopy, dx, sep proc	Y		A2	14.6530	$606.41
58558	Hysteroscopy, biopsy	Y		A2	16.7390	$692.73
58559	Hysteroscopy, lysis	Y		A2	15.9850	$661.52
58560	Hysteroscopy, resect septum	Y		A2	23.7850	$984.31
58561	Hysteroscopy, remove myoma	Y		A2	23.7850	$984.31
58562	Hysteroscopy, remove fb	Y		A2	16.7390	$692.73
58563	Hysteroscopy, ablation	Y		A2	33.5530	$1,388.57
58565	Hysteroscopy, sterilization	Y		A2	37.0540	$1,533.42
58600	Division of fallopian tube	Y		G2	33.0750	$1,368.77
58615	Occlude fallopian tube(s)	Y		G2	19.3930	$802.56
58660	Laparoscopy, lysis	Y		A2	31.0690	$1,285.77

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58661	Laparoscopy, remove adnexa	Y		A2	31.0690	$1,285.77
58662	Laparoscopy, excise lesions	Y		A2	31.0690	$1,285.77
58670	Laparoscopy, tubal cautery	Y		A2	28.6300	$1,184.83
58671	Laparoscopy, tubal block	Y		A2	28.6300	$1,184.83
58672	Laparoscopy, fimbrioplasty	Y		A2	31.0690	$1,285.77
58673	Laparoscopy, salpingostomy	Y		A2	31.0690	$1,285.77
58800	Drainage of ovarian cyst(s)	Y		A2	15.7060	$649.98
58805	Drainage of ovarian cyst(s)	Y		G2	33.0750	$1,368.77
58820	Drain ovary abscess, open	Y		A2	22.5470	$933.09
58900	Biopsy of ovary(s)	Y		A2	15.7060	$649.98
58970	Retrieval of oocyte	Y		A2	4.3800	$181.27
58974	Transfer of embryo	Y		A2	4.3800	$181.27
58976	Transfer of embryo	Y		A2	4.3800	$181.27
59000	Amniocentesis, diagnostic	Y		P3	1.4330	$59.30
59001	Amniocentesis, therapeutic	Y		R2	6.1740	$255.50
59012	Fetal cord puncture,prenatal	Y		G2	2.9650	$122.70
59015	Chorion biopsy	Y		P3	1.1370	$47.05
59020	Fetal contract stress test	Y		P3	0.6230	$25.78
59025	Fetal non-stress test	Y		P3	0.3270	$13.54
59070	Transabdom amnioinfus w/us	Y		G2	2.9650	$122.70
59072	Umbilical cord occlud w/us	Y		G2	2.9650	$122.70
59076	Fetal shunt placement, w/us	Y		G2	2.9650	$122.70
59100	Remove uterus lesion	Y		R2	33.0750	$1,368.77
59150	Treat ectopic pregnancy	Y		G2	45.2410	$1,872.25
59151	Treat ectopic pregnancy	Y		G2	45.2410	$1,872.25
59160	D & c after delivery	Y		A2	15.7060	$649.98
59200	Insert cervical dilator	Y		P3	0.7870	$32.55
59300	Episiotomy or vaginal repair	Y		P3	1.6820	$69.61
59320	Revision of cervix	Y		A2	13.6200	$563.66
59412	Antepartum manipulation	Y		G2	19.3930	$802.56
59414	Deliver placenta	Y		G2	19.3930	$802.56
59812	Treatment of miscarriage	Y		A2	18.1450	$750.92
59820	Care of miscarriage	Y		A2	18.1450	$750.92
59821	Treatment of miscarriage	Y		A2	18.1450	$750.92
59840	Abortion	Y		A2	18.1450	$750.92
59841	Abortion	Y		A2	18.1450	$750.92
59866	Abortion (mpr)	Y		G2	2.9650	$122.70
59870	Evacuate mole of uterus	Y		A2	18.1450	$750.92
59871	Remove cerclage suture	Y		A2	18.1450	$750.92
60000	Drain thyroid/tongue cyst	Y		A2	7.7040	$318.80

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60100	Biopsy of thyroid	Y		P3	1.0590	$43.83
60200	Remove thyroid lesion	Y		A2	28.2440	$1,168.86
60280	Remove thyroid duct lesion	Y		A2	30.4120	$1,258.58
60281	Remove thyroid duct lesion	Y		A2	30.4120	$1,258.58
60300	Aspir/inj thyroid cyst	Y		P3	1.4180	$58.66
61000	Remove cranial cavity fluid	Y		R2	7.1690	$296.70
61001	Remove cranial cavity fluid	Y		R2	7.1690	$296.70
61020	Remove brain cavity fluid	Y		A2	5.7510	$237.99
61026	Injection into brain canal	Y		A2	5.7510	$237.99
61050	Remove brain canal fluid	Y		A2	5.7510	$237.99
61055	Injection into brain canal	Y		A2	5.7510	$237.99
61070	Brain canal shunt procedure	Y		A2	4.4080	$182.42
61215	Insert brain-fluid device	Y		A2	26.5890	$1,100.37
61330	Decompress eye socket	Y		G2	40.5970	$1,680.05
61334	Explore orbit/remove object	Y		G2	40.5970	$1,680.05
61790	Treat trigeminal nerve	Y		A2	15.0000	$620.75
61791	Treat trigeminal tract	Y		A2	11.2950	$467.41
61795	Brain surgery using computer	N		N1		
61880	Revise/remove neuroelectrode	Y		G2	18.9770	$785.35
61885	Insrt/redo neurostim 1 array	N		H8	261.0240	$10,802.21
61886	Implant neurostim arrays	N		H8	397.5750	$16,453.25
61888	Revise/remove neuroreceiver	Y		A2	18.1160	$749.72
62194	Replace/irrigate catheter	Y		A2	7.5090	$310.74
62225	Replace/irrigate catheter	Y		A2	11.4850	$475.29
62230	Replace/revise brain shunt	Y		A2	25.8350	$1,069.16
62252	Csf shunt reprogram	N		P3	1.0830	$44.80
62263	Epidural lysis mult sessions	Y		A2	7.5090	$310.74
62264	Epidural lysis on single day	Y		A2	11.0710	$458.18
62268	Drain spinal cord cyst	Y		A2	5.7510	$237.99
62269	Needle biopsy, spinal cord	Y		A2	8.6130	$356.45
62270	Spinal fluid tap, diagnostic	Y		A2	3.4390	$142.33
62272	Drain cerebro spinal fluid	Y		A2	3.4390	$142.33
62273	Inject epidural patch	Y		A2	5.7250	$236.93
62280	Treat spinal cord lesion	Y		A2	7.5090	$310.74
62281	Treat spinal cord lesion	Y		A2	7.5090	$310.74
62282	Treat spinal canal lesion	Y		A2	7.5090	$310.74
62284	Injection for myelogram	N		N1		
62287	Percutaneous diskectomy	Y		A2	33.4200	$1,383.07
62290	Inject for spine disk x-ray	N		N1		
62291	Inject for spine disk x-ray	N		N1		

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62292	Injection into disk lesion	Y		R2	7.1690	$296.70
62294	Injection into spinal artery	Y		A2	5.7510	$237.99
62310	Inject spine c/t	Y		A2	7.5090	$310.74
62311	Inject spine l/s (cd)	Y		A2	7.5090	$310.74
62318	Inject spine w/cath, c/t	Y		A2	7.5090	$310.74
62319	Inject spine w/cath l/s (cd)	Y		A2	7.5090	$310.74
62350	Implant spinal canal cath	Y		A2	25.8350	$1,069.16
62355	Remove spinal canal catheter	Y		A2	12.4030	$513.29
62360	Insert spine infusion device	Y		A2	25.8350	$1,069.16
62361	Implant spine infusion pump	Y		H8	259.4590	$10,737.43
62362	Implant spine infusion pump	Y		H8	259.4590	$10,737.43
62365	Remove spine infusion device	Y		A2	22.8980	$947.60
62367	Analyze spine infusion pump	N		P3	0.3740	$15.47
62368	Analyze spine infusion pump	N		P3	0.4750	$19.66
63600	Remove spinal cord lesion	Y		A2	14.2460	$589.54
63610	Stimulation of spinal cord	Y		A2	12.9140	$534.44
63615	Remove lesion of spinal cord	Y		R2	17.9800	$744.09
63650	Implant neuroelectrodes	N		H8	76.3030	$3,157.73
63655	Implant neuroelectrodes	N		J8	108.3350	$4,483.34
63660	Revise/remove neuroelectrode	Y		A2	13.4120	$555.06
63685	Insrt/redo spine n generator	N		H8	347.1470	$14,366.35
63688	Revise/remove neuroreceiver	Y		A2	18.1160	$749.72
63744	Revision of spinal shunt	Y		A2	26.5890	$1,100.37
63746	Removal of spinal shunt	Y		A2	12.4030	$513.29
64400	N block inj, trigeminal	Y		P3	1.2070	$49.95
64402	N block inj, facial	Y		P3	1.1450	$47.38
64405	N block inj, occipital	Y		P3	0.9660	$39.96
64408	N block inj, vagus	Y		P3	1.1920	$49.31
64410	N block inj, phrenic	Y		A2	7.5090	$310.74
64412	N block inj, spinal accessor	Y		P3	1.7830	$73.80
64413	N block inj, cervical plexus	Y		P3	1.1290	$46.73
64415	N block inj, brachial plexus	Y		A2	3.4390	$142.33
64416	N block cont infuse, b plex	Y		G2	7.1690	$296.70
64417	N block inj, axillary	Y		A2	3.4390	$142.33
64418	N block inj, suprascapular	Y		P3	1.5890	$65.75
64420	N block inj, intercost, sng	Y		A2	3.4390	$142.33
64421	N block inj, intercost, mlt	Y		A2	7.5090	$310.74
64425	N block inj, ilio-ing/hypogi	Y		P3	1.0900	$45.12
64430	N block inj, pudendal	Y		A2	5.2230	$216.13
64435	N block inj, paracervical	Y		P3	1.6590	$68.65

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64445	N block inj, sciatic, sng	Y		P3	1.4640	$60.59
64446	N blk inj, sciatic, cont inf	Y		G2	14.2950	$591.59
64447	N block inj fem, single	Y		R2	3.6030	$149.10
64450	N block, other peripheral	Y		P3	0.9890	$40.93
64470	Inj paravertebral c/t	Y		A2	7.5090	$310.74
64472	Inj paravertebral c/t add-on	Y		A2	5.7250	$236.93
64475	Inj paravertebral l/s	Y		A2	7.5090	$310.74
64476	Inj paravertebral l/s add-on	Y		A2	5.1460	$212.95
64479	Inj foramen epidural c/t	Y		A2	7.5090	$310.74
64480	Inj foramen epidural add-on	Y		A2	5.7250	$236.93
64483	Inj foramen epidural l/s	Y		A2	7.5090	$310.74
64484	Inj foramen epidural add-on	Y		A2	5.7250	$236.93
64505	N block, spenopalatine gangl	Y		P3	0.8880	$36.74
64508	N block, carotid sinus s/p	Y	CH	P3	1.9000	$78.64
64510	N block, stellate ganglion	Y		A2	7.5090	$310.74
64517	N block inj, hypogas plxs	Y		A2	5.2230	$216.13
64520	N block, lumbar/thoracic	Y		A2	7.5090	$310.74
64530	N block inj, celiac pelus	Y		A2	7.5090	$310.74
64553	Implant neuroelectrodes	N		H8	120.9850	$5,006.86
64555	Implant neuroelectrodes	N		J8	84.8820	$3,512.75
64560	Implant neuroelectrodes	N		J8	84.8820	$3,512.75
64561	Implant neuroelectrodes	N		H8	77.0570	$3,188.94
64565	Implant neuroelectrodes	N		J8	84.8820	$3,512.75
64573	Implant neuroelectrodes	N		H8	120.9850	$5,006.86
64575	Implant neuroelectrodes	N		H8	96.7820	$4,005.22
64577	Implant neuroelectrodes	N		H8	96.7820	$4,005.22
64580	Implant neuroelectrodes	N		H8	96.7820	$4,005.22
64581	Implant neuroelectrodes	N		H8	98.8680	$4,091.54
64585	Revise/remove neuroelectrode	Y		A2	13.4120	$555.06
64590	Insrt/redo pn/gastr stimul	N		H8	261.0240	$10,802.21
64595	Revise/rmv pn/gastr stimul	Y		A2	18.1160	$749.72
64600	Injection treatment of nerve	Y		A2	11.0710	$458.18
64605	Injection treatment of nerve	Y		A2	11.0710	$458.18
64610	Injection treatment of nerve	Y		A2	11.0710	$458.18
64612	Destroy nerve, face muscle	Y		P3	1.4100	$58.33
64613	Destroy nerve, neck muscle	Y		P3	1.3710	$56.72
64614	Destroy nerve, extrem musc	Y		P3	1.5730	$65.10
64620	Injection treatment of nerve	Y		A2	7.5090	$310.74
64622	Destr paravertebrl nerve l/s	Y		A2	11.0710	$458.18
64623	Destr paravertebral n add-on	Y		A2	7.5090	$310.74

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64626	Destr paravertebrl nerve c/t	Y		A2	11.0710	$458.18
64627	Destr paravertebral n add-on	Y		A2	5.1460	$212.95
64630	Injection treatment of nerve	Y		A2	7.7320	$319.96
64640	Injection treatment of nerve	Y		P3	2.2350	$92.50
64650	Chemodenerv eccrine glands	Y		P3	0.7550	$31.26
64653	Chemodenerv eccrine glands	Y		P3	0.8020	$33.20
64680	Injection treatment of nerve	Y		A2	11.7540	$486.44
64681	Injection treatment of nerve	Y		A2	12.4030	$513.29
64702	Revise finger/toe nerve	Y		A2	12.9140	$534.44
64704	Revise hand/foot nerve	Y		A2	12.9140	$534.44
64708	Revise arm/leg nerve	Y		A2	14.2460	$589.54
64712	Revision of sciatic nerve	Y		A2	14.2460	$589.54
64713	Revision of arm nerve(s)	Y		A2	14.2460	$589.54
64714	Revise low back nerve(s)	Y		A2	14.2460	$589.54
64716	Revision of cranial nerve	Y		A2	15.0000	$620.75
64718	Revise ulnar nerve at elbow	Y		A2	14.2460	$589.54
64719	Revise ulnar nerve at wrist	Y		A2	14.2460	$589.54
64721	Carpal tunnel surgery	Y		A2	14.2460	$589.54
64722	Relieve pressure on nerve(s)	Y		A2	12.9140	$534.44
64726	Release foot/toe nerve	Y		A2	12.9140	$534.44
64727	Internal nerve revision	Y		A2	12.9140	$534.44
64732	Incision of brow nerve	Y		A2	14.2460	$589.54
64734	Incision of cheek nerve	Y		A2	14.2460	$589.54
64736	Incision of chin nerve	Y		A2	14.2460	$589.54
64738	Incision of jaw nerve	Y		A2	14.2460	$589.54
64740	Incision of tongue nerve	Y		A2	14.2460	$589.54
64742	Incision of facial nerve	Y		A2	14.2460	$589.54
64744	Incise nerve, back of head	Y		A2	14.2460	$589.54
64746	Incise diaphragm nerve	Y		A2	14.2460	$589.54
64761	Incision of pelvis nerve	Y		G2	17.9800	$744.09
64763	Incise hip/thigh nerve	Y		G2	17.9800	$744.09
64766	Incise hip/thigh nerve	Y		G2	35.2840	$1,460.21
64771	Sever cranial nerve	Y		A2	14.2460	$589.54
64772	Incision of spinal nerve	Y		A2	14.2460	$589.54
64774	Remove skin nerve lesion	Y		A2	14.2460	$589.54
64776	Remove digit nerve lesion	Y		A2	15.0000	$620.75
64778	Digit nerve surgery add-on	Y		A2	14.2460	$589.54
64782	Remove limb nerve lesion	Y		A2	15.0000	$620.75
64783	Limb nerve surgery add-on	Y		A2	14.2460	$589.54
64784	Remove nerve lesion	Y		A2	15.0000	$620.75

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64786	Remove sciatic nerve lesion	Y		A2	23.6520	$978.81
64787	Implant nerve end	Y		A2	14.2460	$589.54
64788	Remove skin nerve lesion	Y		A2	15.0000	$620.75
64790	Removal of nerve lesion	Y		A2	15.0000	$620.75
64792	Removal of nerve lesion	Y		A2	23.6520	$978.81
64795	Biopsy of nerve	Y		A2	14.2460	$589.54
64802	Remove sympathetic nerves	Y		A2	14.2460	$589.54
64820	Remove sympathetic nerves	Y		G2	17.9800	$744.09
64821	Remove sympathetic nerves	Y		A2	21.1630	$875.80
64822	Remove sympathetic nerves	Y		G2	27.4790	$1,137.17
64823	Remove sympathetic nerves	Y		G2	27.4790	$1,137.17
64831	Repair of digit nerve	Y		A2	25.0660	$1,037.32
64832	Repair nerve add-on	Y		A2	21.5660	$892.49
64834	Repair of hand or foot nerve	Y		A2	22.8980	$947.60
64835	Repair of hand or foot nerve	Y		A2	23.6520	$978.81
64836	Repair of hand or foot nerve	Y		A2	23.6520	$978.81
64837	Repair nerve add-on	Y		A2	21.5660	$892.49
64840	Repair of leg nerve	Y		A2	22.8980	$947.60
64856	Repair/transpose nerve	Y		A2	22.8980	$947.60
64857	Repair arm/leg nerve	Y		A2	22.8980	$947.60
64858	Repair sciatic nerve	Y		A2	22.8980	$947.60
64859	Nerve surgery	Y		A2	21.5660	$892.49
64861	Repair of arm nerves	Y		A2	23.6520	$978.81
64862	Repair of low back nerves	Y		A2	23.6520	$978.81
64864	Repair of facial nerve	Y		A2	23.6520	$978.81
64865	Repair of facial nerve	Y		A2	25.0660	$1,037.32
64870	Fusion of facial/other nerve	Y		A2	25.0660	$1,037.32
64872	Subsequent repair of nerve	Y		A2	22.8980	$947.60
64874	Repair & revise nerve add-on	Y		A2	23.6520	$978.81
64876	Repair nerve/shorten bone	Y		A2	23.6520	$978.81
64885	Nerve graft, head or neck	Y		A2	22.8980	$947.60
64886	Nerve graft, head or neck	Y		A2	22.8980	$947.60
64890	Nerve graft, hand or foot	Y		A2	22.8980	$947.60
64891	Nerve graft, hand or foot	Y		A2	22.8980	$947.60
64892	Nerve graft, arm or leg	Y		A2	22.8980	$947.60
64893	Nerve graft, arm or leg	Y		A2	22.8980	$947.60
64895	Nerve graft, hand or foot	Y		A2	23.6520	$978.81
64896	Nerve graft, hand or foot	Y		A2	23.6520	$978.81
64897	Nerve graft, arm or leg	Y		A2	23.6520	$978.81
64898	Nerve graft, arm or leg	Y		A2	23.6520	$978.81

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64901	Nerve graft add-on	Y		A2	22.8980	$947.60
64902	Nerve graft add-on	Y		A2	22.8980	$947.60
64905	Nerve pedicle transfer	Y		A2	22.8980	$947.60
64907	Nerve pedicle transfer	Y		A2	21.5660	$892.49
64910	Nerve repair w/allograft	Y		G2	35.2840	$1,460.21
65091	Revise eye	Y		A2	24.6480	$1,020.04
65093	Revise eye with implant	Y		A2	24.6480	$1,020.04
65101	Removal of eye	Y		A2	24.6480	$1,020.04
65103	Remove eye/insert implant	Y		A2	24.6480	$1,020.04
65105	Remove eye/attach implant	Y		A2	26.0620	$1,078.55
65110	Removal of eye	Y		A2	27.0870	$1,120.98
65112	Remove eye/revise socket	Y		A2	30.3630	$1,256.55
65114	Remove eye/revise socket	Y		A2	30.3630	$1,256.55
65125	Revise ocular implant	Y		G2	24.8610	$1,028.86
65130	Insert ocular implant	Y		A2	18.4400	$763.13
65135	Insert ocular implant	Y		A2	17.6860	$731.92
65140	Attach ocular implant	Y		A2	24.6480	$1,020.04
65150	Revise ocular implant	Y		A2	17.6860	$731.92
65155	Reinsert ocular implant	Y		A2	24.6480	$1,020.04
65175	Removal of ocular implant	Y		A2	13.2600	$548.74
65205	Remove foreign body from eye	N		P3	0.4590	$19.01
65210	Remove foreign body from eye	N		P3	0.5760	$23.85
65220	Remove foreign body from eye	N		G2	0.8910	$36.89
65222	Remove foreign body from eye	N		P3	0.6310	$26.11
65235	Remove foreign body from eye	Y		A2	13.2100	$546.68
65260	Remove foreign body from eye	Y		A2	8.8480	$366.18
65265	Remove foreign body from eye	Y		A2	18.1840	$752.52
65270	Repair of eye wound	Y		A2	14.5910	$603.84
65272	Repair of eye wound	Y		A2	16.9530	$701.60
65275	Repair of eye wound	Y		A2	19.1220	$791.33
65280	Repair of eye wound	Y		A2	18.1840	$752.52
65285	Repair of eye wound	Y		A2	25.9000	$1,071.86
65286	Repair of eye wound	Y		P2	4.4840	$185.58
65290	Repair of eye socket wound	Y		A2	17.9610	$743.31
65400	Removal of eye lesion	Y		A2	11.8780	$491.57
65410	Biopsy of cornea	Y		A2	13.2100	$546.68
65420	Removal of eye lesion	Y		A2	13.2100	$546.68
65426	Removal of eye lesion	Y		A2	20.1470	$833.76
65430	Corneal smear	N		P2	0.8910	$36.89
65435	Curette/treat cornea	Y		P3	0.7010	$29.01

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65436	Curette/treat cornea	Y	CH	P3	3.0220	$125.05
65450	Treatment of corneal lesion	N		G2	2.0500	$84.84
65600	Revision of cornea	Y		P3	3.5980	$148.90
65710	Corneal transplant	Y		A2	30.1010	$1,245.69
65730	Corneal transplant	Y		A2	30.1010	$1,245.69
65750	Corneal transplant	Y		A2	30.1010	$1,245.69
65755	Corneal transplant	Y		A2	30.1010	$1,245.69
65770	Revise cornea with implant	Y	CH	H8	151.9050	$6,286.43
65772	Correction of astigmatism	Y		A2	15.3780	$636.40
65775	Correction of astigmatism	Y		A2	15.3780	$636.40
65780	Ocular reconst, transplant	Y		A2	26.8250	$1,110.12
65781	Ocular reconst, transplant	Y		A2	26.8250	$1,110.12
65782	Ocular reconst, transplant	Y		A2	26.8250	$1,110.12
65800	Drainage of eye	Y		A2	11.8780	$491.57
65805	Drainage of eye	Y		A2	11.8780	$491.57
65810	Drainage of eye	Y		A2	17.7080	$732.81
65815	Drainage of eye	Y		A2	16.9530	$701.60
65820	Relieve inner eye pressure	Y		A2	6.1660	$255.18
65850	Incision of eye	Y		A2	19.1220	$791.33
65855	Laser surgery of eye	Y		P3	2.8970	$119.89
65860	Incise inner eye adhesions	Y		P3	2.7100	$112.16
65865	Incise inner eye adhesions	Y		A2	11.8780	$491.57
65870	Incise inner eye adhesions	Y		A2	19.1220	$791.33
65875	Incise inner eye adhesions	Y		A2	19.1220	$791.33
65880	Incise inner eye adhesions	Y		A2	15.3780	$636.40
65900	Remove eye lesion	Y		A2	16.4030	$678.83
65920	Remove implant of eye	Y		A2	23.4230	$969.32
65930	Remove blood clot from eye	Y		A2	20.1470	$833.76
66020	Injection treatment of eye	Y		A2	11.8780	$491.57
66030	Injection treatment of eye	Y		A2	6.1660	$255.18
66130	Remove eye lesion	Y		A2	23.4230	$969.32
66150	Glaucoma surgery	Y		A2	19.1220	$791.33
66155	Glaucoma surgery	Y		A2	19.1220	$791.33
66160	Glaucoma surgery	Y		A2	16.9530	$701.60
66165	Glaucoma surgery	Y		A2	19.1220	$791.33
66170	Glaucoma surgery	Y		A2	19.1220	$791.33
66172	Incision of eye	Y		A2	19.1220	$791.33
66180	Implant eye shunt	Y		A2	28.0130	$1,159.28
66185	Revise eye shunt	Y		A2	24.8200	$1,027.13
66220	Repair eye lesion	Y		A2	24.4870	$1,013.35

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66225	Repair/graft eye lesion	Y		A2	26.9880	$1,116.85
66250	Follow-up surgery of eye	Y		A2	13.2100	$546.68
66500	Incision of iris	Y		A2	6.1660	$255.18
66505	Incision of iris	Y		A2	6.1660	$255.18
66600	Remove iris and lesion	Y		A2	17.7080	$732.81
66605	Removal of iris	Y		A2	17.7080	$732.81
66625	Removal of iris	Y		A2	6.6370	$274.65
66630	Removal of iris	Y		A2	17.7080	$732.81
66635	Removal of iris	Y		A2	17.7080	$732.81
66680	Repair iris & ciliary body	Y		A2	17.7080	$732.81
66682	Repair iris & ciliary body	Y		A2	16.9530	$701.60
66700	Destruction, ciliary body	Y		A2	13.2100	$546.68
66710	Ciliary transsleral therapy	Y		A2	13.2100	$546.68
66711	Ciliary endoscopic ablation	Y		A2	13.2100	$546.68
66720	Destruction, ciliary body	Y		A2	13.2100	$546.68
66740	Destruction, ciliary body	Y		A2	16.9530	$701.60
66761	Revision of iris	Y		P3	4.0570	$167.91
66762	Revision of iris	Y		P3	4.1200	$170.49
66770	Removal of inner eye lesion	Y	CH	P3	4.4550	$184.35
66820	Incision, secondary cataract	Y		G2	4.4840	$185.58
66821	After cataract laser surgery	Y		A2	6.2830	$260.01
66825	Reposition intraocular lens	Y		A2	19.1220	$791.33
66830	Removal of lens lesion	Y		A2	6.6370	$274.65
66840	Removal of lens material	Y		A2	14.3310	$593.07
66850	Removal of lens material	Y		A2	26.9910	$1,116.98
66852	Removal of lens material	Y		A2	22.6890	$938.98
66920	Extraction of lens	Y		A2	22.6890	$938.98
66930	Extraction of lens	Y		A2	23.7150	$981.41
66940	Extraction of lens	Y		A2	15.3560	$635.50
66982	Cataract surgery, complex	Y		A2	23.2440	$961.91
66983	Cataract surg w/iol, 1 stage	Y		A2	23.2440	$961.91
66984	Cataract surg w/iol, 1 stage	Y		A2	23.2440	$961.91
66985	Insert lens prosthesis	Y		A2	21.5110	$890.22
66986	Exchange lens prosthesis	Y		A2	21.5110	$890.22
66990	Ophthalmic endoscope add-on	N		N1		
67005	Partial removal of eye fluid	Y		A2	18.1840	$752.52
67010	Partial removal of eye fluid	Y		A2	18.1840	$752.52
67015	Release of eye fluid	Y		A2	22.4010	$927.03
67025	Replace eye fluid	Y		A2	14.6840	$607.69
67027	Implant eye drug system	Y		A2	25.9000	$1,071.86

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67028	Injection eye drug	Y	CH	P3	1.7990	$74.45
67030	Incise inner eye strands	Y		A2	14.6840	$607.69
67031	Laser surgery, eye strands	Y		A2	6.2830	$260.01
67036	Removal of inner eye fluid	Y		A2	25.9000	$1,071.86
67039	Laser treatment of retina	Y		A2	30.2020	$1,249.86
67040	Laser treatment of retina	Y		A2	30.2020	$1,249.86
67041	Vit for macular pucker	Y		G2	36.9540	$1,529.29
67042	Vit for macular hole	Y		G2	36.9540	$1,529.29
67043	Vit for membrane dissect	Y		G2	36.9540	$1,529.29
67101	Repair detached retina	Y	CH	P2	5.6770	$234.95
67105	Repair detached retina	Y		P2	5.2010	$215.23
67107	Repair detached retina	Y		A2	26.9260	$1,114.29
67108	Repair detached retina	Y		A2	30.2020	$1,249.86
67110	Repair detached retina	Y		P3	7.2740	$301.01
67112	Rerepair detached retina	Y		A2	30.2020	$1,249.86
67113	Repair retinal detach, cplx	Y		G2	36.9540	$1,529.29
67115	Release encircling material	Y		A2	16.0160	$662.79
67120	Remove eye implant material	Y		A2	16.0160	$662.79
67121	Remove eye implant material	Y		A2	16.0160	$662.79
67141	Treatment of retina	Y		A2	5.6880	$235.37
67145	Treatment of retina	Y		P3	4.2680	$176.61
67208	Treatment of retinal lesion	Y		P3	4.5320	$187.57
67210	Treatment of retinal lesion	Y	CH	P3	4.7820	$197.88
67218	Treatment of retinal lesion	Y		A2	19.2090	$794.95
67220	Treatment of choroid lesion	Y		P2	5.6770	$234.95
67221	Ocular photodynamic ther	Y		P3	2.5700	$106.35
67225	Eye photodynamic ther add-on	Y		P3	0.1790	$7.41
67227	Treatment of retinal lesion	Y		A2	14.6840	$607.69
67228	Treatment of retinal lesion	Y		P2	5.2010	$215.23
67229*	Tr retinal les preterm inf	Y		R2	5.2010	$215.23
67250	Reinforce eye wall	Y		A2	15.3450	$635.05
67255	Reinforce/graft eye wall	Y		A2	16.7700	$694.00
67311	Revise eye muscle	Y		A2	17.9610	$743.31
67312	Revise two eye muscles	Y		A2	19.3750	$801.82
67314	Revise eye muscle	Y		A2	19.3750	$801.82
67316	Revise two eye muscles	Y		A2	19.3750	$801.82
67318	Revise eye muscle(s)	Y		A2	19.3750	$801.82
67320	Revise eye muscle(s) add-on	Y		A2	19.3750	$801.82
67331	Eye surgery follow-up add-on	Y		A2	19.3750	$801.82
67332	Rerevise eye muscles add-on	Y		A2	19.3750	$801.82

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HCPCS Code	Short Descriptor	Subject to Multiple Procedure Discounting	Comment Indicator	Payment Indicator	CY 2009 Second Year Transition Payment Weight	CY 2009 Second Year Transition Payment
67334	Revise eye muscle w/suture	Y		A2	19.3750	$801.82
67335	Eye suture during surgery	Y		A2	19.3750	$801.82
67340	Revise eye muscle add-on	Y		A2	19.3750	$801.82
67343	Release eye tissue	Y		A2	23.6760	$979.82
67345	Destroy nerve of eye muscle	Y		P3	1.7910	$74.13
67346	Biopsy, eye muscle	Y		A2	10.9330	$452.45
67400	Explore/biopsy eye socket	Y		A2	15.3450	$635.05
67405	Explore/drain eye socket	Y		A2	19.8540	$821.64
67412	Explore/treat eye socket	Y		A2	17.7850	$736.00
67413	Explore/treat eye socket	Y		A2	20.8790	$864.07
67414	Explr/decompress eye socket	Y		G2	37.2770	$1,542.67
67415	Aspiration, orbital contents	Y		A2	13.2600	$548.74
67420	Explore/treat eye socket	Y		A2	27.0870	$1,120.98
67430	Explore/treat eye socket	Y		A2	27.0870	$1,120.98
67440	Explore/drain eye socket	Y		A2	27.0870	$1,120.98
67445	Explr/decompress eye socket	Y		A2	27.0870	$1,120.98
67450	Explore/biopsy eye socket	Y		A2	27.0870	$1,120.98
67500	Inject/treat eye socket	N		G2	2.0500	$84.84
67505	Inject/treat eye socket	Y	CH	P3	0.5690	$23.53
67515	Inject/treat eye socket	Y		P3	0.5690	$23.53
67550	Insert eye socket implant	Y		A2	26.0620	$1,078.55
67560	Revise eye socket implant	Y		A2	17.6860	$731.92
67570	Decompress optic nerve	Y		A2	26.0620	$1,078.55
67700	Drainage of eyelid abscess	Y		P2	2.9240	$121.02
67710	Incision of eyelid	Y		P3	3.2320	$133.75
67715	Incision of eyelid fold	Y		A2	13.2600	$548.74
67800	Remove eyelid lesion	Y		P3	1.1370	$47.05
67801	Remove eyelid lesions	Y		P3	1.3710	$56.72
67805	Remove eyelid lesions	Y		P3	1.7830	$73.80
67808	Remove eyelid lesion(s)	Y		A2	14.5910	$603.84
67810	Biopsy of eyelid	Y		P2	2.9240	$121.02
67820	Revise eyelashes	N		P3	0.3740	$15.47
67825	Revise eyelashes	Y		P3	1.1680	$48.34
67830	Revise eyelashes	Y		A2	9.1000	$376.58
67835	Revise eyelashes	Y		A2	14.5910	$603.84
67840	Remove eyelid lesion	Y		P3	3.3720	$139.55
67850	Treat eyelid lesion	Y		P3	2.6710	$110.54
67875	Closure of eyelid by suture	Y		G2	7.6890	$318.19
67880	Revision of eyelid	Y		A2	13.9640	$577.89
67882	Revision of eyelid	Y		A2	15.3450	$635.05

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HCPCS Code	Short Descriptor	Subject to Multiple Procedure Discounting	Comment Indicator	Payment Indicator	CY 2009 Second Year Transition Payment Weight	CY 2009 Second Year Transition Payment
67900	Repair brow defect	Y		A2	19.8540	$821.64
67901	Repair eyelid defect	Y		A2	17.7850	$736.00
67902	Repair eyelid defect	Y		A2	20.8790	$864.07
67903	Repair eyelid defect	Y		A2	16.7590	$693.57
67904	Repair eyelid defect	Y		A2	16.7590	$693.57
67906	Repair eyelid defect	Y		A2	17.7850	$736.00
67908	Repair eyelid defect	Y		A2	16.7590	$693.57
67909	Revise eyelid defect	Y		A2	16.7590	$693.57
67911	Revise eyelid defect	Y		A2	15.3450	$635.05
67912	Correction eyelid w/implant	Y		A2	15.3450	$635.05
67914	Repair eyelid defect	Y		A2	15.3450	$635.05
67915	Repair eyelid defect	Y		P3	3.7150	$153.73
67916	Repair eyelid defect	Y		A2	16.7590	$693.57
67917	Repair eyelid defect	Y		A2	16.7590	$693.57
67921	Repair eyelid defect	Y		A2	15.3450	$635.05
67922	Repair eyelid defect	Y		P3	3.6140	$149.54
67923	Repair eyelid defect	Y		A2	16.7590	$693.57
67924	Repair eyelid defect	Y		A2	16.7590	$693.57
67930	Repair eyelid wound	Y		P3	3.7070	$153.41
67935	Repair eyelid wound	Y		A2	14.5910	$603.84
67938	Remove eyelid foreign body	N		P2	2.0500	$84.84
67950	Revision of eyelid	Y		A2	14.5910	$603.84
67961	Revision of eyelid	Y		A2	15.3450	$635.05
67966	Revision of eyelid	Y		A2	15.3450	$635.05
67971	Reconstruction of eyelid	Y		A2	15.3450	$635.05
67973	Reconstruction of eyelid	Y		A2	18.4400	$763.13
67974	Reconstruction of eyelid	Y		A2	15.3450	$635.05
67975	Reconstruction of eyelid	Y		A2	15.3450	$635.05
68020	Incise/drain eyelid lining	Y		P3	1.0050	$41.57
68040	Treatment of eyelid lesions	N		P3	0.4910	$20.30
68100	Biopsy of eyelid lining	Y		P3	2.0250	$83.79
68110	Remove eyelid lining lesion	Y		P3	2.6090	$107.97
68115	Remove eyelid lining lesion	Y		A2	14.5910	$603.84
68130	Remove eyelid lining lesion	Y		A2	13.2100	$546.68
68135	Remove eyelid lining lesion	Y		P3	1.2930	$53.50
68200	Treat eyelid by injection	N		P3	0.3740	$15.47
68320	Revise/graft eyelid lining	Y		A2	19.8540	$821.64
68325	Revise/graft eyelid lining	Y		A2	19.8540	$821.64
68326	Revise/graft eyelid lining	Y		A2	16.7590	$693.57
68328	Revise/graft eyelid lining	Y		A2	19.8540	$821.64

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HCPCS Code	Short Descriptor	Subject to Multiple Procedure Discounting	Comment Indicator	Payment Indicator	CY 2009 Second Year Transition Payment Weight	CY 2009 Second Year Transition Payment
68330	Revise eyelid lining	Y		A2	19.1220	$791.33
68335	Revise/graft eyelid lining	Y		A2	19.8540	$821.64
68340	Separate eyelid adhesions	Y		A2	16.7590	$693.57
68360	Revise eyelid lining	Y		A2	16.9530	$701.60
68362	Revise eyelid lining	Y		A2	16.9530	$701.60
68371	Harvest eye tissue, alograft	Y		A2	13.2100	$546.68
68400	Incise/drain tear gland	Y		P2	2.9240	$121.02
68420	Incise/drain tear sac	Y		P3	3.9170	$162.11
68440	Incise tear duct opening	Y		P3	1.1450	$47.38
68500	Removal of tear gland	Y		A2	18.4400	$763.13
68505	Partial removal, tear gland	Y		A2	18.4400	$763.13
68510	Biopsy of tear gland	Y		A2	13.2600	$548.74
68520	Removal of tear sac	Y		A2	18.4400	$763.13
68525	Biopsy of tear sac	Y		A2	13.2600	$548.74
68530	Clearance of tear duct	Y	CH	P2	2.9240	$121.02
68540	Remove tear gland lesion	Y		A2	15.3450	$635.05
68550	Remove tear gland lesion	Y		A2	18.4400	$763.13
68700	Repair tear ducts	Y		A2	14.5910	$603.84
68705	Revise tear duct opening	Y	CH	P3	2.6010	$107.64
68720	Create tear sac drain	Y		A2	19.8540	$821.64
68745	Create tear duct drain	Y		A2	19.8540	$821.64
68750	Create tear duct drain	Y		A2	19.8540	$821.64
68760	Close tear duct opening	Y	CH	P3	2.2200	$91.85
68761	Close tear duct opening	Y		P3	1.5260	$63.17
68770	Close tear system fistula	Y		A2	19.8540	$821.64
68801	Dilate tear duct opening	N		P2	0.8910	$36.89
68810	Probe nasolacrimal duct	N		A2	2.5790	$106.72
68811	Probe nasolacrimal duct	Y		A2	14.5910	$603.84
68815	Probe nasolacrimal duct	Y		A2	14.5910	$603.84
68816*	Probe nl duct w/balloon	Y		P3	10.0070	$414.14
68840	Explore/irrigate tear ducts	N		P3	1.1990	$49.63
68850	Injection for tear sac x-ray	N		N1		
69000	Drain external ear lesion	Y		P2	1.3920	$57.59
69005	Drain external ear lesion	Y		P3	2.3360	$96.69
69020	Drain outer ear canal lesion	Y		P2	1.3920	$57.59
69100	Biopsy of external ear	Y		P3	1.4100	$58.33
69105	Biopsy of external ear canal	Y		P3	2.0090	$83.15
69110	Remove external ear, partial	Y		A2	11.6630	$482.66
69120	Removal of external ear	Y		A2	17.2680	$714.63
69140	Remove ear canal lesion(s)	Y		A2	17.2680	$714.63

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HCPCS Code	Short Descriptor	Subject to Multiple Procedure Discounting	Comment Indicator	Payment Indicator	CY 2009 Second Year Transition Payment Weight	CY 2009 Second Year Transition Payment
69145	Remove ear canal lesion(s)	Y		A2	12.9940	$537.76
69150	Extensive ear canal surgery	Y		A2	9.2490	$382.75
69200	Clear outer ear canal	N		P2	0.6320	$26.16
69205	Clear outer ear canal	Y		A2	14.5290	$601.28
69210	Remove impacted ear wax	N		P3	0.4670	$19.34
69220	Clean out mastoid cavity	Y		P2	0.8130	$33.63
69222	Clean out mastoid cavity	Y		P3	3.0680	$126.98
69300	Revise external ear	Y		A2	18.0220	$745.84
69310	Rebuild outer ear canal	Y		A2	26.3080	$1,088.73
69320	Rebuild outer ear canal	Y		A2	32.0230	$1,325.24
69400	Inflate middle ear canal	Y		P3	2.0640	$85.41
69401	Inflate middle ear canal	Y		P3	1.0830	$44.80
69405	Catheterize middle ear canal	Y		P3	2.8270	$116.99
69420	Incision of eardrum	Y	CH	P3	2.5540	$105.71
69421	Incision of eardrum	Y		A2	14.3950	$595.72
69424	Remove ventilating tube	Y		P3	1.7990	$74.45
69433	Create eardrum opening	Y		P3	2.5470	$105.39
69436	Create eardrum opening	Y		A2	14.3950	$595.72
69440	Exploration of middle ear	Y		A2	18.0220	$745.84
69450	Eardrum revision	Y		A2	24.2220	$1,002.41
69501	Mastoidectomy	Y		A2	32.0230	$1,325.24
69502	Mastoidectomy	Y		A2	23.7370	$982.35
69505	Remove mastoid structures	Y		A2	32.0230	$1,325.24
69511	Extensive mastoid surgery	Y		A2	32.0230	$1,325.24
69530	Extensive mastoid surgery	Y		A2	32.0230	$1,325.24
69540	Remove ear lesion	Y		P3	3.0060	$124.40
69550	Remove ear lesion	Y		A2	28.7470	$1,189.67
69552	Remove ear lesion	Y		A2	32.0230	$1,325.24
69601	Mastoid surgery revision	Y		A2	32.0230	$1,325.24
69602	Mastoid surgery revision	Y		A2	32.0230	$1,325.24
69603	Mastoid surgery revision	Y		A2	32.0230	$1,325.24
69604	Mastoid surgery revision	Y		A2	32.0230	$1,325.24
69605	Mastoid surgery revision	Y		A2	32.0230	$1,325.24
69610	Repair of eardrum	Y		P3	3.9560	$163.72
69620	Repair of eardrum	Y		A2	17.2680	$714.63
69631	Repair eardrum structures	Y		A2	28.7470	$1,189.67
69632	Rebuild eardrum structures	Y		A2	28.7470	$1,189.67
69633	Rebuild eardrum structures	Y		A2	28.7470	$1,189.67
69635	Repair eardrum structures	Y		A2	32.0230	$1,325.24
69636	Rebuild eardrum structures	Y		A2	32.0230	$1,325.24

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69637	Rebuild eardrum structures	Y		A2	32.0230	$1,325.24
69641	Revise middle ear & mastoid	Y		A2	32.0230	$1,325.24
69642	Revise middle ear & mastoid	Y		A2	32.0230	$1,325.24
69643	Revise middle ear & mastoid	Y		A2	32.0230	$1,325.24
69644	Revise middle ear & mastoid	Y		A2	32.0230	$1,325.24
69645	Revise middle ear & mastoid	Y		A2	32.0230	$1,325.24
69646	Revise middle ear & mastoid	Y		A2	32.0230	$1,325.24
69650	Release middle ear bone	Y		A2	23.7370	$982.35
69660	Revise middle ear bone	Y		A2	28.7470	$1,189.67
69661	Revise middle ear bone	Y		A2	28.7470	$1,189.67
69662	Revise middle ear bone	Y		A2	28.7470	$1,189.67
69666	Repair middle ear structures	Y		A2	27.7220	$1,147.24
69667	Repair middle ear structures	Y		A2	27.7220	$1,147.24
69670	Remove mastoid air cells	Y		A2	26.3080	$1,088.73
69676	Remove middle ear nerve	Y		A2	26.3080	$1,088.73
69700	Close mastoid fistula	Y		A2	26.3080	$1,088.73
69711	Remove/repair hearing aid	Y		A2	24.2220	$1,002.41
69714	Implant temple bone w/stimul	Y		A2	74.5740	$3,086.15
69715	Temple bne implnt w/stimulat	Y		A2	74.5740	$3,086.15
69717	Temple bone implant revision	Y		A2	74.5740	$3,086.15
69718	Revise temple bone implant	Y		A2	74.5740	$3,086.15
69720	Release facial nerve	Y		A2	28.7470	$1,189.67
69740	Repair facial nerve	Y		A2	28.7470	$1,189.67
69745	Repair facial nerve	Y		A2	28.7470	$1,189.67
69801	Incise inner ear	Y		A2	28.7470	$1,189.67
69802	Incise inner ear	Y		A2	32.0230	$1,325.24
69805	Explore inner ear	Y		A2	32.0230	$1,325.24
69806	Explore inner ear	Y		A2	32.0230	$1,325.24
69820	Establish inner ear window	Y		A2	28.7470	$1,189.67
69840	Revise inner ear window	Y		A2	28.7470	$1,189.67
69905	Remove inner ear	Y		A2	32.0230	$1,325.24
69910	Remove inner ear & mastoid	Y		A2	32.0230	$1,325.24
69915	Incise inner ear nerve	Y		A2	32.0230	$1,325.24
69930	Implant cochlear device	Y		H8	549.5770	$22,743.69
69990	Microsurgery add-on	N		N1		
C9716	Radiofrequency energy to anu	Y		G2	30.4300	$1,259.30
C9724	EPS gast cardia plic	Y		G2	25.8060	$1,067.94
C9725	Place endorectal app	Y		G2	2.1520	$89.05
C9726	Rxt breast appl place/remov	Y		G2	20.9690	$867.79
C9727	Insert palate implants	Y		G2	7.5590	$312.82

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C9728*	Place device/marker, non pro	N		R2	13.3710	$553.35
G0104	CA screen;flexi sigmoidscope	N		P3	1.9390	$80.25
G0105	Colorectal scrn; hi risk ind	Y		A2	9.1560	$378.90
G0121	Colon ca scrn not hi rsk ind	Y		A2	9.1560	$378.90
G0127	Trim nail(s)	Y		P3	0.2730	$11.28
G0186	Dstry eye lesn,fdr vssl tech	Y		R2	5.6770	$234.95
G0247	Routine footcare pt w lops	Y		P3	0.4990	$20.63
G0259	Inject for sacroiliac joint	N		N1		
G0260	Inj for sacroiliac jt anesth	Y		A2	7.5090	$310.74
G0268	Removal of impacted wax md	N		N1		
G0269	Occlusive device in vein art	N		N1		
G0289	Arthro, loose body + chondro	N		N1		
G0364	Bone marrow aspirate &biopsy	N		P3	0.1250	$5.16
G0392	AV fistula or graft arterial	Y		A2	39.3160	$1,627.05
G0393	AV fistula or graft venous	Y		A2	39.3160	$1,627.05

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ADDENDUM B.--PROPOSED OPPS PAYMENT BY HCPCS CODE FOR CY 2009

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0001F	Heart failure composite		M					
0005F	Osteoarthritis composite		M					
00100	Anesth, salivary gland		N					
00102	Anesth, repair of cleft lip		N					
00103	Anesth, blepharoplasty		N					
00104	Anesth, electroshock		N					
00120	Anesth, ear surgery		N					
00124	Anesth, ear exam		N					
00126	Anesth, tympanotomy		N					
0012F	Cap bacterial assess		M					
00140	Anesth, procedures on eye		N					
00142	Anesth, lens surgery		N					
00144	Anesth, corneal transplant		N					
00145	Anesth, vitreoretinal surg		N					
00147	Anesth, iridectomy		N					
00148	Anesth, eye exam		N					
0014F	Comp preop assess cat surg		M					
0015F	Melan follow-up complete		M					
00160	Anesth, nose/sinus surgery		N					
00162	Anesth, nose/sinus surgery		N					
00164	Anesth, biopsy of nose		N					
0016T	Thermotx choroid vasc lesion		T	0235	5.8210	$382.35		$76.47
00170	Anesth, procedure on mouth		N					
00172	Anesth, cleft palate repair		N					
00174	Anesth, pharyngeal surgery		N					
00176	Anesth, pharyngeal surgery		C					
0017T	Photocoagulat macular drusen		T	0235	5.8210	$382.35		$76.47
00190	Anesth, face/skull bone surg		N					
00192	Anesth, facial bone surgery		C					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0019T	Extracorp shock wv tx,ms nos		A					
00210	Anesth, open head surgery		N					
00212	Anesth, skull drainage		N					
00214	Anesth, skull drainage		C					
00215	Anesth, skull repair/fract		C					
00216	Anesth, head vessel surgery		N					
00218	Anesth, special head surgery		N					
00220	Anesth, intrcrn nerve		N					
00222	Anesth, head nerve surgery		N					
0026T	Measure remnant lipoproteins		A					
0027T	Endoscopic epidural lysis		T	0220	18.4356	$1,210.92		$242.19
0028T	Dexa body composition study		N					
0029T	Magnetic tx for incontinence		A					
00300	Anesth, head/neck/ptrunk		N					
0030T	Antiprothrombin antibody		A					
0031T	Speculoscopy		N					
00320	Anesth, neck organ, 1 & over		N					
00322	Anesth, biopsy of thyroid		N					
00326	Anesth, larynx/trach, < 1 yr		N					
0032T	Speculoscopy w/direct sample		N					
00350	Anesth, neck vessel surgery		N					
00352	Anesth, neck vessel surgery		N					
00400	Anesth, skin, ext/per/atrunk		N					
00402	Anesth, surgery of breast		N					
00404	Anesth, surgery of breast		N					
00406	Anesth, surgery of breast		N					
00410	Anesth, correct heart rhythm		N					
0041T	Detect ur infect agnt w/cpas		A					
0042T	Ct perfusion w/contrast, cbf		N					
0043T	Co expired gas analysis		A					
00450	Anesth, surgery of shoulder		N					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
00452	Anesth, surgery of shoulder		C					
00454	Anesth, collar bone biopsy		N					
0046T	Cath lavage, mammary duct(s)		T	0021	15.8699	$1,042.40	$219.48	$208.48
00470	Anesth, removal of rib		N					
00472	Anesth, chest wall repair		N					
00474	Anesth, surgery of rib(s)		C					
0047T	Cath lavage, mammary duct(s)		T	0021	15.8699	$1,042.40	$219.48	$208.48
0048T	Implant ventricular device		C					
0049T	External circulation assist		C					
00500	Anesth, esophageal surgery		N					
0050T	Removal circulation assist		C					
0051T	Implant total heart system		C					
00520	Anesth, chest procedure		N					
00522	Anesth, chest lining biopsy		N					
00524	Anesth, chest drainage		C					
00528	Anesth, chest partition view		N					
00529	Anesth, chest partition view		N					
0052T	Replace component heart syst		C					
00530	Anesth, pacemaker insertion		N					
00532	Anesth, vascular access		N					
00534	Anesth, cardioverter/defib		N					
00537	Anesth, cardiac electrophys		N					
00539	Anesth, trach-bronch reconst		N					
0053T	Replace component heart syst		C					
00540	Anesth, chest surgery		C					
00541	Anesth, one lung ventilation		N					
00542	Anesth, release of lung		C					
00546	Anesth, lung,chest wall surg		C					
00548	Anesth, trachea,bronchi surg		N					
00550	Anesth, sternal debridement		N					
00560	Anesth, heart surg w/o pump		C					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
00561	Anesth, heart surg < age 1		C					
00562	Anesth, heart surg w/pump		C					
00563	Anesth, heart surg w/arrest		N					
00566	Anesth, cabg w/o pump		N					
00580	Anesth, heart/lung transplnt		C					
0058T	Cryopreservation, ovary tiss		X	0344	0.8373	$55.00	$15.66	$11.00
0059T	Cryopreservation, oocyte		X	0344	0.8373	$55.00	$15.66	$11.00
00600	Anesth, spine, cord surgery		N					
00604	Anesth, sitting procedure		C					
0060T	Electrical impedance scan		B					
0061T	Destruction of tumor, breast		B					
00620	Anesth, spine, cord surgery		N					
00622	Anesth, removal of nerves		C					
00625	Anes spine tranthor w/o vent		N					
00626	Anes, spine transthor w/vent		N					
0062T	Rep intradisc annulus;1 lev		T	0050	29.4401	$1,933.74		$386.75
00630	Anesth, spine, cord surgery		N					
00632	Anesth, removal of nerves		C					
00634	Anesth for chemonucleolysis		N					
00635	Anesth, lumbar puncture		N					
0063T	Rep intradisc annulus;>1lev		T	0050	29.4401	$1,933.74		$386.75
00640	Anesth, spine manipulation		N					
0064T	Spectroscop eval expired gas		X	0367	0.5744	$37.73	$13.76	$7.55
0066T	Ct colonography;screen		E					
00670	Anesth, spine, cord surgery		C					
0067T	Ct colonography;dx	CH	Q3	0332	2.9900	$196.40	$75.24	$39.28
0068T	Interp/rept heart sound		B					
0069T	Analysis only heart sound		N					
00700	Anesth, abdominal wall surg		N					
00702	Anesth, for liver biopsy		N					
0070T	Interp only heart sound		B					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0071T	U/s leiomyomata ablate <200		S	0067	55.7874	$3,664.34		$732.87
0072T	U/s leiomyomata ablate >200		S	0067	55.7874	$3,664.34		$732.87
00730	Anesth, abdominal wall surg		N					
0073T	Delivery, comp imrt		S	0412	5.5272	$363.05		$72.61
00740	Anesth, upper gi visualize		N					
00750	Anesth, repair of hernia		N					
00752	Anesth, repair of hernia		N					
00754	Anesth, repair of hernia		N					
00756	Anesth, repair of hernia		N					
0075T	Perq stent/chest vert art		C					
0076T	S&i stent/chest vert art		C					
00770	Anesth, blood vessel repair		N					
0077T	Cereb therm perfusion probe		C					
0078T	Endovasc aort repr w/device		C					
00790	Anesth, surg upper abdomen		N					
00792	Anesth, hemorr/excise liver		C					
00794	Anesth, pancreas removal		C					
00796	Anesth, for liver transplant		C					
00797	Anesth, surgery for obesity		N					
0079T	Endovasc visc extnsn repr		C					
00800	Anesth, abdominal wall surg		N					
00802	Anesth, fat layer removal		C					
0080T	Endovasc aort repr rad s&i		C					
00810	Anesth, low intestine scope		N					
0081T	Endovasc visc extnsn s&i		C					
00820	Anesth, abdominal wall surg		N					
00830	Anesth, repair of hernia		N					
00832	Anesth, repair of hernia		N					
00834	Anesth, hernia repair< 1 yr		N					
00836	Anesth hernia repair preemie		N					
00840	Anesth, surg lower abdomen		N					

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00842	Anesth, amniocentesis		N					
00844	Anesth, pelvis surgery		C					
00846	Anesth, hysterectomy		C					
00848	Anesth, pelvic organ surg		C					
0084T	Temp prostate urethral stent		T	0164	2.2063	$144.92		$28.99
00851	Anesth, tubal ligation		N					
0085T	Breath test heart reject		X	0340	0.6481	$42.57		$8.52
00860	Anesth, surgery of abdomen		N					
00862	Anesth, kidney/ureter surg		N					
00864	Anesth, removal of bladder		C					
00865	Anesth, removal of prostate		C					
00866	Anesth, removal of adrenal		C					
00868	Anesth, kidney transplant		C					
0086T	L ventricle fill pressure		N					
00870	Anesth, bladder stone surg		N					
00872	Anesth kidney stone destruct		N					
00873	Anesth kidney stone destruct		N					
0087T	Sperm eval hyaluronan		X	0344	0.8373	$55.00	$15.66	$11.00
00880	Anesth, abdomen vessel surg		N					
00882	Anesth, major vein ligation		C					
0088T	Rf tongue base vol reduxn		T	0253	17.1953	$1,129.46	$282.29	$225.90
0089T	Actigraphy testing, 3-day		S	0218	1.2004	$78.85		$15.77
00902	Anesth, anorectal surgery		N					
00904	Anesth, perineal surgery		C					
00906	Anesth, removal of vulva		N					
00908	Anesth, removal of prostate		C					
0090T	Cervical artific disc		C					
00910	Anesth, bladder surgery		N					
00912	Anesth, bladder tumor surg		N					
00914	Anesth, removal of prostate		N					
00916	Anesth, bleeding control		N					

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00918	Anesth, stone removal		N					
00920	Anesth, genitalia surgery		N					
00921	Anesth, vasectomy		N					
00922	Anesth, sperm duct surgery		N					
00924	Anesth, testis exploration		N					
00926	Anesth, removal of testis		N					
00928	Anesth, removal of testis		N					
0092T	Artific disc addl		C					
00930	Anesth, testis suspension		N					
00932	Anesth, amputation of penis		C					
00934	Anesth, penis, nodes removal		C					
00936	Anesth, penis, nodes removal		C					
00938	Anesth, insert penis device		N					
0093T	Cervical artific diskectomy		C					
00940	Anesth, vaginal procedures		N					
00942	Anesth, surg on vag/urethral		N					
00944	Anesth, vaginal hysterectomy		C					
00948	Anesth, repair of cervix		N					
00950	Anesth, vaginal endoscopy		N					
00952	Anesth, hysteroscope/graph		N					
0095T	Artific diskectomy addl		C					
0096T	Rev cervical artific disc		C					
0098T	Rev artific disc addl		C					
0099T	Implant corneal ring		T	0233	16.3116	$1,071.41	$266.33	$214.29
0100T	Prosth retina receive&gen		T	0672	37.8896	$2,488.74		$497.75
0101T	Extracorp shockwv tx,hi enrg		T	0050	29.4401	$1,933.74		$386.75
0102T	Extracorp shockwv tx,anesth		T	0050	29.4401	$1,933.74		$386.75
0103T	Holotranscobalamin		A					
0104T	At rest cardio gas rebreathe		A					
0105T	Exerc cardio gas rebreathe		A					
0106T	Touch quant sensory test		X	0341	0.0847	$5.56	$2.14	$1.12

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0107T	Vibrate quant sensory test		X	0341	0.0847	$5.56	$2.14	$1.12
0108T	Cool quant sensory test		X	0341	0.0847	$5.56	$2.14	$1.12
0109T	Heat quant sensory test		X	0341	0.0847	$5.56	$2.14	$1.12
0110T	Nos quant sensory test		X	0341	0.0847	$5.56	$2.14	$1.12
01112	Anesth, bone aspirate/bx		N					
0111T	Rbc membranes fatty acids		A					
01120	Anesth, pelvis surgery		N					
01130	Anesth, body cast procedure		N					
01140	Anesth, amputation at pelvis		C					
01150	Anesth, pelvic tumor surgery		C					
01160	Anesth, pelvis procedure		N					
01170	Anesth, pelvis surgery		N					
01173	Anesth, fx repair, pelvis		N					
01180	Anesth, pelvis nerve removal		N					
01190	Anesth, pelvis nerve removal		N					
01200	Anesth, hip joint procedure		N					
01202	Anesth, arthroscopy of hip		N					
01210	Anesth, hip joint surgery		N					
01212	Anesth, hip disarticulation		C					
01214	Anesth, hip arthroplasty		C					
01215	Anesth, revise hip repair		N					
01220	Anesth, procedure on femur		N					
01230	Anesth, surgery of femur		N					
01232	Anesth, amputation of femur		C					
01234	Anesth, radical femur surg		C					
0123T	Scleral fistulization		T	0234	23.9886	$1,575.67	$511.31	$315.14
0124T	Conjunctival drug placement		T	0232	4.5980	$302.02	$75.66	$60.41
01250	Anesth, upper leg surgery		N					
01260	Anesth, upper leg veins surg		N					
0126T	Chd risk imt study		Q1	0340	0.6481	$42.57		$8.52
01270	Anesth, thigh arteries surg		N					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
01272	Anesth, femoral artery surg		C					
01274	Anesth, femoral embolectomy		C					
0130T	Chron care drug investigatn		B					
01320	Anesth, knee area surgery		N					
01340	Anesth, knee area procedure		N					
01360	Anesth, knee area surgery		N					
0137T	Prostate saturation sampling		T	0184	11.8068	$775.52		$155.11
01380	Anesth, knee joint procedure		N					
01382	Anesth, dx knee arthroscopy		N					
01390	Anesth, knee area procedure		N					
01392	Anesth, knee area surgery		N					
01400	Anesth, knee joint surgery		N					
01402	Anesth, knee arthroplasty		C					
01404	Anesth, amputation at knee		C					
0140T	Exhaled breath condensate ph		A					
0141T	Perq islet transplant		E					
01420	Anesth, knee joint casting		N					
0142T	Open islet transplant		E					
01430	Anesth, knee veins surgery		N					
01432	Anesth, knee vessel surg		N					
0143T	Laparoscopic islet transplnt		E					
01440	Anesth, knee arteries surg		N					
01442	Anesth, knee artery surg		C					
01444	Anesth, knee artery repair		C					
0144T	CT heart wo dye; qual calc		S	0282	1.6117	$105.86	$37.81	$21.18
0145T	CT heart w/wo dye funct		S	0383	4.3282	$284.29	$111.16	$56.86
01462	Anesth, lower leg procedure		N					
01464	Anesth, ankle/ft arthroscopy		N					
0146T	CCTA w/wo dye		S	0383	4.3282	$284.29	$111.16	$56.86
01470	Anesth, lower leg surgery		N					
01472	Anesth, achilles tendon surg		N					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
01474	Anesth, lower leg surgery		N					
0147T	CCTA w/wo, quan calcium		S	0383	4.3282	$284.29	$111.16	$56.86
01480	Anesth, lower leg bone surg		N					
01482	Anesth, radical leg surgery		N					
01484	Anesth, lower leg revision		N					
01486	Anesth, ankle replacement		C					
0148T	CCTA w/wo, strxr		S	0383	4.3282	$284.29	$111.16	$56.86
01490	Anesth, lower leg casting		N					
0149T	CCTA w/wo, strxr quan calc		S	0383	4.3282	$284.29	$111.16	$56.86
01500	Anesth, leg arteries surg		N					
01502	Anesth, lwr leg embolectomy		C					
0150T	CCTA w/wo, disease strxr		S	0383	4.3282	$284.29	$111.16	$56.86
0151T	CT heart funct add-on		S	0282	1.6117	$105.86	$37.81	$21.18
01520	Anesth, lower leg vein surg		N					
01522	Anesth, lower leg vein surg		N					
0155T	Lap impl gast curve electrd		T	0130	37.5470	$2,466.24	$659.53	$493.25
0156T	Lap remv gast curve electrd		T	0130	37.5470	$2,466.24	$659.53	$493.25
0157T	Open impl gast curve electrd		C					
0158T	Open remv gast curve electrd		C					
0159T	Cad breast mri		N					
0160T	Tcranial magn stim tx plan		S	0216	2.7194	$178.62		$35.73
01610	Anesth, surgery of shoulder		N					
0161T	Tcranial magn stim tx deliv		S	0216	2.7194	$178.62		$35.73
01620	Anesth, shoulder procedure		N					
01622	Anes dx shoulder arthroscopy		N					
0162T	Anal program gast neurostim		S	0692	1.7241	$113.25		$22.65
01630	Anesth, surgery of shoulder		N					
01632	Anesth, surgery of shoulder		C					
01634	Anesth, shoulder joint amput		C					
01636	Anesth, forequarter amput		C					
01638	Anesth, shoulder replacement		C					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0163T	Lumb artif diskectomy addl		C					
0164T	Remove lumb artif disc addl		C					
01650	Anesth, shoulder artery surg		N					
01652	Anesth, shoulder vessel surg		C					
01654	Anesth, shoulder vessel surg		C					
01656	Anesth, arm-leg vessel surg		C					
0165T	Revise lumb artif disc addl		C					
0166T	Tcath vsd close w/o bypass		C					
01670	Anesth, shoulder vein surg		N					
0167T	Tcath vsd close w bypass		C					
01680	Anesth, shoulder casting		N					
01682	Anesth, airplane cast		N					
0168T	Rhinophototx light app bilat		T	0251	3.1568	$207.35		$41.47
0169T	Place stereo cath brain		C					
0170T	Anorectal fistula plug rpr		T	0150	31.2003	$2,049.36	$437.12	$409.88
01710	Anesth, elbow area surgery		N					
01712	Anesth, uppr arm tendon surg		N					
01714	Anesth, uppr arm tendon surg		N					
01716	Anesth, biceps tendon repair		N					
0171T	Lumbar spine proces distract	CH	T	0052	85.4915	$5,615.42		$1,123.09
0172T	Lumbar spine process addl	CH	T	0052	85.4915	$5,615.42		$1,123.09
01730	Anesth, uppr arm procedure		N					
01732	Anesth, dx elbow arthroscopy		N					
0173T	Iop monit io pressure		N					
01740	Anesth, upper arm surgery		N					
01742	Anesth, humerus surgery		N					
01744	Anesth, humerus repair		N					
0174T	Cad cxr with interp		N					
01756	Anesth, radical humerus surg		C					
01758	Anesth, humeral lesion surg		N					
0175T	Cad cxr remote		N					

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01760	Anesth, elbow replacement		N					
0176T	Aqu canal dilat w/o retent		T	0673	40.1189	$2,635.17	$649.56	$527.04
01770	Anesth, uppr arm artery surg		N					
01772	Anesth, uppr arm embolectomy		N					
0177T	Aqu canal dilat w retent		T	0673	40.1189	$2,635.17	$649.56	$527.04
01780	Anesth, upper arm vein surg		N					
01782	Anesth, uppr arm vein repair		N					
0178T	64 lead ecg w i&r		B					
0179T	64 lead ecg w tracing		X	0100	2.5931	$170.33	$41.44	$34.07
0180T	64 lead ecg w i&r only		B					
01810	Anesth, lower arm surgery		N					
0181T	Corneal hysteresis		S	0230	0.6359	$41.77		$8.36
01820	Anesth, lower arm procedure		N					
01829	Anesth, dx wrist arthroscopy		N					
0182T	Hdr elect brachytherapy		S	1519		$1,750.00		$350.00
01830	Anesth, lower arm surgery		N					
01832	Anesth, wrist replacement		N					
0183T	Wound ultrasound		T	0015	1.5126	$99.35		$19.87
01840	Anesth, lwr arm artery surg		N					
01842	Anesth, lwr arm embolectomy		N					
01844	Anesth, vascular shunt surg		N					
0184T	Exc rectal tumor endoscopic		C					
01850	Anesth, lower arm vein surg		N					
01852	Anesth, lwr arm vein repair		N					
0185T	Comptr probability analysis		N					
01860	Anesth, lower arm casting		N					
0186T	Suprachoroidal drug delivery	CH	T	0237	22.0653	$1,449.34		$289.87
0187T	Ophthalmic dx image anterior		S	0230	0.6359	$41.77		$8.36
01916	Anesth, dx arteriography		N					
01920	Anesth, catheterize heart		N					
01922	Anesth, cat or MRI scan		N					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
01924	Anes, ther interven rad, art		N					
01925	Anes, ther interven rad, car		N					
01926	Anes, tx interv rad hrt/cran		N					
01930	Anes, ther interven rad, vei		N					
01931	Anes, ther interven rad, tip		N					
01932	Anes, tx interv rad, th vein		N					
01933	Anes, tx interv rad, cran v		N					
01935	Anesth, perc img dx sp proc		N					
01936	Anesth, perc img tx sp proc		N					
01951	Anesth, burn, less 4 percent		N					
01952	Anesth, burn, 4-9 percent		N					
01953	Anesth, burn, each 9 percent		N					
01958	Anesth, antepartum manipul		N					
01960	Anesth, vaginal delivery		N					
01961	Anesth, cs delivery		N					
01962	Anesth, emer hysterectomy		N					
01963	Anesth, cs hysterectomy		N					
01965	Anesth, inc/missed ab proc		N					
01966	Anesth, induced ab procedure		N					
01967	Anesth/analg, vag delivery		N					
01968	Anes/analg cs deliver add-on		N					
01969	Anesth/analg cs hyst add-on		N					
01990	Support for organ donor		C					
01991	Anesth, nerve block/inj		N					
01992	Anesth, n block/inj, prone		N					
01996	Hosp manage cont drug admin		N					
01999	Unlisted anesth procedure		N					
0500F	Initial prenatal care visit		M					
0501F	Prenatal flow sheet		M					
0502F	Subsequent prenatal care		M					
0503F	Postpartum care visit		M					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0505F	Hemodialysis plan docd		M					
0507F	Periton dialysis plan docd		M					
0509F	Urine incon plan docd		M					
0513F	Elev bp plan of care docd		M					
0514F	Care plan hgb docd esa pt		M					
0516F	Anemia plan of care docd		M					
0517F	Glaucoma plan of care docd		M					
0518F	Fall plan of care docd		M					
0519F	Pland chemo docd b/4 txmnt		M					
0520F	Tissue dose done w/in 5 days		M					
0521F	Plan of care 4 pain docd		M					
0525F	Initial visit for episode		M					
0526F	Subs visit for episode		M					
1000F	Tobacco use assessed		M					
10021	Fna w/o image		T	0002	1.5340	$100.76		$20.16
10022	Fna w/image		T	0004	4.5254	$297.25		$59.45
1002F	Assess anginal symptom/level		M					
1003F	Level of activity assess		M					
10040	Acne surgery		T	0013	0.8332	$54.73		$10.95
1004F	Clin symp vol ovrld assess		M					
1005F	Asthma symptoms evaluate		M					
10060	Drainage of skin abscess		T	0006	1.4267	$93.71		$18.75
10061	Drainage of skin abscess		T	0006	1.4267	$93.71		$18.75
1006F	Osteoarthritis assess		M					
1007F	Anti-inflm/anlgsc otc assess		M					
10080	Drainage of pilonidal cyst		T	0006	1.4267	$93.71		$18.75
10081	Drainage of pilonidal cyst		T	0007	12.8052	$841.10		$168.22
1008F	Gi/renal risk assess		M					
10120	Remove foreign body	CH	T	0016	2.7062	$177.75		$35.55
10121	Remove foreign body		T	0021	15.8699	$1,042.40	$219.48	$208.48
10140	Drainage of hematoma/fluid		T	0007	12.8052	$841.10		$168.22

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
1015F	Copd symptoms assess		M					
10160	Puncture drainage of lesion		T	0006	1.4267	$93.71		$18.75
10180	Complex drainage, wound		T	0008	19.5771	$1,285.90		$257.18
1018F	Assess dyspnea not present		M					
1019F	Assess dyspnea present		M					
1022F	Pneumo imm status assess		M					
1026F	Co-morbid condition assess		M					
1030F	Influenza imm status assess		M					
1034F	Current tobacco smoker		M					
1035F	Smokeless tobacco user		M					
1036F	Tobacco non-user		M					
1038F	Persistent asthma		M					
1039F	Intermittent asthma		M					
1040F	DSM-IV info MDD docd		M					
1050F	History of mole changes		M					
1055F	Visual funct status assess		M					
1060F	Doc perm/cont/parox atr fib		M					
1061F	Doc lack perm+cont+parox fib		M					
1065F	Ischm stroke symp lt3 hrsb/4		M					
1066F	Ischm stroke symp ge3 hrsb/4		M					
1070F	Alarm symp assessed-absent		M					
1071F	Alarm symp assessed-1+ prsnt		M					
1090F	Pres/absn urine incon assess		M					
1091F	Urine incon characterized		M					
11000	Debride infected skin	CH	T	0015	1.5126	$99.35		$19.87
11001	Debride infected skin add-on		T	0013	0.8332	$54.73		$10.95
11004	Debride genitalia & perineum		C					
11005	Debride abdom wall		C					
11006	Debride genit/per/abdom wall		C					
11008	Remove mesh from abd wall		C					
1100F	Ptfalls assess-docd ge2+/yr		M					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
11010	Debride skin, fx		T	0019	4.3877	$288.20	$71.87	$57.64
11011	Debride skin/muscle, fx		T	0019	4.3877	$288.20	$71.87	$57.64
11012	Debride skin/muscle/bone, fx		T	0019	4.3877	$288.20	$71.87	$57.64
1101F	Pt falls assess-docd le1/yr		M					
11040	Debride skin, partial		T	0015	1.5126	$99.35		$19.87
11041	Debride skin, full		T	0015	1.5126	$99.35		$19.87
11042	Debride skin/tissue		T	0016	2.7062	$177.75		$35.55
11043	Debride tissue/muscle		T	0016	2.7062	$177.75		$35.55
11044	Debride tissue/muscle/bone		T	0682	7.3423	$482.27	$158.65	$96.46
11055	Trim skin lesion		T	0013	0.8332	$54.73		$10.95
11056	Trim skin lesions, 2 to 4		T	0013	0.8332	$54.73		$10.95
11057	Trim skin lesions, over 4	CH	T	0013	0.8332	$54.73		$10.95
11100	Biopsy, skin lesion	CH	T	0015	1.5126	$99.35		$19.87
11101	Biopsy, skin add-on		T	0013	0.8332	$54.73		$10.95
1110F	Pt lft inpt fac w/in 60 days		M					
1111F	Dschrg med/current med merge		M					
1116F	Auric/peri pain assessed		M					
1118F	GERD symps assessed 12 month		M					
1119F	Init eval for condition		M					
11200	Removal of skin tags		T	0013	0.8332	$54.73		$10.95
11201	Remove skin tags add-on	CH	T	0013	0.8332	$54.73		$10.95
1121F	Subs eval for condition		M					
1123F	ACP discuss/dscn mkr docd		M					
1124F	ACP discuss-no dscnmkr docd		M					
1125F	Amnt pain noted pain prsnt		M					
1126F	Amnt pain noted none prsnt		M					
1127F	New episode for condition		M					
1128F	Subs episode for condition		M					
11300	Shave skin lesion		T	0013	0.8332	$54.73		$10.95
11301	Shave skin lesion		T	0013	0.8332	$54.73		$10.95
11302	Shave skin lesion		T	0013	0.8332	$54.73		$10.95

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
11303	Shave skin lesion		T	0015	1.5126	$99.35		$19.87
11305	Shave skin lesion		T	0013	0.8332	$54.73		$10.95
11306	Shave skin lesion		T	0013	0.8332	$54.73		$10.95
11307	Shave skin lesion		T	0013	0.8332	$54.73		$10.95
11308	Shave skin lesion		T	0013	0.8332	$54.73		$10.95
1130F	Bk pain + fxn assessed		M					
11310	Shave skin lesion		T	0013	0.8332	$54.73		$10.95
11311	Shave skin lesion		T	0013	0.8332	$54.73		$10.95
11312	Shave skin lesion		T	0013	0.8332	$54.73		$10.95
11313	Shave skin lesion		T	0013	0.8332	$54.73		$10.95
1134F	Epsd bk pain for =< 6 wks		M					
1135F	Epsd bk pain for > 6 wks		M					
1136F	Epsd bk pain for <= 12 wks		M					
1137F	Epsd bk pain for > 12 wks		M					
11400	Exc tr-ext b9+marg 0.5 < cm		T	0019	4.3877	$288.20	$71.87	$57.64
11401	Exc tr-ext b9+marg 0.6-1 cm		T	0019	4.3877	$288.20	$71.87	$57.64
11402	Exc tr-ext b9+marg 1.1-2 cm		T	0019	4.3877	$288.20	$71.87	$57.64
11403	Exc tr-ext b9+marg 2.1-3 cm		T	0020	7.9864	$524.58		$104.92
11404	Exc tr-ext b9+marg 3.1-4 cm		T	0021	15.8699	$1,042.40	$219.48	$208.48
11406	Exc tr-ext b9+marg > 4.0 cm		T	0021	15.8699	$1,042.40	$219.48	$208.48
11420	Exc h-f-nk-sp b9+marg 0.5 <		T	0020	7.9864	$524.58		$104.92
11421	Exc h-f-nk-sp b9+marg 0.6-1		T	0020	7.9864	$524.58		$104.92
11422	Exc h-f-nk-sp b9+marg 1.1-2		T	0020	7.9864	$524.58		$104.92
11423	Exc h-f-nk-sp b9+marg 2.1-3		T	0021	15.8699	$1,042.40	$219.48	$208.48
11424	Exc h-f-nk-sp b9+marg 3.1-4		T	0021	15.8699	$1,042.40	$219.48	$208.48
11426	Exc h-f-nk-sp b9+marg > 4 cm		T	0022	21.7477	$1,428.48	$354.45	$285.70
11440	Exc face-mm b9+marg 0.5 < cm		T	0019	4.3877	$288.20	$71.87	$57.64
11441	Exc face-mm b9+marg 0.6-1 cm		T	0019	4.3877	$288.20	$71.87	$57.64
11442	Exc face-mm b9+marg 1.1-2 cm		T	0020	7.9864	$524.58		$104.92
11443	Exc face-mm b9+marg 2.1-3 cm		T	0020	7.9864	$524.58		$104.92
11444	Exc face-mm b9+marg 3.1-4 cm		T	0020	7.9864	$524.58		$104.92

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11446	Exc face-mm b9+marg > 4 cm		T	0022	21.7477	$1,428.48	$354.45	$285.70
11450	Removal, sweat gland lesion		T	0022	21.7477	$1,428.48	$354.45	$285.70
11451	Removal, sweat gland lesion		T	0022	21.7477	$1,428.48	$354.45	$285.70
11462	Removal, sweat gland lesion		T	0022	21.7477	$1,428.48	$354.45	$285.70
11463	Removal, sweat gland lesion		T	0022	21.7477	$1,428.48	$354.45	$285.70
11470	Removal, sweat gland lesion		T	0022	21.7477	$1,428.48	$354.45	$285.70
11471	Removal, sweat gland lesion		T	0022	21.7477	$1,428.48	$354.45	$285.70
11600	Exc tr-ext mlg+marg 0.5 < cm		T	0019	4.3877	$288.20	$71.87	$57.64
11601	Exc tr-ext mlg+marg 0.6-1 cm		T	0019	4.3877	$288.20	$71.87	$57.64
11602	Exc tr-ext mlg+marg 1.1-2 cm		T	0019	4.3877	$288.20	$71.87	$57.64
11603	Exc tr-ext mlg+marg 2.1-3 cm		T	0020	7.9864	$524.58		$104.92
11604	Exc tr-ext mlg+marg 3.1-4 cm		T	0020	7.9864	$524.58		$104.92
11606	Exc tr-ext mlg+marg > 4 cm		T	0021	15.8699	$1,042.40	$219.48	$208.48
11620	Exc h-f-nk-sp mlg+marg 0.5 <		T	0020	7.9864	$524.58		$104.92
11621	Exc h-f-nk-sp mlg+marg 0.6-1		T	0019	4.3877	$288.20	$71.87	$57.64
11622	Exc h-f-nk-sp mlg+marg 1.1-2		T	0020	7.9864	$524.58		$104.92
11623	Exc h-f-nk-sp mlg+marg 2.1-3	CH	T	0021	15.8699	$1,042.40	$219.48	$208.48
11624	Exc h-f-nk-sp mlg+marg 3.1-4		T	0021	15.8699	$1,042.40	$219.48	$208.48
11626	Exc h-f-nk-sp mlg+mar > 4 cm		T	0022	21.7477	$1,428.48	$354.45	$285.70
11640	Exc face-mm malig+marg 0.5 <	CH	T	0020	7.9864	$524.58		$104.92
11641	Exc face-mm malig+marg 0.6-1	CH	T	0020	7.9864	$524.58		$104.92
11642	Exc face-mm malig+marg 1.1-2		T	0020	7.9864	$524.58		$104.92
11643	Exc face-mm malig+marg 2.1-3		T	0020	7.9864	$524.58		$104.92
11644	Exc face-mm malig+marg 3.1-4		T	0021	15.8699	$1,042.40	$219.48	$208.48
11646	Exc face-mm mlg+marg > 4 cm		T	0022	21.7477	$1,428.48	$354.45	$285.70
11719	Trim nail(s)		T	0013	0.8332	$54.73		$10.95
11720	Debride nail, 1-5		T	0013	0.8332	$54.73		$10.95
11721	Debride nail, 6 or more		T	0013	0.8332	$54.73		$10.95
11730	Removal of nail plate		T	0013	0.8332	$54.73		$10.95
11732	Remove nail plate, add-on		T	0013	0.8332	$54.73		$10.95
11740	Drain blood from under nail		T	0012	0.3156	$20.73		$4.15

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
11750	Removal of nail bed		T	0019	4.3877	$288.20	$71.87	$57.64
11752	Remove nail bed/finger tip		T	0022	21.7477	$1,428.48	$354.45	$285.70
11755	Biopsy, nail unit		T	0019	4.3877	$288.20	$71.87	$57.64
11760	Repair of nail bed		T	0134	3.5321	$232.00		$46.40
11762	Reconstruction of nail bed		T	0136	16.0086	$1,051.51		$210.31
11765	Excision of nail fold, toe	CH	T	0013	0.8332	$54.73		$10.95
11770	Removal of pilonidal lesion		T	0022	21.7477	$1,428.48	$354.45	$285.70
11771	Removal of pilonidal lesion		T	0022	21.7477	$1,428.48	$354.45	$285.70
11772	Removal of pilonidal lesion		T	0022	21.7477	$1,428.48	$354.45	$285.70
11900	Injection into skin lesions		T	0013	0.8332	$54.73		$10.95
11901	Added skin lesions injection		T	0013	0.8332	$54.73		$10.95
11920	Correct skin color defects		T	0134	3.5321	$232.00		$46.40
11921	Correct skin color defects		T	0134	3.5321	$232.00		$46.40
11922	Correct skin color defects		T	0134	3.5321	$232.00		$46.40
11950	Therapy for contour defects		T	0133	1.3704	$90.01	$25.67	$18.01
11951	Therapy for contour defects		T	0133	1.3704	$90.01	$25.67	$18.01
11952	Therapy for contour defects		T	0133	1.3704	$90.01	$25.67	$18.01
11954	Therapy for contour defects		T	0133	1.3704	$90.01	$25.67	$18.01
11960	Insert tissue expander(s)		T	0137	20.8007	$1,366.27		$273.26
11970	Replace tissue expander		T	0051	45.4359	$2,984.41		$596.89
11971	Remove tissue expander(s)		T	0022	21.7477	$1,428.48	$354.45	$285.70
11975	Insert contraceptive cap		E					
11976	Removal of contraceptive cap		T	0019	4.3877	$288.20	$71.87	$57.64
11977	Removal/reinsert contra cap		E					
11980	Implant hormone pellet(s)		X	0340	0.6481	$42.57		$8.52
11981	Insert drug implant device		X	0340	0.6481	$42.57		$8.52
11982	Remove drug implant device		X	0340	0.6481	$42.57		$8.52
11983	Remove/insert drug implant		X	0340	0.6481	$42.57		$8.52
12001	Repair superficial wound(s)		T	0133	1.3704	$90.01	$25.67	$18.01
12002	Repair superficial wound(s)		T	0133	1.3704	$90.01	$25.67	$18.01
12004	Repair superficial wound(s)		T	0133	1.3704	$90.01	$25.67	$18.01

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
12005	Repair superficial wound(s)		T	0133	1.3704	$90.01	$25.67	$18.01
12006	Repair superficial wound(s)		T	0133	1.3704	$90.01	$25.67	$18.01
12007	Repair superficial wound(s)		T	0133	1.3704	$90.01	$25.67	$18.01
12011	Repair superficial wound(s)		T	0133	1.3704	$90.01	$25.67	$18.01
12013	Repair superficial wound(s)		T	0133	1.3704	$90.01	$25.67	$18.01
12014	Repair superficial wound(s)		T	0133	1.3704	$90.01	$25.67	$18.01
12015	Repair superficial wound(s)		T	0133	1.3704	$90.01	$25.67	$18.01
12016	Repair superficial wound(s)		T	0133	1.3704	$90.01	$25.67	$18.01
12017	Repair superficial wound(s)		T	0133	1.3704	$90.01	$25.67	$18.01
12018	Repair superficial wound(s)		T	0133	1.3704	$90.01	$25.67	$18.01
12020	Closure of split wound		T	0135	4.7503	$312.02		$62.41
12021	Closure of split wound	CH	T	0134	3.5321	$232.00		$46.40
12031	Layer closure of wound(s)	CH	T	0133	1.3704	$90.01	$25.67	$18.01
12032	Layer closure of wound(s)	CH	T	0133	1.3704	$90.01	$25.67	$18.01
12034	Layer closure of wound(s)	CH	T	0133	1.3704	$90.01	$25.67	$18.01
12035	Layer closure of wound(s)	CH	T	0133	1.3704	$90.01	$25.67	$18.01
12036	Layer closure of wound(s)		T	0134	3.5321	$232.00		$46.40
12037	Layer closure of wound(s)		T	0134	3.5321	$232.00		$46.40
12041	Layer closure of wound(s)	CH	T	0133	1.3704	$90.01	$25.67	$18.01
12042	Layer closure of wound(s)	CH	T	0133	1.3704	$90.01	$25.67	$18.01
12044	Layer closure of wound(s)	CH	T	0133	1.3704	$90.01	$25.67	$18.01
12045	Layer closure of wound(s)		T	0134	3.5321	$232.00		$46.40
12046	Layer closure of wound(s)		T	0134	3.5321	$232.00		$46.40
12047	Layer closure of wound(s)		T	0134	3.5321	$232.00		$46.40
12051	Layer closure of wound(s)	CH	T	0133	1.3704	$90.01	$25.67	$18.01
12052	Layer closure of wound(s)	CH	T	0133	1.3704	$90.01	$25.67	$18.01
12053	Layer closure of wound(s)	CH	T	0133	1.3704	$90.01	$25.67	$18.01
12054	Layer closure of wound(s)	CH	T	0133	1.3704	$90.01	$25.67	$18.01
12055	Layer closure of wound(s)		T	0134	3.5321	$232.00		$46.40
12056	Layer closure of wound(s)		T	0134	3.5321	$232.00		$46.40
12057	Layer closure of wound(s)		T	0134	3.5321	$232.00		$46.40

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
13100	Repair of wound or lesion		T	0135	4.7503	$312.02		$62.41
13101	Repair of wound or lesion		T	0135	4.7503	$312.02		$62.41
13102	Repair wound/lesion add-on		T	0135	4.7503	$312.02		$62.41
13120	Repair of wound or lesion		T	0134	3.5321	$232.00		$46.40
13121	Repair of wound or lesion	CH	T	0134	3.5321	$232.00		$46.40
13122	Repair wound/lesion add-on		T	0134	3.5321	$232.00		$46.40
13131	Repair of wound or lesion	CH	T	0134	3.5321	$232.00		$46.40
13132	Repair of wound or lesion	CH	T	0134	3.5321	$232.00		$46.40
13133	Repair wound/lesion add-on	CH	T	0134	3.5321	$232.00		$46.40
13150	Repair of wound or lesion		T	0135	4.7503	$312.02		$62.41
13151	Repair of wound or lesion		T	0135	4.7503	$312.02		$62.41
13152	Repair of wound or lesion		T	0135	4.7503	$312.02		$62.41
13153	Repair wound/lesion add-on		T	0134	3.5321	$232.00		$46.40
13160	Late closure of wound		T	0137	20.8007	$1,366.27		$273.26
14000	Skin tissue rearrangement		T	0136	16.0086	$1,051.51		$210.31
14001	Skin tissue rearrangement		T	0136	16.0086	$1,051.51		$210.31
14020	Skin tissue rearrangement		T	0136	16.0086	$1,051.51		$210.31
14021	Skin tissue rearrangement		T	0136	16.0086	$1,051.51		$210.31
14040	Skin tissue rearrangement		T	0136	16.0086	$1,051.51		$210.31
14041	Skin tissue rearrangement		T	0136	16.0086	$1,051.51		$210.31
14060	Skin tissue rearrangement		T	0136	16.0086	$1,051.51		$210.31
14061	Skin tissue rearrangement		T	0136	16.0086	$1,051.51		$210.31
14300	Skin tissue rearrangement		T	0137	20.8007	$1,366.27		$273.26
14350	Skin tissue rearrangement		T	0137	20.8007	$1,366.27		$273.26
15002	Wnd prep, ch/inf, trk/arm/lg		T	0135	4.7503	$312.02		$62.41
15003	Wnd prep, ch/inf addl 100 cm		T	0135	4.7503	$312.02		$62.41
15004	Wnd prep ch/inf, f/n/hf/g		T	0135	4.7503	$312.02		$62.41
15005	Wnd prep, f/n/hf/g, addl cm		T	0135	4.7503	$312.02		$62.41
15040	Harvest cultured skin graft		T	0134	3.5321	$232.00		$46.40
15050	Skin pinch graft		T	0135	4.7503	$312.02		$62.41
15100	Skin splt grft, trnk/arm/leg		T	0137	20.8007	$1,366.27		$273.26

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
15101	Skin splt grft t/a/l, add-on		T	0137	20.8007	$1,366.27		$273.26
15110	Epidrm autogrft trnk/arm/leg		T	0135	4.7503	$312.02		$62.41
15111	Epidrm autogrft t/a/l add-on		T	0135	4.7503	$312.02		$62.41
15115	Epidrm a-grft face/nck/hf/g		T	0135	4.7503	$312.02		$62.41
15116	Epidrm a-grft f/n/hf/g addl		T	0135	4.7503	$312.02		$62.41
15120	Skn splt a-grft fac/nck/hf/g		T	0137	20.8007	$1,366.27		$273.26
15121	Skn splt a-grft f/n/hf/g add		T	0137	20.8007	$1,366.27		$273.26
15130	Derm autograft, trnk/arm/leg		T	0136	16.0086	$1,051.51		$210.31
15131	Derm autograft t/a/l add-on		T	0136	16.0086	$1,051.51		$210.31
15135	Derm autograft face/nck/hf/g		T	0136	16.0086	$1,051.51		$210.31
15136	Derm autograft, f/n/hf/g add		T	0136	16.0086	$1,051.51		$210.31
15150	Cult epiderm grft t/arm/leg		T	0135	4.7503	$312.02		$62.41
15151	Cult epiderm grft t/a/l addl		T	0135	4.7503	$312.02		$62.41
15152	Cult epiderm graft t/a/l +%		T	0135	4.7503	$312.02		$62.41
15155	Cult epiderm graft, f/n/hf/g		T	0135	4.7503	$312.02		$62.41
15156	Cult epidrm grft f/n/hfg add		T	0135	4.7503	$312.02		$62.41
15157	Cult epiderm grft f/n/hfg +%		T	0135	4.7503	$312.02		$62.41
15170	Acell graft trunk/arms/legs		T	0134	3.5321	$232.00		$46.40
15171	Acell graft t/arm/leg add-on		T	0134	3.5321	$232.00		$46.40
15175	Acellular graft, f/n/hf/g		T	0135	4.7503	$312.02		$62.41
15176	Acell graft, f/n/hf/g add-on		T	0135	4.7503	$312.02		$62.41
15200	Skin full graft, trunk		T	0136	16.0086	$1,051.51		$210.31
15201	Skin full graft trunk add-on		T	0136	16.0086	$1,051.51		$210.31
15220	Skin full graft sclp/arm/leg		T	0136	16.0086	$1,051.51		$210.31
15221	Skin full graft add-on		T	0135	4.7503	$312.02		$62.41
15240	Skin full grft face/genit/hf		T	0136	16.0086	$1,051.51		$210.31
15241	Skin full graft add-on		T	0135	4.7503	$312.02		$62.41
15260	Skin full graft een & lips		T	0136	16.0086	$1,051.51		$210.31
15261	Skin full graft add-on		T	0136	16.0086	$1,051.51		$210.31
15300	Apply skinallogrft, t/arm/lg		T	0135	4.7503	$312.02		$62.41
15301	Apply sknallogrft t/a/l addl		T	0135	4.7503	$312.02		$62.41

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
15320	Apply skin allogrft f/n/hf/g		T	0135	4.7503	$312.02		$62.41
15321	Aply sknallogrft f/n/hfg add		T	0135	4.7503	$312.02		$62.41
15330	Aply acell alogrft t/arm/leg		T	0135	4.7503	$312.02		$62.41
15331	Aply acell grft t/a/l add-on		T	0135	4.7503	$312.02		$62.41
15335	Apply acell graft, f/n/hf/g		T	0135	4.7503	$312.02		$62.41
15336	Aply acell grft f/n/hf/g add		T	0135	4.7503	$312.02		$62.41
15340	Apply cult skin substitute		T	0134	3.5321	$232.00		$46.40
15341	Apply cult skin sub add-on		T	0134	3.5321	$232.00		$46.40
15360	Apply cult derm sub, t/a/l		T	0134	3.5321	$232.00		$46.40
15361	Aply cult derm sub t/a/l add		T	0134	3.5321	$232.00		$46.40
15365	Apply cult derm sub f/n/hf/g		T	0134	3.5321	$232.00		$46.40
15366	Apply cult derm f/hf/g add		T	0134	3.5321	$232.00		$46.40
15400	Apply skin xenograft, t/a/l		T	0135	4.7503	$312.02		$62.41
15401	Apply skn xenogrft t/a/l add		T	0135	4.7503	$312.02		$62.41
15420	Apply skin xgraft, f/n/hf/g		T	0135	4.7503	$312.02		$62.41
15421	Apply skn xgrft f/n/hf/g add		T	0135	4.7503	$312.02		$62.41
15430	Apply acellular xenograft		T	0135	4.7503	$312.02		$62.41
15431	Apply acellular xgraft add		T	0135	4.7503	$312.02		$62.41
15570	Form skin pedicle flap		T	0137	20.8007	$1,366.27		$273.26
15572	Form skin pedicle flap		T	0137	20.8007	$1,366.27		$273.26
15574	Form skin pedicle flap		T	0137	20.8007	$1,366.27		$273.26
15576	Form skin pedicle flap		T	0137	20.8007	$1,366.27		$273.26
15600	Skin graft		T	0137	20.8007	$1,366.27		$273.26
15610	Skin graft		T	0137	20.8007	$1,366.27		$273.26
15620	Skin graft		T	0137	20.8007	$1,366.27		$273.26
15630	Skin graft		T	0137	20.8007	$1,366.27		$273.26
15650	Transfer skin pedicle flap		T	0137	20.8007	$1,366.27		$273.26
15731	Forehead flap w/vasc pedicle		T	0137	20.8007	$1,366.27		$273.26
15732	Muscle-skin graft, head/neck		T	0137	20.8007	$1,366.27		$273.26
15734	Muscle-skin graft, trunk		T	0137	20.8007	$1,366.27		$273.26
15736	Muscle-skin graft, arm		T	0137	20.8007	$1,366.27		$273.26

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
15738	Muscle-skin graft, leg		T	0137	20.8007	$1,366.27		$273.26
15740	Island pedicle flap graft		T	0136	16.0086	$1,051.51		$210.31
15750	Neurovascular pedicle graft		T	0137	20.8007	$1,366.27		$273.26
15756	Free myo/skin flap microvasc		C					
15757	Free skin flap, microvasc		C					
15758	Free fascial flap, microvasc		C					
15760	Composite skin graft		T	0137	20.8007	$1,366.27		$273.26
15770	Derma-fat-fascia graft		T	0137	20.8007	$1,366.27		$273.26
15775	Hair transplant punch grafts		T	0133	1.3704	$90.01	$25.67	$18.01
15776	Hair transplant punch grafts		T	0133	1.3704	$90.01	$25.67	$18.01
15780	Abrasion treatment of skin		T	0022	21.7477	$1,428.48	$354.45	$285.70
15781	Abrasion treatment of skin		T	0019	4.3877	$288.20	$71.87	$57.64
15782	Abrasion treatment of skin		T	0019	4.3877	$288.20	$71.87	$57.64
15783	Abrasion treatment of skin		T	0016	2.7062	$177.75		$35.55
15786	Abrasion, lesion, single		T	0013	0.8332	$54.73		$10.95
15787	Abrasion, lesions, add-on		T	0013	0.8332	$54.73		$10.95
15788	Chemical peel, face, epiderm		T	0013	0.8332	$54.73		$10.95
15789	Chemical peel, face, dermal		T	0015	1.5126	$99.35		$19.87
15792	Chemical peel, nonfacial		T	0015	1.5126	$99.35		$19.87
15793	Chemical peel, nonfacial		T	0013	0.8332	$54.73		$10.95
15819	Plastic surgery, neck		T	0134	3.5321	$232.00		$46.40
15820	Revision of lower eyelid		T	0137	20.8007	$1,366.27		$273.26
15821	Revision of lower eyelid		T	0137	20.8007	$1,366.27		$273.26
15822	Revision of upper eyelid		T	0137	20.8007	$1,366.27		$273.26
15823	Revision of upper eyelid		T	0137	20.8007	$1,366.27		$273.26
15824	Removal of forehead wrinkles		T	0137	20.8007	$1,366.27		$273.26
15825	Removal of neck wrinkles		T	0137	20.8007	$1,366.27		$273.26
15826	Removal of brow wrinkles		T	0137	20.8007	$1,366.27		$273.26
15828	Removal of face wrinkles		T	0137	20.8007	$1,366.27		$273.26
15829	Removal of skin wrinkles		T	0137	20.8007	$1,366.27		$273.26
15830	Exc skin abd		T	0022	21.7477	$1,428.48	$354.45	$285.70

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
15832	Excise excessive skin tissue		T	0022	21.7477	$1,428.48	$354.45	$285.70
15833	Excise excessive skin tissue		T	0022	21.7477	$1,428.48	$354.45	$285.70
15834	Excise excessive skin tissue		T	0022	21.7477	$1,428.48	$354.45	$285.70
15835	Excise excessive skin tissue		T	0022	21.7477	$1,428.48	$354.45	$285.70
15836	Excise excessive skin tissue		T	0021	15.8699	$1,042.40	$219.48	$208.48
15837	Excise excessive skin tissue		T	0021	15.8699	$1,042.40	$219.48	$208.48
15838	Excise excessive skin tissue		T	0021	15.8699	$1,042.40	$219.48	$208.48
15839	Excise excessive skin tissue		T	0021	15.8699	$1,042.40	$219.48	$208.48
15840	Graft for face nerve palsy		T	0137	20.8007	$1,366.27		$273.26
15841	Graft for face nerve palsy		T	0137	20.8007	$1,366.27		$273.26
15842	Flap for face nerve palsy		T	0137	20.8007	$1,366.27		$273.26
15845	Skin and muscle repair, face		T	0137	20.8007	$1,366.27		$273.26
15847	Exc skin abd add-on		T	0022	21.7477	$1,428.48	$354.45	$285.70
15850	Removal of sutures		T	0016	2.7062	$177.75		$35.55
15851	Removal of sutures		T	0016	2.7062	$177.75		$35.55
15852	Dressing change not for burn		X	0340	0.6481	$42.57		$8.52
15860	Test for blood flow in graft		X	0340	0.6481	$42.57		$8.52
15876	Suction assisted lipectomy		T	0137	20.8007	$1,366.27		$273.26
15877	Suction assisted lipectomy		T	0137	20.8007	$1,366.27		$273.26
15878	Suction assisted lipectomy		T	0137	20.8007	$1,366.27		$273.26
15879	Suction assisted lipectomy		T	0137	20.8007	$1,366.27		$273.26
15920	Removal of tail bone ulcer		T	0019	4.3877	$288.20	$71.87	$57.64
15922	Removal of tail bone ulcer		T	0137	20.8007	$1,366.27		$273.26
15931	Remove sacrum pressure sore		T	0022	21.7477	$1,428.48	$354.45	$285.70
15933	Remove sacrum pressure sore		T	0022	21.7477	$1,428.48	$354.45	$285.70
15934	Remove sacrum pressure sore		T	0137	20.8007	$1,366.27		$273.26
15935	Remove sacrum pressure sore		T	0137	20.8007	$1,366.27		$273.26
15936	Remove sacrum pressure sore		T	0136	16.0086	$1,051.51		$210.31
15937	Remove sacrum pressure sore		T	0137	20.8007	$1,366.27		$273.26
15940	Remove hip pressure sore		T	0022	21.7477	$1,428.48	$354.45	$285.70
15941	Remove hip pressure sore		T	0022	21.7477	$1,428.48	$354.45	$285.70

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
15944	Remove hip pressure sore		T	0137	20.8007	$1,366.27		$273.26
15945	Remove hip pressure sore		T	0137	20.8007	$1,366.27		$273.26
15946	Remove hip pressure sore		T	0137	20.8007	$1,366.27		$273.26
15950	Remove thigh pressure sore		T	0022	21.7477	$1,428.48	$354.45	$285.70
15951	Remove thigh pressure sore		T	0022	21.7477	$1,428.48	$354.45	$285.70
15952	Remove thigh pressure sore		T	0136	16.0086	$1,051.51		$210.31
15953	Remove thigh pressure sore		T	0136	16.0086	$1,051.51		$210.31
15956	Remove thigh pressure sore		T	0136	16.0086	$1,051.51		$210.31
15958	Remove thigh pressure sore		T	0136	16.0086	$1,051.51		$210.31
15999	Removal of pressure sore		T	0019	4.3877	$288.20	$71.87	$57.64
16000	Initial treatment of burn(s)		T	0013	0.8332	$54.73		$10.95
16020	Dress/debrid p-thick burn, s		T	0015	1.5126	$99.35		$19.87
16025	Dress/debrid p-thick burn, m	CH	T	0015	1.5126	$99.35		$19.87
16030	Dress/debrid p-thick burn, l	CH	T	0015	1.5126	$99.35		$19.87
16035	Incision of burn scab, initi	CH	T	0015	1.5126	$99.35		$19.87
16036	Escharotomy; add'l incision		C					
17000	Destruct premalg lesion		T	0013	0.8332	$54.73		$10.95
17003	Destruct premalg les, 2-14		T	0012	0.3156	$20.73		$4.15
17004	Destroy premlg lesions 15+		T	0016	2.7062	$177.75		$35.55
17106	Destruction of skin lesions		T	0016	2.7062	$177.75		$35.55
17107	Destruction of skin lesions		T	0016	2.7062	$177.75		$35.55
17108	Destruction of skin lesions		T	0016	2.7062	$177.75		$35.55
17110	Destruct b9 lesion, 1-14		T	0013	0.8332	$54.73		$10.95
17111	Destruct lesion, 15 or more		T	0015	1.5126	$99.35		$19.87
17250	Chemical cautery, tissue		T	0015	1.5126	$99.35		$19.87
17260	Destruction of skin lesions		T	0015	1.5126	$99.35		$19.87
17261	Destruction of skin lesions		T	0015	1.5126	$99.35		$19.87
17262	Destruction of skin lesions		T	0015	1.5126	$99.35		$19.87
17263	Destruction of skin lesions		T	0015	1.5126	$99.35		$19.87
17264	Destruction of skin lesions		T	0015	1.5126	$99.35		$19.87
17266	Destruction of skin lesions		T	0016	2.7062	$177.75		$35.55

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
17270	Destruction of skin lesions		T	0015	1.5126	$99.35		$19.87
17271	Destruction of skin lesions		T	0015	1.5126	$99.35		$19.87
17272	Destruction of skin lesions		T	0015	1.5126	$99.35		$19.87
17273	Destruction of skin lesions		T	0016	2.7062	$177.75		$35.55
17274	Destruction of skin lesions		T	0016	2.7062	$177.75		$35.55
17276	Destruction of skin lesions		T	0016	2.7062	$177.75		$35.55
17280	Destruction of skin lesions		T	0015	1.5126	$99.35		$19.87
17281	Destruction of skin lesions		T	0016	2.7062	$177.75		$35.55
17282	Destruction of skin lesions		T	0016	2.7062	$177.75		$35.55
17283	Destruction of skin lesions		T	0016	2.7062	$177.75		$35.55
17284	Destruction of skin lesions		T	0016	2.7062	$177.75		$35.55
17286	Destruction of skin lesions		T	0016	2.7062	$177.75		$35.55
17311	Mohs, 1 stage, h/n/hf/g		T	0694	4.3668	$286.83	$91.69	$57.37
17312	Mohs addl stage		T	0694	4.3668	$286.83	$91.69	$57.37
17313	Mohs, 1 stage, t/a/l		T	0694	4.3668	$286.83	$91.69	$57.37
17314	Mohs, addl stage, t/a/l		T	0694	4.3668	$286.83	$91.69	$57.37
17315	Mohs surg, addl block		T	0694	4.3668	$286.83	$91.69	$57.37
17340	Cryotherapy of skin		T	0013	0.8332	$54.73		$10.95
17360	Skin peel therapy		T	0013	0.8332	$54.73		$10.95
17380	Hair removal by electrolysis		T	0013	0.8332	$54.73		$10.95
17999	Skin tissue procedure		T	0012	0.3156	$20.73		$4.15
19000	Drainage of breast lesion		T	0004	4.5254	$297.25		$59.45
19001	Drain breast lesion add-on		T	0002	1.5340	$100.76		$20.16
19020	Incision of breast lesion		T	0008	19.5771	$1,285.90		$257.18
19030	Injection for breast x-ray		N					
19100	Bx breast percut w/o image		T	0004	4.5254	$297.25		$59.45
19101	Biopsy of breast, open		T	0028	21.5003	$1,412.23	$303.74	$282.45
19102	Bx breast percut w/image		T	0005	7.3814	$484.84		$96.97
19103	Bx breast percut w/device		T	0037	13.5257	$888.42	$228.76	$177.69
19105	Cryosurg ablate fa, each		T	0029	33.7028	$2,213.73	$581.52	$442.75
19110	Nipple exploration		T	0028	21.5003	$1,412.23	$303.74	$282.45

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19112	Excise breast duct fistula		T	0028	21.5003	$1,412.23	$303.74	$282.45
19120	Removal of breast lesion		T	0028	21.5003	$1,412.23	$303.74	$282.45
19125	Excision, breast lesion		T	0028	21.5003	$1,412.23	$303.74	$282.45
19126	Excision, addl breast lesion		T	0028	21.5003	$1,412.23	$303.74	$282.45
19260	Removal of chest wall lesion		T	0021	15.8699	$1,042.40	$219.48	$208.48
19271	Revision of chest wall		C					
19272	Extensive chest wall surgery		C					
19290	Place needle wire, breast		N					
19291	Place needle wire, breast		N					
19295	Place breast clip, percut		N					
19296	Place po breast cath for rad		T	0648	57.9012	$3,803.18		$760.64
19297	Place breast cath for rad		T	0648	57.9012	$3,803.18		$760.64
19298	Place breast rad tube/caths		T	0648	57.9012	$3,803.18		$760.64
19300	Removal of breast tissue		T	0028	21.5003	$1,412.23	$303.74	$282.45
19301	Partical mastectomy		T	0028	21.5003	$1,412.23	$303.74	$282.45
19302	P-mastectomy w/ln removal		T	0030	40.6119	$2,667.55	$747.07	$533.51
19303	Mast, simple, complete		T	0029	33.7028	$2,213.73	$581.52	$442.75
19304	Mast, subq		T	0029	33.7028	$2,213.73	$581.52	$442.75
19305	Mast, radical		C					
19306	Mast, rad, urban type		C					
19307	Mast, mod rad		T	0030	40.6119	$2,667.55	$747.07	$533.51
19316	Suspension of breast		T	0029	33.7028	$2,213.73	$581.52	$442.75
19318	Reduction of large breast		T	0030	40.6119	$2,667.55	$747.07	$533.51
19324	Enlarge breast		T	0030	40.6119	$2,667.55	$747.07	$533.51
19325	Enlarge breast with implant		T	0648	57.9012	$3,803.18		$760.64
19328	Removal of breast implant		T	0029	33.7028	$2,213.73	$581.52	$442.75
19330	Removal of implant material		T	0029	33.7028	$2,213.73	$581.52	$442.75
19340	Immediate breast prosthesis		T	0030	40.6119	$2,667.55	$747.07	$533.51
19342	Delayed breast prosthesis		T	0648	57.9012	$3,803.18		$760.64
19350	Breast reconstruction		T	0028	21.5003	$1,412.23	$303.74	$282.45
19355	Correct inverted nipple(s)		T	0029	33.7028	$2,213.73	$581.52	$442.75

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
19357	Breast reconstruction		T	0648	57.9012	$3,803.18		$760.64
19361	Breast reconstr w/lat flap		C					
19364	Breast reconstruction		C					
19366	Breast reconstruction		T	0029	33.7028	$2,213.73	$581.52	$442.75
19367	Breast reconstruction		C					
19368	Breast reconstruction		C					
19369	Breast reconstruction		C					
19370	Surgery of breast capsule		T	0029	33.7028	$2,213.73	$581.52	$442.75
19371	Removal of breast capsule		T	0029	33.7028	$2,213.73	$581.52	$442.75
19380	Revise breast reconstruction		T	0030	40.6119	$2,667.55	$747.07	$533.51
19396	Design custom breast implant		T	0029	33.7028	$2,213.73	$581.52	$442.75
19499	Breast surgery procedure		T	0028	21.5003	$1,412.23	$303.74	$282.45
20000	Incision of abscess		T	0006	1.4267	$93.71		$18.75
20005	Incision of deep abscess		T	0049	22.3967	$1,471.10		$294.22
2000F	Blood pressure measure		M					
2001F	Weight recorded		M					
2002F	Clin sign vol ovrld assess		M					
2004F	Initial exam involved joints		M					
20100	Explore wound, neck	CH	T	0252	7.7504	$509.08	$109.16	$101.82
20101	Explore wound, chest		T	0137	20.8007	$1,366.27		$273.26
20102	Explore wound, abdomen		T	0137	20.8007	$1,366.27		$273.26
20103	Explore wound, extremity	CH	T	0136	16.0086	$1,051.51		$210.31
2010F	Vital signs recorded		M					
2014F	Mental status assess		M					
20150	Excise epiphyseal bar		T	0051	45.4359	$2,984.41		$596.89
2018F	Hydration status assess		M					
2019F	Dilated macul exam done		M					
20200	Muscle biopsy		T	0021	15.8699	$1,042.40	$219.48	$208.48
20205	Deep muscle biopsy		T	0021	15.8699	$1,042.40	$219.48	$208.48
20206	Needle biopsy, muscle		T	0005	7.3814	$484.84		$96.97
2020F	Dilated fundus eval done		M					

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2021F	Dilat macul+ exam done		M					
20220	Bone biopsy, trocar/needle		T	0020	7.9864	$524.58		$104.92
20225	Bone biopsy, trocar/needle	CH	T	0021	15.8699	$1,042.40	$219.48	$208.48
2022F	Dil retina exam interp rev		M					
20240	Bone biopsy, excisional		T	0022	21.7477	$1,428.48	$354.45	$285.70
20245	Bone biopsy, excisional		T	0022	21.7477	$1,428.48	$354.45	$285.70
2024F	7 field photo interp doc rev		M					
20250	Open bone biopsy		T	0049	22.3967	$1,471.10		$294.22
20251	Open bone biopsy		T	0049	22.3967	$1,471.10		$294.22
2026F	Eye image valid to dx rev		M					
2027F	Optic nerve head eval done		M					
2028F	Foot exam performed		M					
2029F	Complete phys skin exam done		M					
2030F	H2O stat docd, normal		M					
2031F	H2O stat docd, dehydrated		M					
2035F	Tymp memb motion examd		M					
2040F	Bk pn xm on init visit date		M					
2044F	Doc mntl tst b/4 bk trxmnt		M					
20500	Injection of sinus tract	CH	T	0252	7.7504	$509.08	$109.16	$101.82
20501	Inject sinus tract for x-ray		N					
20520	Removal of foreign body		T	0019	4.3877	$288.20	$71.87	$57.64
20525	Removal of foreign body		T	0022	21.7477	$1,428.48	$354.45	$285.70
20526	Ther injection, carp tunnel		T	0204	2.5055	$164.57	$40.13	$32.92
20550	Inj tendon sheath/ligament		T	0204	2.5055	$164.57	$40.13	$32.92
20551	Inj tendon origin/insertion		T	0204	2.5055	$164.57	$40.13	$32.92
20552	Inj trigger point, 1/2 muscl		T	0204	2.5055	$164.57	$40.13	$32.92
20553	Inject trigger points, =/> 3		T	0204	2.5055	$164.57	$40.13	$32.92
20555	Place ndl musc/tis for rt		T	0050	29.4401	$1,933.74		$386.75
20600	Drain/inject, joint/bursa		T	0204	2.5055	$164.57	$40.13	$32.92
20605	Drain/inject, joint/bursa		T	0204	2.5055	$164.57	$40.13	$32.92
20610	Drain/inject, joint/bursa		T	0204	2.5055	$164.57	$40.13	$32.92

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
20612	Aspirate/inj ganglion cyst		T	0204	2.5055	$164.57	$40.13	$32.92
20615	Treatment of bone cyst		T	0004	4.5254	$297.25		$59.45
20650	Insert and remove bone pin		T	0049	22.3967	$1,471.10		$294.22
20660	Apply, rem fixation device	CH	T	0138	6.0607	$398.09		$79.62
20661	Application of head brace		C					
20662	Application of pelvis brace		T	0049	22.3967	$1,471.10		$294.22
20663	Application of thigh brace		T	0049	22.3967	$1,471.10		$294.22
20664	Halo brace application		C					
20665	Removal of fixation device		X	0340	0.6481	$42.57		$8.52
20670	Removal of support implant		T	0021	15.8699	$1,042.40	$219.48	$208.48
20680	Removal of support implant		T	0022	21.7477	$1,428.48	$354.45	$285.70
20690	Apply bone fixation device		T	0050	29.4401	$1,933.74		$386.75
20692	Apply bone fixation device		T	0050	29.4401	$1,933.74		$386.75
20693	Adjust bone fixation device		T	0049	22.3967	$1,471.10		$294.22
20694	Remove bone fixation device		T	0049	22.3967	$1,471.10		$294.22
20802	Replantation, arm, complete		C					
20805	Replant forearm, complete		C					
20808	Replantation hand, complete		C					
20816	Replantation digit, complete		C					
20822	Replantation digit, complete		T	0054	28.1744	$1,850.61		$370.13
20824	Replantation thumb, complete		C					
20827	Replantation thumb, complete		C					
20838	Replantation foot, complete		C					
20900	Removal of bone for graft		T	0050	29.4401	$1,933.74		$386.75
20902	Removal of bone for graft		T	0050	29.4401	$1,933.74		$386.75
20910	Remove cartilage for graft		T	0137	20.8007	$1,366.27		$273.26
20912	Remove cartilage for graft		T	0137	20.8007	$1,366.27		$273.26
20920	Removal of fascia for graft		T	0136	16.0086	$1,051.51		$210.31
20922	Removal of fascia for graft		T	0136	16.0086	$1,051.51		$210.31
20924	Removal of tendon for graft		T	0050	29.4401	$1,933.74		$386.75
20926	Removal of tissue for graft		T	0135	4.7503	$312.02		$62.41

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
20930	Sp bone algrft morsel add-on		C					
20931	Sp bone algrft struct add-on		C					
20936	Sp bone agrft local add-on		C					
20937	Sp bone agrft morsel add-on		C					
20938	Sp bone agrft struct add-on		C					
20950	Fluid pressure, muscle		T	0006	1.4267	$93.71		$18.75
20955	Fibula bone graft, microvasc		C					
20956	Iliac bone graft, microvasc		C					
20957	Mt bone graft, microvasc		C					
20962	Other bone graft, microvasc		C					
20969	Bone/skin graft, microvasc		C					
20970	Bone/skin graft, iliac crest		C					
20972	Bone/skin graft, metatarsal		T	0056	47.1767	$3,098.75		$619.75
20973	Bone/skin graft, great toe		T	0056	47.1767	$3,098.75		$619.75
20974	Electrical bone stimulation		A					
20975	Electrical bone stimulation		N					
20979	Us bone stimulation		X	0340	0.6481	$42.57		$8.52
20982	Ablate, bone tumor(s) perq		T	0051	45.4359	$2,984.41		$596.89
20985	Cptr-asst dir ms px		N					
20986	Cptr-asst dir ms px io img		N					
20987	Cptr-asst dir ms px pre img		N					
20999	Musculoskeletal surgery		T	0049	22.3967	$1,471.10		$294.22
21010	Incision of jaw joint		T	0254	24.6341	$1,618.07		$323.62
21015	Resection of facial tumor		T	0253	17.1953	$1,129.46	$282.29	$225.90
21025	Excision of bone, lower jaw		T	0256	41.6247	$2,734.08		$546.82
21026	Excision of facial bone(s)		T	0256	41.6247	$2,734.08		$546.82
21029	Contour of face bone lesion		T	0256	41.6247	$2,734.08		$546.82
21030	Excise max/zygoma b9 tumor		T	0254	24.6341	$1,618.07		$323.62
21031	Remove exostosis, mandible		T	0254	24.6341	$1,618.07		$323.62
21032	Remove exostosis, maxilla		T	0254	24.6341	$1,618.07		$323.62
21034	Excise max/zygoma mlg tumor		T	0256	41.6247	$2,734.08		$546.82

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
21040	Excise mandible lesion		T	0254	24.6341	$1,618.07		$323.62
21044	Removal of jaw bone lesion		T	0256	41.6247	$2,734.08		$546.82
21045	Extensive jaw surgery		C					
21046	Remove mandible cyst complex		T	0256	41.6247	$2,734.08		$546.82
21047	Excise lwr jaw cyst w/repair		T	0256	41.6247	$2,734.08		$546.82
21048	Remove maxilla cyst complex		T	0256	41.6247	$2,734.08		$546.82
21049	Excis uppr jaw cyst w/repair		T	0256	41.6247	$2,734.08		$546.82
21050	Removal of jaw joint		T	0256	41.6247	$2,734.08		$546.82
21060	Remove jaw joint cartilage		T	0256	41.6247	$2,734.08		$546.82
21070	Remove coronoid process		T	0256	41.6247	$2,734.08		$546.82
21073	Mnpj of tmj w/anesth		T	0252	7.7504	$509.08	$109.16	$101.82
21076	Prepare face/oral prosthesis		T	0254	24.6341	$1,618.07		$323.62
21077	Prepare face/oral prosthesis		T	0256	41.6247	$2,734.08		$546.82
21079	Prepare face/oral prosthesis		T	0256	41.6247	$2,734.08		$546.82
21080	Prepare face/oral prosthesis		T	0256	41.6247	$2,734.08		$546.82
21081	Prepare face/oral prosthesis		T	0256	41.6247	$2,734.08		$546.82
21082	Prepare face/oral prosthesis		T	0256	41.6247	$2,734.08		$546.82
21083	Prepare face/oral prosthesis		T	0256	41.6247	$2,734.08		$546.82
21084	Prepare face/oral prosthesis		T	0256	41.6247	$2,734.08		$546.82
21085	Prepare face/oral prosthesis		T	0253	17.1953	$1,129.46	$282.29	$225.90
21086	Prepare face/oral prosthesis		T	0256	41.6247	$2,734.08		$546.82
21087	Prepare face/oral prosthesis		T	0256	41.6247	$2,734.08		$546.82
21088	Prepare face/oral prosthesis		T	0256	41.6247	$2,734.08		$546.82
21089	Prepare face/oral prosthesis	CH	T	0250	1.1335	$74.45	$25.10	$14.89
21100	Maxillofacial fixation		T	0256	41.6247	$2,734.08		$546.82
21110	Interdental fixation		T	0252	7.7504	$509.08	$109.16	$101.82
21116	Injection, jaw joint x-ray		N					
21120	Reconstruction of chin		T	0254	24.6341	$1,618.07		$323.62
21121	Reconstruction of chin		T	0254	24.6341	$1,618.07		$323.62
21122	Reconstruction of chin		T	0254	24.6341	$1,618.07		$323.62
21123	Reconstruction of chin		T	0254	24.6341	$1,618.07		$323.62

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
21125	Augmentation, lower jaw bone		T	0254	24.6341	$1,618.07		$323.62
21127	Augmentation, lower jaw bone		T	0256	41.6247	$2,734.08		$546.82
21137	Reduction of forehead		T	0254	24.6341	$1,618.07		$323.62
21138	Reduction of forehead		T	0256	41.6247	$2,734.08		$546.82
21139	Reduction of forehead		T	0256	41.6247	$2,734.08		$546.82
21141	Reconstruct midface, lefort		C					
21142	Reconstruct midface, lefort		C					
21143	Reconstruct midface, lefort		C					
21145	Reconstruct midface, lefort		C					
21146	Reconstruct midface, lefort		C					
21147	Reconstruct midface, lefort		C					
21150	Reconstruct midface, lefort		T	0256	41.6247	$2,734.08		$546.82
21151	Reconstruct midface, lefort		C					
21154	Reconstruct midface, lefort		C					
21155	Reconstruct midface, lefort		C					
21159	Reconstruct midface, lefort		C					
21160	Reconstruct midface, lefort		C					
21172	Reconstruct orbit/forehead	CH	T	0256	41.6247	$2,734.08		$546.82
21175	Reconstruct orbit/forehead		T	0256	41.6247	$2,734.08		$546.82
21179	Reconstruct entire forehead		C					
21180	Reconstruct entire forehead		C					
21181	Contour cranial bone lesion		T	0254	24.6341	$1,618.07		$323.62
21182	Reconstruct cranial bone		C					
21183	Reconstruct cranial bone		C					
21184	Reconstruct cranial bone		C					
21188	Reconstruction of midface		C					
21193	Reconst lwr jaw w/o graft		C					
21194	Reconst lwr jaw w/graft		C					
21195	Reconst lwr jaw w/o fixation		T	0256	41.6247	$2,734.08		$546.82
21196	Reconst lwr jaw w/fixation		C					
21198	Reconstr lwr jaw segment		T	0256	41.6247	$2,734.08		$546.82

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
21199	Reconstr lwr jaw w/advance		T	0256	41.6247	$2,734.08		$546.82
21206	Reconstruct upper jaw bone		T	0256	41.6247	$2,734.08		$546.82
21208	Augmentation of facial bones		T	0256	41.6247	$2,734.08		$546.82
21209	Reduction of facial bones		T	0256	41.6247	$2,734.08		$546.82
21210	Face bone graft		T	0256	41.6247	$2,734.08		$546.82
21215	Lower jaw bone graft		T	0256	41.6247	$2,734.08		$546.82
21230	Rib cartilage graft		T	0256	41.6247	$2,734.08		$546.82
21235	Ear cartilage graft		T	0254	24.6341	$1,618.07		$323.62
21240	Reconstruction of jaw joint		T	0256	41.6247	$2,734.08		$546.82
21242	Reconstruction of jaw joint		T	0256	41.6247	$2,734.08		$546.82
21243	Reconstruction of jaw joint		T	0256	41.6247	$2,734.08		$546.82
21244	Reconstruction of lower jaw		T	0256	41.6247	$2,734.08		$546.82
21245	Reconstruction of jaw		T	0256	41.6247	$2,734.08		$546.82
21246	Reconstruction of jaw		T	0256	41.6247	$2,734.08		$546.82
21247	Reconstruct lower jaw bone		C					
21248	Reconstruction of jaw		T	0256	41.6247	$2,734.08		$546.82
21249	Reconstruction of jaw		T	0256	41.6247	$2,734.08		$546.82
21255	Reconstruct lower jaw bone		C					
21256	Reconstruction of orbit		C					
21260	Revise eye sockets		T	0256	41.6247	$2,734.08		$546.82
21261	Revise eye sockets		T	0256	41.6247	$2,734.08		$546.82
21263	Revise eye sockets		T	0256	41.6247	$2,734.08		$546.82
21267	Revise eye sockets		T	0256	41.6247	$2,734.08		$546.82
21268	Revise eye sockets		C					
21270	Augmentation, cheek bone		T	0256	41.6247	$2,734.08		$546.82
21275	Revision, orbitofacial bones		T	0256	41.6247	$2,734.08		$546.82
21280	Revision of eyelid		T	0256	41.6247	$2,734.08		$546.82
21282	Revision of eyelid		T	0253	17.1953	$1,129.46	$282.29	$225.90
21295	Revision of jaw muscle/bone		T	0252	7.7504	$509.08	$109.16	$101.82
21296	Revision of jaw muscle/bone		T	0254	24.6341	$1,618.07		$323.62
21299	Cranio/maxillofacial surgery	CH	T	0250	1.1335	$74.45	$25.10	$14.89

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
21310	Treatment of nose fracture	CH	T	0250	1.1335	$74.45	$25.10	$14.89
21315	Treatment of nose fracture	CH	T	0253	17.1953	$1,129.46	$282.29	$225.90
21320	Treatment of nose fracture		T	0253	17.1953	$1,129.46	$282.29	$225.90
21325	Treatment of nose fracture		T	0254	24.6341	$1,618.07		$323.62
21330	Treatment of nose fracture		T	0254	24.6341	$1,618.07		$323.62
21335	Treatment of nose fracture		T	0254	24.6341	$1,618.07		$323.62
21336	Treat nasal septal fracture		T	0062	25.6821	$1,686.90	$372.87	$337.38
21337	Treat nasal septal fracture		T	0253	17.1953	$1,129.46	$282.29	$225.90
21338	Treat nasoethmoid fracture		T	0254	24.6341	$1,618.07		$323.62
21339	Treat nasoethmoid fracture		T	0254	24.6341	$1,618.07		$323.62
21340	Treatment of nose fracture		T	0256	41.6247	$2,734.08		$546.82
21343	Treatment of sinus fracture		C					
21344	Treatment of sinus fracture		C					
21345	Treat nose/jaw fracture		T	0254	24.6341	$1,618.07		$323.62
21346	Treat nose/jaw fracture		C					
21347	Treat nose/jaw fracture		C					
21348	Treat nose/jaw fracture		C					
21355	Treat cheek bone fracture		T	0256	41.6247	$2,734.08		$546.82
21356	Treat cheek bone fracture		T	0254	24.6341	$1,618.07		$323.62
21360	Treat cheek bone fracture		T	0254	24.6341	$1,618.07		$323.62
21365	Treat cheek bone fracture		T	0256	41.6247	$2,734.08		$546.82
21366	Treat cheek bone fracture		C					
21385	Treat eye socket fracture		T	0256	41.6247	$2,734.08		$546.82
21386	Treat eye socket fracture	CH	T	0256	41.6247	$2,734.08		$546.82
21387	Treat eye socket fracture	CH	T	0256	41.6247	$2,734.08		$546.82
21390	Treat eye socket fracture		T	0256	41.6247	$2,734.08		$546.82
21395	Treat eye socket fracture		C					
21400	Treat eye socket fracture		T	0252	7.7504	$509.08	$109.16	$101.82
21401	Treat eye socket fracture		T	0253	17.1953	$1,129.46	$282.29	$225.90
21406	Treat eye socket fracture		T	0256	41.6247	$2,734.08		$546.82
21407	Treat eye socket fracture		T	0256	41.6247	$2,734.08		$546.82

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
21408	Treat eye socket fracture		T	0256	41.6247	$2,734.08		$546.82
21421	Treat mouth roof fracture		T	0254	24.6341	$1,618.07		$323.62
21422	Treat mouth roof fracture		C					
21423	Treat mouth roof fracture		C					
21431	Treat craniofacial fracture		C					
21432	Treat craniofacial fracture		C					
21433	Treat craniofacial fracture		C					
21435	Treat craniofacial fracture		C					
21436	Treat craniofacial fracture		C					
21440	Treat dental ridge fracture		T	0254	24.6341	$1,618.07		$323.62
21445	Treat dental ridge fracture		T	0254	24.6341	$1,618.07		$323.62
21450	Treat lower jaw fracture		T	0251	3.1568	$207.35		$41.47
21451	Treat lower jaw fracture		T	0252	7.7504	$509.08	$109.16	$101.82
21452	Treat lower jaw fracture		T	0253	17.1953	$1,129.46	$282.29	$225.90
21453	Treat lower jaw fracture		T	0256	41.6247	$2,734.08		$546.82
21454	Treat lower jaw fracture		T	0254	24.6341	$1,618.07		$323.62
21461	Treat lower jaw fracture		T	0256	41.6247	$2,734.08		$546.82
21462	Treat lower jaw fracture		T	0256	41.6247	$2,734.08		$546.82
21465	Treat lower jaw fracture		T	0256	41.6247	$2,734.08		$546.82
21470	Treat lower jaw fracture		T	0256	41.6247	$2,734.08		$546.82
21480	Reset dislocated jaw	CH	T	0250	1.1335	$74.45	$25.10	$14.89
21485	Reset dislocated jaw		T	0253	17.1953	$1,129.46	$282.29	$225.90
21490	Repair dislocated jaw		T	0256	41.6247	$2,734.08		$546.82
21495	Treat hyoid bone fracture		T	0253	17.1953	$1,129.46	$282.29	$225.90
21497	Interdental wiring		T	0253	17.1953	$1,129.46	$282.29	$225.90
21499	Head surgery procedure	CH	T	0250	1.1335	$74.45	$25.10	$14.89
21501	Drain neck/chest lesion		T	0008	19.5771	$1,285.90		$257.18
21502	Drain chest lesion		T	0049	22.3967	$1,471.10		$294.22
21510	Drainage of bone lesion		C					
21550	Biopsy of neck/chest	CH	T	0021	15.8699	$1,042.40	$219.48	$208.48
21555	Remove lesion, neck/chest		T	0022	21.7477	$1,428.48	$354.45	$285.70

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
21556	Remove lesion, neck/chest		T	0022	21.7477	$1,428.48	$354.45	$285.70
21557	Remove tumor, neck/chest		T	0022	21.7477	$1,428.48	$354.45	$285.70
21600	Partial removal of rib		T	0050	29.4401	$1,933.74		$386.75
21610	Partial removal of rib		T	0050	29.4401	$1,933.74		$386.75
21615	Removal of rib		C					
21616	Removal of rib and nerves		C					
21620	Partial removal of sternum		C					
21627	Sternal debridement		C					
21630	Extensive sternum surgery		C					
21632	Extensive sternum surgery		C					
21685	Hyoid myotomy & suspension		T	0252	7.7504	$509.08	$109.16	$101.82
21700	Revision of neck muscle		T	0049	22.3967	$1,471.10		$294.22
21705	Revision of neck muscle/rib		C					
21720	Revision of neck muscle		T	0049	22.3967	$1,471.10		$294.22
21725	Revision of neck muscle		T	0006	1.4267	$93.71		$18.75
21740	Reconstruction of sternum		C					
21742	Repair stern/nuss w/o scope		T	0051	45.4359	$2,984.41		$596.89
21743	Repair sternum/nuss w/scope		T	0051	45.4359	$2,984.41		$596.89
21750	Repair of sternum separation		C					
21800	Treatment of rib fracture	CH	T	0129	1.5788	$103.70		$20.74
21805	Treatment of rib fracture		T	0062	25.6821	$1,686.90	$372.87	$337.38
21810	Treatment of rib fracture(s)		C					
21820	Treat sternum fracture	CH	T	0129	1.5788	$103.70		$20.74
21825	Treat sternum fracture		C					
21899	Neck/chest surgery procedure	CH	T	0250	1.1335	$74.45	$25.10	$14.89
21920	Biopsy soft tissue of back		T	0020	7.9864	$524.58		$104.92
21925	Biopsy soft tissue of back		T	0022	21.7477	$1,428.48	$354.45	$285.70
21930	Remove lesion, back or flank		T	0022	21.7477	$1,428.48	$354.45	$285.70
21935	Remove tumor, back		T	0022	21.7477	$1,428.48	$354.45	$285.70
22010	I&d, p-spine, c/t/cerv-thor		C					
22015	I&d, p-spine, l/s/ls		C					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
22100	Remove part of neck vertebra		T	0208	48.3964	$3,178.87		$635.78
22101	Remove part, thorax vertebra		T	0208	48.3964	$3,178.87		$635.78
22102	Remove part, lumbar vertebra		T	0208	48.3964	$3,178.87		$635.78
22103	Remove extra spine segment		T	0208	48.3964	$3,178.87		$635.78
22110	Remove part of neck vertebra		C					
22112	Remove part, thorax vertebra		C					
22114	Remove part, lumbar vertebra		C					
22116	Remove extra spine segment		C					
22206	Cut spine 3 col, thor		C					
22207	Cut spine 3 col, lumb		C					
22208	Cut spine 3 col, addl seg		C					
22210	Revision of neck spine		C					
22212	Revision of thorax spine		C					
22214	Revision of lumbar spine		C					
22216	Revise, extra spine segment		C					
22220	Revision of neck spine		C					
22222	Revision of thorax spine		T	0208	48.3964	$3,178.87		$635.78
22224	Revision of lumbar spine		C					
22226	Revise, extra spine segment		C					
22305	Treat spine process fracture	CH	T	0129	1.5788	$103.70		$20.74
22310	Treat spine fracture	CH	T	0138	6.0607	$398.09		$79.62
22315	Treat spine fracture	CH	T	0139	20.4295	$1,341.89		$268.38
22318	Treat odontoid fx w/o graft		C					
22319	Treat odontoid fx w/graft		C					
22325	Treat spine fracture		C					
22326	Treat neck spine fracture		C					
22327	Treat thorax spine fracture		C					
22328	Treat each add spine fx		C					
22505	Manipulation of spine		T	0045	15.5334	$1,020.30	$268.47	$204.06
22520	Percut vertebroplasty thor		T	0050	29.4401	$1,933.74		$386.75
22521	Percut vertebroplasty lumb		T	0050	29.4401	$1,933.74		$386.75

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
22522	Percut vertebroplasty add'l		T	0050	29.4401	$1,933.74		$386.75
22523	Percut kyphoplasty, thor		T	0052	85.4915	$5,615.42		$1,123.09
22524	Percut kyphoplasty, lumbar		T	0052	85.4915	$5,615.42		$1,123.09
22525	Percut kyphoplasty, add-on		T	0052	85.4915	$5,615.42		$1,123.09
22526	Idet, single level		T	0050	29.4401	$1,933.74		$386.75
22527	Idet, 1 or more levels		T	0050	29.4401	$1,933.74		$386.75
22532	Lat thorax spine fusion		C					
22533	Lat lumbar spine fusion		C					
22534	Lat thor/lumb, add'l seg		C					
22548	Neck spine fusion		C					
22554	Neck spine fusion		C					
22556	Thorax spine fusion		C					
22558	Lumbar spine fusion		C					
22585	Additional spinal fusion		C					
22590	Spine & skull spinal fusion		C					
22595	Neck spinal fusion		C					
22600	Neck spine fusion		C					
22610	Thorax spine fusion		C					
22612	Lumbar spine fusion		T	0208	48.3964	$3,178.87		$635.78
22614	Spine fusion, extra segment		T	0208	48.3964	$3,178.87		$635.78
22630	Lumbar spine fusion		C					
22632	Spine fusion, extra segment		C					
22800	Fusion of spine		C					
22802	Fusion of spine		C					
22804	Fusion of spine		C					
22808	Fusion of spine		C					
22810	Fusion of spine		C					
22812	Fusion of spine		C					
22818	Kyphectomy, 1-2 segments		C					
22819	Kyphectomy, 3 or more		C					
22830	Exploration of spinal fusion		C					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
22840	Insert spine fixation device		C					
22841	Insert spine fixation device		C					
22842	Insert spine fixation device		C					
22843	Insert spine fixation device		C					
22844	Insert spine fixation device		C					
22845	Insert spine fixation device		C					
22846	Insert spine fixation device		C					
22847	Insert spine fixation device		C					
22848	Insert pelv fixation device		C					
22849	Reinsert spinal fixation		C					
22850	Remove spine fixation device		C					
22851	Apply spine prosth device		T	0049	22.3967	$1,471.10		$294.22
22852	Remove spine fixation device		C					
22855	Remove spine fixation device		C					
22857	Lumbar artif diskectomy		C					
22862	Revise lumbar artif disc		C					
22865	Remove lumb artif disc		C					
22899	Spine surgery procedure		T	0049	22.3967	$1,471.10		$294.22
22900	Remove abdominal wall lesion		T	0022	21.7477	$1,428.48	$354.45	$285.70
22999	Abdomen surgery procedure		T	0049	22.3967	$1,471.10		$294.22
23000	Removal of calcium deposits		T	0021	15.8699	$1,042.40	$219.48	$208.48
23020	Release shoulder joint		T	0051	45.4359	$2,984.41		$596.89
23030	Drain shoulder lesion		T	0008	19.5771	$1,285.90		$257.18
23031	Drain shoulder bursa		T	0008	19.5771	$1,285.90		$257.18
23035	Drain shoulder bone lesion		T	0049	22.3967	$1,471.10		$294.22
23040	Exploratory shoulder surgery		T	0050	29.4401	$1,933.74		$386.75
23044	Exploratory shoulder surgery		T	0050	29.4401	$1,933.74		$386.75
23065	Biopsy shoulder tissues		T	0020	7.9864	$524.58		$104.92
23066	Biopsy shoulder tissues		T	0022	21.7477	$1,428.48	$354.45	$285.70
23075	Removal of shoulder lesion		T	0021	15.8699	$1,042.40	$219.48	$208.48
23076	Removal of shoulder lesion		T	0022	21.7477	$1,428.48	$354.45	$285.70

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
23077	Remove tumor of shoulder		T	0022	21.7477	$1,428.48	$354.45	$285.70
23100	Biopsy of shoulder joint		T	0049	22.3967	$1,471.10		$294.22
23101	Shoulder joint surgery		T	0050	29.4401	$1,933.74		$386.75
23105	Remove shoulder joint lining		T	0050	29.4401	$1,933.74		$386.75
23106	Incision of collarbone joint		T	0050	29.4401	$1,933.74		$386.75
23107	Explore treat shoulder joint		T	0050	29.4401	$1,933.74		$386.75
23120	Partial removal, collar bone		T	0050	29.4401	$1,933.74		$386.75
23125	Removal of collar bone		T	0050	29.4401	$1,933.74		$386.75
23130	Remove shoulder bone, part		T	0051	45.4359	$2,984.41		$596.89
23140	Removal of bone lesion		T	0049	22.3967	$1,471.10		$294.22
23145	Removal of bone lesion		T	0050	29.4401	$1,933.74		$386.75
23146	Removal of bone lesion		T	0050	29.4401	$1,933.74		$386.75
23150	Removal of humerus lesion		T	0050	29.4401	$1,933.74		$386.75
23155	Removal of humerus lesion		T	0050	29.4401	$1,933.74		$386.75
23156	Removal of humerus lesion		T	0050	29.4401	$1,933.74		$386.75
23170	Remove collar bone lesion		T	0050	29.4401	$1,933.74		$386.75
23172	Remove shoulder blade lesion		T	0050	29.4401	$1,933.74		$386.75
23174	Remove humerus lesion		T	0050	29.4401	$1,933.74		$386.75
23180	Remove collar bone lesion		T	0050	29.4401	$1,933.74		$386.75
23182	Remove shoulder blade lesion		T	0050	29.4401	$1,933.74		$386.75
23184	Remove humerus lesion		T	0050	29.4401	$1,933.74		$386.75
23190	Partial removal of scapula		T	0050	29.4401	$1,933.74		$386.75
23195	Removal of head of humerus		T	0050	29.4401	$1,933.74		$386.75
23200	Removal of collar bone		C					
23210	Removal of shoulder blade		C					
23220	Partial removal of humerus		C					
23221	Partial removal of humerus		C					
23222	Partial removal of humerus		C					
23330	Remove shoulder foreign body		T	0020	7.9864	$524.58		$104.92
23331	Remove shoulder foreign body		T	0022	21.7477	$1,428.48	$354.45	$285.70
23332	Remove shoulder foreign body		C					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
23350	Injection for shoulder x-ray		N					
23395	Muscle transfer,shoulder/arm		T	0051	45.4359	$2,984.41		$596.89
23397	Muscle transfers		T	0052	85.4915	$5,615.42		$1,123.09
23400	Fixation of shoulder blade		T	0050	29.4401	$1,933.74		$386.75
23405	Incision of tendon & muscle		T	0050	29.4401	$1,933.74		$386.75
23406	Incise tendon(s) & muscle(s)		T	0050	29.4401	$1,933.74		$386.75
23410	Repair rotator cuff, acute		T	0051	45.4359	$2,984.41		$596.89
23412	Repair rotator cuff, chronic		T	0051	45.4359	$2,984.41		$596.89
23415	Release of shoulder ligament		T	0051	45.4359	$2,984.41		$596.89
23420	Repair of shoulder		T	0051	45.4359	$2,984.41		$596.89
23430	Repair biceps tendon		T	0051	45.4359	$2,984.41		$596.89
23440	Remove/transplant tendon		T	0051	45.4359	$2,984.41		$596.89
23450	Repair shoulder capsule		T	0052	85.4915	$5,615.42		$1,123.09
23455	Repair shoulder capsule		T	0052	85.4915	$5,615.42		$1,123.09
23460	Repair shoulder capsule		T	0052	85.4915	$5,615.42		$1,123.09
23462	Repair shoulder capsule		T	0051	45.4359	$2,984.41		$596.89
23465	Repair shoulder capsule		T	0052	85.4915	$5,615.42		$1,123.09
23466	Repair shoulder capsule		T	0051	45.4359	$2,984.41		$596.89
23470	Reconstruct shoulder joint		T	0425	120.5685	$7,919.42		$1,583.89
23472	Reconstruct shoulder joint		C					
23480	Revision of collar bone		T	0051	45.4359	$2,984.41		$596.89
23485	Revision of collar bone		T	0052	85.4915	$5,615.42		$1,123.09
23490	Reinforce clavicle		T	0051	45.4359	$2,984.41		$596.89
23491	Reinforce shoulder bones		T	0052	85.4915	$5,615.42		$1,123.09
23500	Treat clavicle fracture	CH	T	0129	1.5788	$103.70		$20.74
23505	Treat clavicle fracture	CH	T	0139	20.4295	$1,341.89		$268.38
23515	Treat clavicle fracture		T	0064	62.0926	$4,078.49	$835.79	$815.70
23520	Treat clavicle dislocation	CH	T	0138	6.0607	$398.09		$79.62
23525	Treat clavicle dislocation	CH	T	0138	6.0607	$398.09		$79.62
23530	Treat clavicle dislocation		T	0063	42.5770	$2,796.63		$559.33
23532	Treat clavicle dislocation		T	0062	25.6821	$1,686.90	$372.87	$337.38

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
23540	Treat clavicle dislocation	CH	T	0129	1.5788	$103.70		$20.74
23545	Treat clavicle dislocation	CH	T	0138	6.0607	$398.09		$79.62
23550	Treat clavicle dislocation		T	0063	42.5770	$2,796.63		$559.33
23552	Treat clavicle dislocation		T	0063	42.5770	$2,796.63		$559.33
23570	Treat shoulder blade fx	CH	T	0129	1.5788	$103.70		$20.74
23575	Treat shoulder blade fx	CH	T	0138	6.0607	$398.09		$79.62
23585	Treat scapula fracture		T	0064	62.0926	$4,078.49	$835.79	$815.70
23600	Treat humerus fracture	CH	T	0129	1.5788	$103.70		$20.74
23605	Treat humerus fracture	CH	T	0139	20.4295	$1,341.89		$268.38
23615	Treat humerus fracture		T	0064	62.0926	$4,078.49	$835.79	$815.70
23616	Treat humerus fracture		T	0064	62.0926	$4,078.49	$835.79	$815.70
23620	Treat humerus fracture	CH	T	0129	1.5788	$103.70		$20.74
23625	Treat humerus fracture	CH	T	0139	20.4295	$1,341.89		$268.38
23630	Treat humerus fracture		T	0064	62.0926	$4,078.49	$835.79	$815.70
23650	Treat shoulder dislocation	CH	T	0129	1.5788	$103.70		$20.74
23655	Treat shoulder dislocation		T	0045	15.5334	$1,020.30	$268.47	$204.06
23660	Treat shoulder dislocation		T	0063	42.5770	$2,796.63		$559.33
23665	Treat dislocation/fracture	CH	T	0138	6.0607	$398.09		$79.62
23670	Treat dislocation/fracture		T	0064	62.0926	$4,078.49	$835.79	$815.70
23675	Treat dislocation/fracture	CH	T	0129	1.5788	$103.70		$20.74
23680	Treat dislocation/fracture		T	0063	42.5770	$2,796.63		$559.33
23700	Fixation of shoulder		T	0045	15.5334	$1,020.30	$268.47	$204.06
23800	Fusion of shoulder joint		T	0052	85.4915	$5,615.42		$1,123.09
23802	Fusion of shoulder joint		T	0051	45.4359	$2,984.41		$596.89
23900	Amputation of arm & girdle		C					
23920	Amputation at shoulder joint		C					
23921	Amputation follow-up surgery		T	0136	16.0086	$1,051.51		$210.31
23929	Shoulder surgery procedure	CH	T	0129	1.5788	$103.70		$20.74
23930	Drainage of arm lesion		T	0008	19.5771	$1,285.90		$257.18
23931	Drainage of arm bursa		T	0008	19.5771	$1,285.90		$257.18
23935	Drain arm/elbow bone lesion		T	0049	22.3967	$1,471.10		$294.22

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
24000	Exploratory elbow surgery		T	0050	29.4401	$1,933.74		$386.75
24006	Release elbow joint		T	0050	29.4401	$1,933.74		$386.75
24065	Biopsy arm/elbow soft tissue		T	0021	15.8699	$1,042.40	$219.48	$208.48
24066	Biopsy arm/elbow soft tissue		T	0021	15.8699	$1,042.40	$219.48	$208.48
24075	Remove arm/elbow lesion		T	0021	15.8699	$1,042.40	$219.48	$208.48
24076	Remove arm/elbow lesion		T	0022	21.7477	$1,428.48	$354.45	$285.70
24077	Remove tumor of arm/elbow		T	0022	21.7477	$1,428.48	$354.45	$285.70
24100	Biopsy elbow joint lining		T	0049	22.3967	$1,471.10		$294.22
24101	Explore/treat elbow joint		T	0050	29.4401	$1,933.74		$386.75
24102	Remove elbow joint lining		T	0050	29.4401	$1,933.74		$386.75
24105	Removal of elbow bursa		T	0049	22.3967	$1,471.10		$294.22
24110	Remove humerus lesion		T	0049	22.3967	$1,471.10		$294.22
24115	Remove/graft bone lesion		T	0050	29.4401	$1,933.74		$386.75
24116	Remove/graft bone lesion		T	0050	29.4401	$1,933.74		$386.75
24120	Remove elbow lesion		T	0049	22.3967	$1,471.10		$294.22
24125	Remove/graft bone lesion		T	0050	29.4401	$1,933.74		$386.75
24126	Remove/graft bone lesion		T	0050	29.4401	$1,933.74		$386.75
24130	Removal of head of radius		T	0050	29.4401	$1,933.74		$386.75
24134	Removal of arm bone lesion		T	0050	29.4401	$1,933.74		$386.75
24136	Remove radius bone lesion		T	0050	29.4401	$1,933.74		$386.75
24138	Remove elbow bone lesion		T	0050	29.4401	$1,933.74		$386.75
24140	Partial removal of arm bone		T	0050	29.4401	$1,933.74		$386.75
24145	Partial removal of radius		T	0050	29.4401	$1,933.74		$386.75
24147	Partial removal of elbow		T	0050	29.4401	$1,933.74		$386.75
24149	Radical resection of elbow		T	0050	29.4401	$1,933.74		$386.75
24150	Extensive humerus surgery		T	0051	45.4359	$2,984.41		$596.89
24151	Extensive humerus surgery		T	0052	85.4915	$5,615.42		$1,123.09
24152	Extensive radius surgery		T	0051	45.4359	$2,984.41		$596.89
24153	Extensive radius surgery		T	0052	85.4915	$5,615.42		$1,123.09
24155	Removal of elbow joint		T	0051	45.4359	$2,984.41		$596.89
24160	Remove elbow joint implant		T	0050	29.4401	$1,933.74		$386.75

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
24164	Remove radius head implant		T	0050	29.4401	$1,933.74		$386.75
24200	Removal of arm foreign body		T	0019	4.3877	$288.20	$71.87	$57.64
24201	Removal of arm foreign body		T	0021	15.8699	$1,042.40	$219.48	$208.48
24220	Injection for elbow x-ray		N					
24300	Manipulate elbow w/anesth		T	0045	15.5334	$1,020.30	$268.47	$204.06
24301	Muscle/tendon transfer		T	0050	29.4401	$1,933.74		$386.75
24305	Arm tendon lengthening		T	0050	29.4401	$1,933.74		$386.75
24310	Revision of arm tendon		T	0049	22.3967	$1,471.10		$294.22
24320	Repair of arm tendon		T	0051	45.4359	$2,984.41		$596.89
24330	Revision of arm muscles		T	0052	85.4915	$5,615.42		$1,123.09
24331	Revision of arm muscles		T	0051	45.4359	$2,984.41		$596.89
24332	Tenolysis, triceps		T	0049	22.3967	$1,471.10		$294.22
24340	Repair of biceps tendon		T	0051	45.4359	$2,984.41		$596.89
24341	Repair arm tendon/muscle		T	0051	45.4359	$2,984.41		$596.89
24342	Repair of ruptured tendon		T	0051	45.4359	$2,984.41		$596.89
24343	Repr elbow lat ligmnt w/tiss		T	0050	29.4401	$1,933.74		$386.75
24344	Reconstruct elbow lat ligmnt		T	0052	85.4915	$5,615.42		$1,123.09
24345	Repr elbw med ligmnt w/tissu		T	0050	29.4401	$1,933.74		$386.75
24346	Reconstruct elbow med ligmnt		T	0051	45.4359	$2,984.41		$596.89
24357	Repair elbow, perc		T	0050	29.4401	$1,933.74		$386.75
24358	Repair elbow w/deb, open		T	0050	29.4401	$1,933.74		$386.75
24359	Repair elbow deb/attch open		T	0050	29.4401	$1,933.74		$386.75
24360	Reconstruct elbow joint		T	0047	37.8828	$2,488.29	$537.03	$497.66
24361	Reconstruct elbow joint		T	0425	120.5685	$7,919.42		$1,583.89
24362	Reconstruct elbow joint		T	0048	52.8676	$3,472.56		$694.52
24363	Replace elbow joint		T	0425	120.5685	$7,919.42		$1,583.89
24365	Reconstruct head of radius		T	0047	37.8828	$2,488.29	$537.03	$497.66
24366	Reconstruct head of radius		T	0425	120.5685	$7,919.42		$1,583.89
24400	Revision of humerus		T	0050	29.4401	$1,933.74		$386.75
24410	Revision of humerus		T	0050	29.4401	$1,933.74		$386.75
24420	Revision of humerus		T	0051	45.4359	$2,984.41		$596.89

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
24430	Repair of humerus		T	0052	85.4915	$5,615.42		$1,123.09
24435	Repair humerus with graft		T	0052	85.4915	$5,615.42		$1,123.09
24470	Revision of elbow joint		T	0051	45.4359	$2,984.41		$596.89
24495	Decompression of forearm		T	0050	29.4401	$1,933.74		$386.75
24498	Reinforce humerus		T	0052	85.4915	$5,615.42		$1,123.09
24500	Treat humerus fracture	CH	T	0129	1.5788	$103.70		$20.74
24505	Treat humerus fracture	CH	T	0129	1.5788	$103.70		$20.74
24515	Treat humerus fracture		T	0064	62.0926	$4,078.49	$835.79	$815.70
24516	Treat humerus fracture		T	0064	62.0926	$4,078.49	$835.79	$815.70
24530	Treat humerus fracture	CH	T	0129	1.5788	$103.70		$20.74
24535	Treat humerus fracture	CH	T	0138	6.0607	$398.09		$79.62
24538	Treat humerus fracture		T	0062	25.6821	$1,686.90	$372.87	$337.38
24545	Treat humerus fracture		T	0064	62.0926	$4,078.49	$835.79	$815.70
24546	Treat humerus fracture		T	0064	62.0926	$4,078.49	$835.79	$815.70
24560	Treat humerus fracture	CH	T	0129	1.5788	$103.70		$20.74
24565	Treat humerus fracture	CH	T	0129	1.5788	$103.70		$20.74
24566	Treat humerus fracture		T	0062	25.6821	$1,686.90	$372.87	$337.38
24575	Treat humerus fracture		T	0064	62.0926	$4,078.49	$835.79	$815.70
24576	Treat humerus fracture	CH	T	0129	1.5788	$103.70		$20.74
24577	Treat humerus fracture	CH	T	0138	6.0607	$398.09		$79.62
24579	Treat humerus fracture		T	0064	62.0926	$4,078.49	$835.79	$815.70
24582	Treat humerus fracture		T	0062	25.6821	$1,686.90	$372.87	$337.38
24586	Treat elbow fracture		T	0064	62.0926	$4,078.49	$835.79	$815.70
24587	Treat elbow fracture		T	0064	62.0926	$4,078.49	$835.79	$815.70
24600	Treat elbow dislocation	CH	T	0129	1.5788	$103.70		$20.74
24605	Treat elbow dislocation		T	0045	15.5334	$1,020.30	$268.47	$204.06
24615	Treat elbow dislocation		T	0064	62.0926	$4,078.49	$835.79	$815.70
24620	Treat elbow fracture	CH	T	0139	20.4295	$1,341.89		$268.38
24635	Treat elbow fracture		T	0064	62.0926	$4,078.49	$835.79	$815.70
24640	Treat elbow dislocation	CH	T	0129	1.5788	$103.70		$20.74
24650	Treat radius fracture	CH	T	0129	1.5788	$103.70		$20.74

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
24655	Treat radius fracture	CH	T	0138	6.0607	$398.09		$79.62
24665	Treat radius fracture		T	0063	42.5770	$2,796.63		$559.33
24666	Treat radius fracture		T	0064	62.0926	$4,078.49	$835.79	$815.70
24670	Treat ulnar fracture	CH	T	0129	1.5788	$103.70		$20.74
24675	Treat ulnar fracture	CH	T	0129	1.5788	$103.70		$20.74
24685	Treat ulnar fracture		T	0063	42.5770	$2,796.63		$559.33
24800	Fusion of elbow joint		T	0051	45.4359	$2,984.41		$596.89
24802	Fusion/graft of elbow joint		T	0051	45.4359	$2,984.41		$596.89
24900	Amputation of upper arm		C					
24920	Amputation of upper arm		C					
24925	Amputation follow-up surgery		T	0049	22.3967	$1,471.10		$294.22
24930	Amputation follow-up surgery		C					
24931	Amputate upper arm & implant		C					
24935	Revision of amputation		T	0052	85.4915	$5,615.42		$1,123.09
24940	Revision of upper arm		C					
24999	Upper arm/elbow surgery	CH	T	0129	1.5788	$103.70		$20.74
25000	Incision of tendon sheath		T	0049	22.3967	$1,471.10		$294.22
25001	Incise flexor carpi radialis		T	0049	22.3967	$1,471.10		$294.22
25020	Decompress forearm 1 space		T	0049	22.3967	$1,471.10		$294.22
25023	Decompress forearm 1 space		T	0050	29.4401	$1,933.74		$386.75
25024	Decompress forearm 2 spaces		T	0050	29.4401	$1,933.74		$386.75
25025	Decompress forearm 2 spaces		T	0050	29.4401	$1,933.74		$386.75
25028	Drainage of forearm lesion		T	0049	22.3967	$1,471.10		$294.22
25031	Drainage of forearm bursa		T	0049	22.3967	$1,471.10		$294.22
25035	Treat forearm bone lesion		T	0049	22.3967	$1,471.10		$294.22
25040	Explore/treat wrist joint		T	0050	29.4401	$1,933.74		$386.75
25065	Biopsy forearm soft tissues		T	0020	7.9864	$524.58		$104.92
25066	Biopsy forearm soft tissues		T	0022	21.7477	$1,428.48	$354.45	$285.70
25075	Removal forearm lesion subcu		T	0021	15.8699	$1,042.40	$219.48	$208.48
25076	Removal forearm lesion deep		T	0022	21.7477	$1,428.48	$354.45	$285.70
25077	Remove tumor, forearm/wrist		T	0022	21.7477	$1,428.48	$354.45	$285.70

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
25085	Incision of wrist capsule		T	0049	22.3967	$1,471.10		$294.22
25100	Biopsy of wrist joint		T	0049	22.3967	$1,471.10		$294.22
25101	Explore/treat wrist joint		T	0050	29.4401	$1,933.74		$386.75
25105	Remove wrist joint lining		T	0050	29.4401	$1,933.74		$386.75
25107	Remove wrist joint cartilage		T	0050	29.4401	$1,933.74		$386.75
25109	Excise tendon forearm/wrist		T	0049	22.3967	$1,471.10		$294.22
25110	Remove wrist tendon lesion		T	0049	22.3967	$1,471.10		$294.22
25111	Remove wrist tendon lesion		T	0053	16.9978	$1,116.48	$253.49	$223.30
25112	Reremove wrist tendon lesion		T	0053	16.9978	$1,116.48	$253.49	$223.30
25115	Remove wrist/forearm lesion		T	0049	22.3967	$1,471.10		$294.22
25116	Remove wrist/forearm lesion		T	0049	22.3967	$1,471.10		$294.22
25118	Excise wrist tendon sheath		T	0050	29.4401	$1,933.74		$386.75
25119	Partial removal of ulna		T	0050	29.4401	$1,933.74		$386.75
25120	Removal of forearm lesion		T	0050	29.4401	$1,933.74		$386.75
25125	Remove/graft forearm lesion		T	0050	29.4401	$1,933.74		$386.75
25126	Remove/graft forearm lesion		T	0050	29.4401	$1,933.74		$386.75
25130	Removal of wrist lesion		T	0050	29.4401	$1,933.74		$386.75
25135	Remove & graft wrist lesion		T	0050	29.4401	$1,933.74		$386.75
25136	Remove & graft wrist lesion		T	0050	29.4401	$1,933.74		$386.75
25145	Remove forearm bone lesion		T	0050	29.4401	$1,933.74		$386.75
25150	Partial removal of ulna		T	0050	29.4401	$1,933.74		$386.75
25151	Partial removal of radius		T	0050	29.4401	$1,933.74		$386.75
25170	Extensive forearm surgery		T	0051	45.4359	$2,984.41		$596.89
25210	Removal of wrist bone		T	0054	28.1744	$1,850.61		$370.13
25215	Removal of wrist bones		T	0054	28.1744	$1,850.61		$370.13
25230	Partial removal of radius		T	0050	29.4401	$1,933.74		$386.75
25240	Partial removal of ulna		T	0050	29.4401	$1,933.74		$386.75
25246	Injection for wrist x-ray		N					
25248	Remove forearm foreign body		T	0049	22.3967	$1,471.10		$294.22
25250	Removal of wrist prosthesis		T	0050	29.4401	$1,933.74		$386.75
25251	Removal of wrist prosthesis		T	0050	29.4401	$1,933.74		$386.75

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
25259	Manipulate wrist w/anesthes	CH	T	0139	20.4295	$1,341.89		$268.38
25260	Repair forearm tendon/muscle		T	0050	29.4401	$1,933.74		$386.75
25263	Repair forearm tendon/muscle		T	0050	29.4401	$1,933.74		$386.75
25265	Repair forearm tendon/muscle		T	0050	29.4401	$1,933.74		$386.75
25270	Repair forearm tendon/muscle		T	0050	29.4401	$1,933.74		$386.75
25272	Repair forearm tendon/muscle		T	0050	29.4401	$1,933.74		$386.75
25274	Repair forearm tendon/muscle		T	0050	29.4401	$1,933.74		$386.75
25275	Repair forearm tendon sheath		T	0050	29.4401	$1,933.74		$386.75
25280	Revise wrist/forearm tendon		T	0050	29.4401	$1,933.74		$386.75
25290	Incise wrist/forearm tendon		T	0050	29.4401	$1,933.74		$386.75
25295	Release wrist/forearm tendon		T	0049	22.3967	$1,471.10		$294.22
25300	Fusion of tendons at wrist		T	0050	29.4401	$1,933.74		$386.75
25301	Fusion of tendons at wrist		T	0050	29.4401	$1,933.74		$386.75
25310	Transplant forearm tendon		T	0051	45.4359	$2,984.41		$596.89
25312	Transplant forearm tendon		T	0051	45.4359	$2,984.41		$596.89
25315	Revise palsy hand tendon(s)		T	0051	45.4359	$2,984.41		$596.89
25316	Revise palsy hand tendon(s)		T	0052	85.4915	$5,615.42		$1,123.09
25320	Repair/revise wrist joint		T	0051	45.4359	$2,984.41		$596.89
25332	Revise wrist joint		T	0047	37.8828	$2,488.29	$537.03	$497.66
25335	Realignment of hand		T	0051	45.4359	$2,984.41		$596.89
25337	Reconstruct ulna/radioulnar		T	0051	45.4359	$2,984.41		$596.89
25350	Revision of radius		T	0052	85.4915	$5,615.42		$1,123.09
25355	Revision of radius		T	0051	45.4359	$2,984.41		$596.89
25360	Revision of ulna		T	0050	29.4401	$1,933.74		$386.75
25365	Revise radius & ulna		T	0050	29.4401	$1,933.74		$386.75
25370	Revise radius or ulna		T	0051	45.4359	$2,984.41		$596.89
25375	Revise radius & ulna		T	0051	45.4359	$2,984.41		$596.89
25390	Shorten radius or ulna		T	0050	29.4401	$1,933.74		$386.75
25391	Lengthen radius or ulna		T	0051	45.4359	$2,984.41		$596.89
25392	Shorten radius & ulna		T	0050	29.4401	$1,933.74		$386.75
25393	Lengthen radius & ulna		T	0051	45.4359	$2,984.41		$596.89

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
25394	Repair carpal bone, shorten		T	0053	16.9978	$1,116.48	$253.49	$223.30
25400	Repair radius or ulna	CH	T	0051	45.4359	$2,984.41		$596.89
25405	Repair/graft radius or ulna		T	0052	85.4915	$5,615.42		$1,123.09
25415	Repair radius & ulna		T	0052	85.4915	$5,615.42		$1,123.09
25420	Repair/graft radius & ulna		T	0052	85.4915	$5,615.42		$1,123.09
25425	Repair/graft radius or ulna		T	0051	45.4359	$2,984.41		$596.89
25426	Repair/graft radius & ulna		T	0051	45.4359	$2,984.41		$596.89
25430	Vasc graft into carpal bone		T	0054	28.1744	$1,850.61		$370.13
25431	Repair nonunion carpal bone		T	0054	28.1744	$1,850.61		$370.13
25440	Repair/graft wrist bone		T	0052	85.4915	$5,615.42		$1,123.09
25441	Reconstruct wrist joint		T	0425	120.5685	$7,919.42		$1,583.89
25442	Reconstruct wrist joint		T	0425	120.5685	$7,919.42		$1,583.89
25443	Reconstruct wrist joint		T	0048	52.8676	$3,472.56		$694.52
25444	Reconstruct wrist joint		T	0048	52.8676	$3,472.56		$694.52
25445	Reconstruct wrist joint		T	0048	52.8676	$3,472.56		$694.52
25446	Wrist replacement		T	0425	120.5685	$7,919.42		$1,583.89
25447	Repair wrist joint(s)		T	0047	37.8828	$2,488.29	$537.03	$497.66
25449	Remove wrist joint implant		T	0047	37.8828	$2,488.29	$537.03	$497.66
25450	Revision of wrist joint		T	0051	45.4359	$2,984.41		$596.89
25455	Revision of wrist joint		T	0051	45.4359	$2,984.41		$596.89
25490	Reinforce radius		T	0051	45.4359	$2,984.41		$596.89
25491	Reinforce ulna		T	0051	45.4359	$2,984.41		$596.89
25492	Reinforce radius and ulna		T	0051	45.4359	$2,984.41		$596.89
25500	Treat fracture of radius	CH	T	0129	1.5788	$103.70		$20.74
25505	Treat fracture of radius	CH	T	0138	6.0607	$398.09		$79.62
25515	Treat fracture of radius		T	0063	42.5770	$2,796.63		$559.33
25520	Treat fracture of radius	CH	T	0138	6.0607	$398.09		$79.62
25525	Treat fracture of radius		T	0063	42.5770	$2,796.63		$559.33
25526	Treat fracture of radius		T	0063	42.5770	$2,796.63		$559.33
25530	Treat fracture of ulna	CH	T	0129	1.5788	$103.70		$20.74
25535	Treat fracture of ulna	CH	T	0129	1.5788	$103.70		$20.74

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
25545	Treat fracture of ulna		T	0063	42.5770	$2,796.63		$559.33
25560	Treat fracture radius & ulna	CH	T	0129	1.5788	$103.70		$20.74
25565	Treat fracture radius & ulna	CH	T	0138	6.0607	$398.09		$79.62
25574	Treat fracture radius & ulna		T	0064	62.0926	$4,078.49	$835.79	$815.70
25575	Treat fracture radius/ulna		T	0064	62.0926	$4,078.49	$835.79	$815.70
25600	Treat fracture radius/ulna	CH	T	0129	1.5788	$103.70		$20.74
25605	Treat fracture radius/ulna	CH	T	0138	6.0607	$398.09		$79.62
25606	Treat fx distal radial		T	0062	25.6821	$1,686.90	$372.87	$337.38
25607	Treat fx rad extra-articul		T	0064	62.0926	$4,078.49	$835.79	$815.70
25608	Treat fx rad intra-articul		T	0064	62.0926	$4,078.49	$835.79	$815.70
25609	Treat fx radial 3+ frag		T	0064	62.0926	$4,078.49	$835.79	$815.70
25622	Treat wrist bone fracture	CH	T	0129	1.5788	$103.70		$20.74
25624	Treat wrist bone fracture	CH	T	0138	6.0607	$398.09		$79.62
25628	Treat wrist bone fracture		T	0063	42.5770	$2,796.63		$559.33
25630	Treat wrist bone fracture	CH	T	0129	1.5788	$103.70		$20.74
25635	Treat wrist bone fracture	CH	T	0138	6.0607	$398.09		$79.62
25645	Treat wrist bone fracture		T	0063	42.5770	$2,796.63		$559.33
25650	Treat wrist bone fracture	CH	T	0129	1.5788	$103.70		$20.74
25651	Pin ulnar styloid fracture		T	0062	25.6821	$1,686.90	$372.87	$337.38
25652	Treat fracture ulnar styloid		T	0063	42.5770	$2,796.63		$559.33
25660	Treat wrist dislocation	CH	T	0129	1.5788	$103.70		$20.74
25670	Treat wrist dislocation		T	0062	25.6821	$1,686.90	$372.87	$337.38
25671	Pin radioulnar dislocation		T	0062	25.6821	$1,686.90	$372.87	$337.38
25675	Treat wrist dislocation	CH	T	0129	1.5788	$103.70		$20.74
25676	Treat wrist dislocation		T	0062	25.6821	$1,686.90	$372.87	$337.38
25680	Treat wrist fracture	CH	T	0129	1.5788	$103.70		$20.74
25685	Treat wrist fracture		T	0062	25.6821	$1,686.90	$372.87	$337.38
25690	Treat wrist dislocation	CH	T	0139	20.4295	$1,341.89		$268.38
25695	Treat wrist dislocation		T	0062	25.6821	$1,686.90	$372.87	$337.38
25800	Fusion of wrist joint		T	0052	85.4915	$5,615.42		$1,123.09
25805	Fusion/graft of wrist joint		T	0051	45.4359	$2,984.41		$596.89

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
25810	Fusion/graft of wrist joint		T	0052	85.4915	$5,615.42		$1,123.09
25820	Fusion of hand bones		T	0053	16.9978	$1,116.48	$253.49	$223.30
25825	Fuse hand bones with graft		T	0052	85.4915	$5,615.42		$1,123.09
25830	Fusion, radioulnar jnt/ulna		T	0052	85.4915	$5,615.42		$1,123.09
25900	Amputation of forearm		C					
25905	Amputation of forearm		C					
25907	Amputation follow-up surgery		T	0049	22.3967	$1,471.10		$294.22
25909	Amputation follow-up surgery		C					
25915	Amputation of forearm		C					
25920	Amputate hand at wrist		C					
25922	Amputate hand at wrist		T	0049	22.3967	$1,471.10		$294.22
25924	Amputation follow-up surgery		C					
25927	Amputation of hand		C					
25929	Amputation follow-up surgery		T	0136	16.0086	$1,051.51		$210.31
25931	Amputation follow-up surgery		T	0049	22.3967	$1,471.10		$294.22
25999	Forearm or wrist surgery	CH	T	0129	1.5788	$103.70		$20.74
26010	Drainage of finger abscess		T	0006	1.4267	$93.71		$18.75
26011	Drainage of finger abscess		T	0007	12.8052	$841.10		$168.22
26020	Drain hand tendon sheath		T	0053	16.9978	$1,116.48	$253.49	$223.30
26025	Drainage of palm bursa		T	0053	16.9978	$1,116.48	$253.49	$223.30
26030	Drainage of palm bursa(s)		T	0053	16.9978	$1,116.48	$253.49	$223.30
26034	Treat hand bone lesion		T	0053	16.9978	$1,116.48	$253.49	$223.30
26035	Decompress fingers/hand		T	0053	16.9978	$1,116.48	$253.49	$223.30
26037	Decompress fingers/hand		T	0053	16.9978	$1,116.48	$253.49	$223.30
26040	Release palm contracture		T	0054	28.1744	$1,850.61		$370.13
26045	Release palm contracture		T	0054	28.1744	$1,850.61		$370.13
26055	Incise finger tendon sheath		T	0053	16.9978	$1,116.48	$253.49	$223.30
26060	Incision of finger tendon		T	0053	16.9978	$1,116.48	$253.49	$223.30
26070	Explore/treat hand joint		T	0053	16.9978	$1,116.48	$253.49	$223.30
26075	Explore/treat finger joint		T	0053	16.9978	$1,116.48	$253.49	$223.30
26080	Explore/treat finger joint		T	0053	16.9978	$1,116.48	$253.49	$223.30

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
26100	Biopsy hand joint lining		T	0053	16.9978	$1,116.48	$253.49	$223.30
26105	Biopsy finger joint lining		T	0053	16.9978	$1,116.48	$253.49	$223.30
26110	Biopsy finger joint lining		T	0053	16.9978	$1,116.48	$253.49	$223.30
26115	Removal hand lesion subcut		T	0022	21.7477	$1,428.48	$354.45	$285.70
26116	Removal hand lesion, deep		T	0022	21.7477	$1,428.48	$354.45	$285.70
26117	Remove tumor, hand/finger		T	0022	21.7477	$1,428.48	$354.45	$285.70
26121	Release palm contracture		T	0054	28.1744	$1,850.61		$370.13
26123	Release palm contracture		T	0054	28.1744	$1,850.61		$370.13
26125	Release palm contracture		T	0053	16.9978	$1,116.48	$253.49	$223.30
26130	Remove wrist joint lining		T	0053	16.9978	$1,116.48	$253.49	$223.30
26135	Revise finger joint, each		T	0054	28.1744	$1,850.61		$370.13
26140	Revise finger joint, each		T	0053	16.9978	$1,116.48	$253.49	$223.30
26145	Tendon excision, palm/finger		T	0053	16.9978	$1,116.48	$253.49	$223.30
26160	Remove tendon sheath lesion		T	0053	16.9978	$1,116.48	$253.49	$223.30
26170	Removal of palm tendon, each		T	0053	16.9978	$1,116.48	$253.49	$223.30
26180	Removal of finger tendon		T	0053	16.9978	$1,116.48	$253.49	$223.30
26185	Remove finger bone		T	0053	16.9978	$1,116.48	$253.49	$223.30
26200	Remove hand bone lesion		T	0053	16.9978	$1,116.48	$253.49	$223.30
26205	Remove/graft bone lesion		T	0054	28.1744	$1,850.61		$370.13
26210	Removal of finger lesion		T	0053	16.9978	$1,116.48	$253.49	$223.30
26215	Remove/graft finger lesion		T	0053	16.9978	$1,116.48	$253.49	$223.30
26230	Partial removal of hand bone		T	0053	16.9978	$1,116.48	$253.49	$223.30
26235	Partial removal, finger bone		T	0053	16.9978	$1,116.48	$253.49	$223.30
26236	Partial removal, finger bone		T	0053	16.9978	$1,116.48	$253.49	$223.30
26250	Extensive hand surgery		T	0053	16.9978	$1,116.48	$253.49	$223.30
26255	Extensive hand surgery		T	0054	28.1744	$1,850.61		$370.13
26260	Extensive finger surgery		T	0053	16.9978	$1,116.48	$253.49	$223.30
26261	Extensive finger surgery		T	0053	16.9978	$1,116.48	$253.49	$223.30
26262	Partial removal of finger		T	0053	16.9978	$1,116.48	$253.49	$223.30
26320	Removal of implant from hand		T	0021	15.8699	$1,042.40	$219.48	$208.48
26340	Manipulate finger w/anesth	CH	T	0138	6.0607	$398.09		$79.62

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
26350	Repair finger/hand tendon		T	0054	28.1744	$1,850.61		$370.13
26352	Repair/graft hand tendon		T	0054	28.1744	$1,850.61		$370.13
26356	Repair finger/hand tendon		T	0054	28.1744	$1,850.61		$370.13
26357	Repair finger/hand tendon		T	0054	28.1744	$1,850.61		$370.13
26358	Repair/graft hand tendon		T	0054	28.1744	$1,850.61		$370.13
26370	Repair finger/hand tendon		T	0054	28.1744	$1,850.61		$370.13
26372	Repair/graft hand tendon		T	0054	28.1744	$1,850.61		$370.13
26373	Repair finger/hand tendon		T	0054	28.1744	$1,850.61		$370.13
26390	Revise hand/finger tendon		T	0054	28.1744	$1,850.61		$370.13
26392	Repair/graft hand tendon		T	0054	28.1744	$1,850.61		$370.13
26410	Repair hand tendon		T	0053	16.9978	$1,116.48	$253.49	$223.30
26412	Repair/graft hand tendon		T	0054	28.1744	$1,850.61		$370.13
26415	Excision, hand/finger tendon		T	0054	28.1744	$1,850.61		$370.13
26416	Graft hand or finger tendon		T	0054	28.1744	$1,850.61		$370.13
26418	Repair finger tendon		T	0053	16.9978	$1,116.48	$253.49	$223.30
26420	Repair/graft finger tendon		T	0054	28.1744	$1,850.61		$370.13
26426	Repair finger/hand tendon		T	0054	28.1744	$1,850.61		$370.13
26428	Repair/graft finger tendon		T	0054	28.1744	$1,850.61		$370.13
26432	Repair finger tendon		T	0053	16.9978	$1,116.48	$253.49	$223.30
26433	Repair finger tendon		T	0053	16.9978	$1,116.48	$253.49	$223.30
26434	Repair/graft finger tendon		T	0054	28.1744	$1,850.61		$370.13
26437	Realignment of tendons		T	0053	16.9978	$1,116.48	$253.49	$223.30
26440	Release palm/finger tendon		T	0053	16.9978	$1,116.48	$253.49	$223.30
26442	Release palm & finger tendon		T	0054	28.1744	$1,850.61		$370.13
26445	Release hand/finger tendon		T	0053	16.9978	$1,116.48	$253.49	$223.30
26449	Release forearm/hand tendon		T	0054	28.1744	$1,850.61		$370.13
26450	Incision of palm tendon		T	0053	16.9978	$1,116.48	$253.49	$223.30
26455	Incision of finger tendon		T	0053	16.9978	$1,116.48	$253.49	$223.30
26460	Incise hand/finger tendon		T	0053	16.9978	$1,116.48	$253.49	$223.30
26471	Fusion of finger tendons		T	0053	16.9978	$1,116.48	$253.49	$223.30
26474	Fusion of finger tendons		T	0053	16.9978	$1,116.48	$253.49	$223.30

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Part II—Continued

Department of Health and Human Services

Centers for Medicare & Medicaid Services

42 CFR Parts 410 and 419

Medicare Program: Proposed Changes to the Hospital Outpatient Prospective Payment System and CY 2009 Payment Rates; Proposed Changes to the Ambulatory Surgical Center Payment System and CY 2009 Payment Rates; Proposed Rule

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
26476	Tendon lengthening		T	0053	16.9978	$1,116.48	$253.49	$223.30
26477	Tendon shortening		T	0053	16.9978	$1,116.48	$253.49	$223.30
26478	Lengthening of hand tendon		T	0053	16.9978	$1,116.48	$253.49	$223.30
26479	Shortening of hand tendon		T	0053	16.9978	$1,116.48	$253.49	$223.30
26480	Transplant hand tendon		T	0054	28.1744	$1,850.61		$370.13
26483	Transplant/graft hand tendon		T	0054	28.1744	$1,850.61		$370.13
26485	Transplant palm tendon		T	0054	28.1744	$1,850.61		$370.13
26489	Transplant/graft palm tendon		T	0054	28.1744	$1,850.61		$370.13
26490	Revise thumb tendon		T	0054	28.1744	$1,850.61		$370.13
26492	Tendon transfer with graft		T	0054	28.1744	$1,850.61		$370.13
26494	Hand tendon/muscle transfer		T	0054	28.1744	$1,850.61		$370.13
26496	Revise thumb tendon		T	0054	28.1744	$1,850.61		$370.13
26497	Finger tendon transfer		T	0054	28.1744	$1,850.61		$370.13
26498	Finger tendon transfer		T	0054	28.1744	$1,850.61		$370.13
26499	Revision of finger		T	0054	28.1744	$1,850.61		$370.13
26500	Hand tendon reconstruction		T	0053	16.9978	$1,116.48	$253.49	$223.30
26502	Hand tendon reconstruction		T	0054	28.1744	$1,850.61		$370.13
26508	Release thumb contracture		T	0053	16.9978	$1,116.48	$253.49	$223.30
26510	Thumb tendon transfer		T	0054	28.1744	$1,850.61		$370.13
26516	Fusion of knuckle joint		T	0054	28.1744	$1,850.61		$370.13
26517	Fusion of knuckle joints		T	0054	28.1744	$1,850.61		$370.13
26518	Fusion of knuckle joints		T	0054	28.1744	$1,850.61		$370.13
26520	Release knuckle contracture		T	0053	16.9978	$1,116.48	$253.49	$223.30
26525	Release finger contracture		T	0053	16.9978	$1,116.48	$253.49	$223.30
26530	Revise knuckle joint		T	0047	37.8828	$2,488.29	$537.03	$497.66
26531	Revise knuckle with implant		T	0048	52.8676	$3,472.56		$694.52
26535	Revise finger joint		T	0047	37.8828	$2,488.29	$537.03	$497.66
26536	Revise/implant finger joint		T	0048	52.8676	$3,472.56		$694.52
26540	Repair hand joint		T	0053	16.9978	$1,116.48	$253.49	$223.30
26541	Repair hand joint with graft		T	0054	28.1744	$1,850.61		$370.13
26542	Repair hand joint with graft		T	0053	16.9978	$1,116.48	$253.49	$223.30

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
26545	Reconstruct finger joint		T	0054	28.1744	$1,850.61		$370.13
26546	Repair nonunion hand		T	0054	28.1744	$1,850.61		$370.13
26548	Reconstruct finger joint		T	0054	28.1744	$1,850.61		$370.13
26550	Construct thumb replacement		T	0054	28.1744	$1,850.61		$370.13
26551	Great toe-hand transfer		C					
26553	Single transfer, toe-hand		C					
26554	Double transfer, toe-hand		C					
26555	Positional change of finger		T	0054	28.1744	$1,850.61		$370.13
26556	Toe joint transfer		C					
26560	Repair of web finger		T	0053	16.9978	$1,116.48	$253.49	$223.30
26561	Repair of web finger		T	0054	28.1744	$1,850.61		$370.13
26562	Repair of web finger		T	0054	28.1744	$1,850.61		$370.13
26565	Correct metacarpal flaw		T	0054	28.1744	$1,850.61		$370.13
26567	Correct finger deformity		T	0054	28.1744	$1,850.61		$370.13
26568	Lengthen metacarpal/finger		T	0054	28.1744	$1,850.61		$370.13
26580	Repair hand deformity		T	0053	16.9978	$1,116.48	$253.49	$223.30
26587	Reconstruct extra finger		T	0053	16.9978	$1,116.48	$253.49	$223.30
26590	Repair finger deformity		T	0053	16.9978	$1,116.48	$253.49	$223.30
26591	Repair muscles of hand		T	0054	28.1744	$1,850.61		$370.13
26593	Release muscles of hand		T	0053	16.9978	$1,116.48	$253.49	$223.30
26596	Excision constricting tissue		T	0053	16.9978	$1,116.48	$253.49	$223.30
26600	Treat metacarpal fracture	CH	T	0129	1.5788	$103.70		$20.74
26605	Treat metacarpal fracture	CH	T	0129	1.5788	$103.70		$20.74
26607	Treat metacarpal fracture	CH	T	0139	20.4295	$1,341.89		$268.38
26608	Treat metacarpal fracture		T	0062	25.6821	$1,686.90	$372.87	$337.38
26615	Treat metacarpal fracture		T	0063	42.5770	$2,796.63		$559.33
26641	Treat thumb dislocation	CH	T	0129	1.5788	$103.70		$20.74
26645	Treat thumb fracture	CH	T	0138	6.0607	$398.09		$79.62
26650	Treat thumb fracture		T	0062	25.6821	$1,686.90	$372.87	$337.38
26665	Treat thumb fracture		T	0063	42.5770	$2,796.63		$559.33
26670	Treat hand dislocation	CH	T	0129	1.5788	$103.70		$20.74

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
26675	Treat hand dislocation	CH	T	0138	6.0607	$398.09		$79.62
26676	Pin hand dislocation		T	0062	25.6821	$1,686.90	$372.87	$337.38
26685	Treat hand dislocation		T	0062	25.6821	$1,686.90	$372.87	$337.38
26686	Treat hand dislocation		T	0064	62.0926	$4,078.49	$835.79	$815.70
26700	Treat knuckle dislocation	CH	T	0129	1.5788	$103.70		$20.74
26705	Treat knuckle dislocation	CH	T	0129	1.5788	$103.70		$20.74
26706	Pin knuckle dislocation	CH	T	0139	20.4295	$1,341.89		$268.38
26715	Treat knuckle dislocation		T	0062	25.6821	$1,686.90	$372.87	$337.38
26720	Treat finger fracture, each	CH	T	0129	1.5788	$103.70		$20.74
26725	Treat finger fracture, each	CH	T	0129	1.5788	$103.70		$20.74
26727	Treat finger fracture, each		T	0062	25.6821	$1,686.90	$372.87	$337.38
26735	Treat finger fracture, each		T	0062	25.6821	$1,686.90	$372.87	$337.38
26740	Treat finger fracture, each	CH	T	0129	1.5788	$103.70		$20.74
26742	Treat finger fracture, each	CH	T	0129	1.5788	$103.70		$20.74
26746	Treat finger fracture, each		T	0062	25.6821	$1,686.90	$372.87	$337.38
26750	Treat finger fracture, each	CH	T	0129	1.5788	$103.70		$20.74
26755	Treat finger fracture, each	CH	T	0129	1.5788	$103.70		$20.74
26756	Pin finger fracture, each		T	0062	25.6821	$1,686.90	$372.87	$337.38
26765	Treat finger fracture, each		T	0062	25.6821	$1,686.90	$372.87	$337.38
26770	Treat finger dislocation	CH	T	0129	1.5788	$103.70		$20.74
26775	Treat finger dislocation		T	0045	15.5334	$1,020.30	$268.47	$204.06
26776	Pin finger dislocation		T	0062	25.6821	$1,686.90	$372.87	$337.38
26785	Treat finger dislocation		T	0062	25.6821	$1,686.90	$372.87	$337.38
26820	Thumb fusion with graft		T	0054	28.1744	$1,850.61		$370.13
26841	Fusion of thumb		T	0054	28.1744	$1,850.61		$370.13
26842	Thumb fusion with graft		T	0054	28.1744	$1,850.61		$370.13
26843	Fusion of hand joint		T	0054	28.1744	$1,850.61		$370.13
26844	Fusion/graft of hand joint		T	0054	28.1744	$1,850.61		$370.13
26850	Fusion of knuckle		T	0054	28.1744	$1,850.61		$370.13
26852	Fusion of knuckle with graft		T	0054	28.1744	$1,850.61		$370.13
26860	Fusion of finger joint		T	0054	28.1744	$1,850.61		$370.13

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
26861	Fusion of finger jnt, add-on		T	0054	28.1744	$1,850.61		$370.13
26862	Fusion/graft of finger joint		T	0054	28.1744	$1,850.61		$370.13
26863	Fuse/graft added joint		T	0054	28.1744	$1,850.61		$370.13
26910	Amputate metacarpal bone		T	0054	28.1744	$1,850.61		$370.13
26951	Amputation of finger/thumb		T	0053	16.9978	$1,116.48	$253.49	$223.30
26952	Amputation of finger/thumb		T	0053	16.9978	$1,116.48	$253.49	$223.30
26989	Hand/finger surgery	CH	T	0129	1.5788	$103.70		$20.74
26990	Drainage of pelvis lesion		T	0049	22.3967	$1,471.10		$294.22
26991	Drainage of pelvis bursa		T	0049	22.3967	$1,471.10		$294.22
26992	Drainage of bone lesion		C					
27000	Incision of hip tendon		T	0049	22.3967	$1,471.10		$294.22
27001	Incision of hip tendon		T	0050	29.4401	$1,933.74		$386.75
27003	Incision of hip tendon		T	0050	29.4401	$1,933.74		$386.75
27005	Incision of hip tendon		C					
27006	Incision of hip tendons		T	0050	29.4401	$1,933.74		$386.75
27025	Incision of hip/thigh fascia		C					
27030	Drainage of hip joint		C					
27033	Exploration of hip joint		T	0051	45.4359	$2,984.41		$596.89
27035	Denervation of hip joint		T	0051	45.4359	$2,984.41		$596.89
27036	Excision of hip joint/muscle		C					
27040	Biopsy of soft tissues		T	0020	7.9864	$524.58		$104.92
27041	Biopsy of soft tissues		T	0020	7.9864	$524.58		$104.92
27047	Remove hip/pelvis lesion		T	0022	21.7477	$1,428.48	$354.45	$285.70
27048	Remove hip/pelvis lesion		T	0022	21.7477	$1,428.48	$354.45	$285.70
27049	Remove tumor, hip/pelvis		T	0022	21.7477	$1,428.48	$354.45	$285.70
27050	Biopsy of sacroiliac joint		T	0049	22.3967	$1,471.10		$294.22
27052	Biopsy of hip joint		T	0049	22.3967	$1,471.10		$294.22
27054	Removal of hip joint lining		C					
27060	Removal of ischial bursa		T	0049	22.3967	$1,471.10		$294.22
27062	Remove femur lesion/bursa		T	0049	22.3967	$1,471.10		$294.22
27065	Removal of hip bone lesion		T	0049	22.3967	$1,471.10		$294.22

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
27066	Removal of hip bone lesion		T	0050	29.4401	$1,933.74		$386.75
27067	Remove/graft hip bone lesion		T	0050	29.4401	$1,933.74		$386.75
27070	Partial removal of hip bone		C					
27071	Partial removal of hip bone		C					
27075	Extensive hip surgery		C					
27076	Extensive hip surgery		C					
27077	Extensive hip surgery		C					
27078	Extensive hip surgery		C					
27079	Extensive hip surgery		C					
27080	Removal of tail bone		T	0050	29.4401	$1,933.74		$386.75
27086	Remove hip foreign body		T	0020	7.9864	$524.58		$104.92
27087	Remove hip foreign body		T	0049	22.3967	$1,471.10		$294.22
27090	Removal of hip prosthesis		C					
27091	Removal of hip prosthesis		C					
27093	Injection for hip x-ray		N					
27095	Injection for hip x-ray		N					
27096	Inject sacroiliac joint		B					
27097	Revision of hip tendon		T	0050	29.4401	$1,933.74		$386.75
27098	Transfer tendon to pelvis		T	0050	29.4401	$1,933.74		$386.75
27100	Transfer of abdominal muscle		T	0051	45.4359	$2,984.41		$596.89
27105	Transfer of spinal muscle		T	0051	45.4359	$2,984.41		$596.89
27110	Transfer of iliopsoas muscle		T	0051	45.4359	$2,984.41		$596.89
27111	Transfer of iliopsoas muscle		T	0051	45.4359	$2,984.41		$596.89
27120	Reconstruction of hip socket		C					
27122	Reconstruction of hip socket		C					
27125	Partial hip replacement		C					
27130	Total hip arthroplasty		C					
27132	Total hip arthroplasty		C					
27134	Revise hip joint replacement		C					
27137	Revise hip joint replacement		C					
27138	Revise hip joint replacement		C					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
27140	Transplant femur ridge		C					
27146	Incision of hip bone		C					
27147	Revision of hip bone		C					
27151	Incision of hip bones		C					
27156	Revision of hip bones		C					
27158	Revision of pelvis		C					
27161	Incision of neck of femur		C					
27165	Incision/fixation of femur		C					
27170	Repair/graft femur head/neck		C					
27175	Treat slipped epiphysis		C					
27176	Treat slipped epiphysis		C					
27177	Treat slipped epiphysis		C					
27178	Treat slipped epiphysis		C					
27179	Revise head/neck of femur		C					
27181	Treat slipped epiphysis		C					
27185	Revision of femur epiphysis		C					
27187	Reinforce hip bones		C					
27193	Treat pelvic ring fracture	CH	T	0129	1.5788	$103.70		$20.74
27194	Treat pelvic ring fracture		T	0045	15.5334	$1,020.30	$268.47	$204.06
27200	Treat tail bone fracture	CH	T	0129	1.5788	$103.70		$20.74
27202	Treat tail bone fracture		T	0063	42.5770	$2,796.63		$559.33
27215	Treat pelvic fracture(s)		C					
27216	Treat pelvic ring fracture		T	0050	29.4401	$1,933.74		$386.75
27217	Treat pelvic ring fracture		C					
27218	Treat pelvic ring fracture		C					
27220	Treat hip socket fracture	CH	T	0129	1.5788	$103.70		$20.74
27222	Treat hip socket fracture		C					
27226	Treat hip wall fracture		C					
27227	Treat hip fracture(s)		C					
27228	Treat hip fracture(s)		C					
27230	Treat thigh fracture	CH	T	0129	1.5788	$103.70		$20.74

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
27232	Treat thigh fracture		C					
27235	Treat thigh fracture		T	0050	29.4401	$1,933.74		$386.75
27236	Treat thigh fracture		C					
27238	Treat thigh fracture	CH	T	0138	6.0607	$398.09		$79.62
27240	Treat thigh fracture		C					
27244	Treat thigh fracture		C					
27245	Treat thigh fracture		C					
27246	Treat thigh fracture	CH	T	0138	6.0607	$398.09		$79.62
27248	Treat thigh fracture		C					
27250	Treat hip dislocation	CH	T	0129	1.5788	$103.70		$20.74
27252	Treat hip dislocation		T	0045	15.5334	$1,020.30	$268.47	$204.06
27253	Treat hip dislocation		C					
27254	Treat hip dislocation		C					
27256	Treat hip dislocation	CH	T	0129	1.5788	$103.70		$20.74
27257	Treat hip dislocation		T	0045	15.5334	$1,020.30	$268.47	$204.06
27258	Treat hip dislocation		C					
27259	Treat hip dislocation		C					
27265	Treat hip dislocation	CH	T	0129	1.5788	$103.70		$20.74
27266	Treat hip dislocation		T	0045	15.5334	$1,020.30	$268.47	$204.06
27267	Cltx thigh fx	CH	T	0129	1.5788	$103.70		$20.74
27268	Cltx thigh fx w/mnpj		C					
27269	Optx thigh fx		C					
27275	Manipulation of hip joint		T	0045	15.5334	$1,020.30	$268.47	$204.06
27280	Fusion of sacroiliac joint		C					
27282	Fusion of pubic bones		C					
27284	Fusion of hip joint		C					
27286	Fusion of hip joint		C					
27290	Amputation of leg at hip		C					
27295	Amputation of leg at hip		C					
27299	Pelvis/hip joint surgery	CH	T	0129	1.5788	$103.70		$20.74
27301	Drain thigh/knee lesion		T	0008	19.5771	$1,285.90		$257.18

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
27303	Drainage of bone lesion		C					
27305	Incise thigh tendon & fascia		T	0049	22.3967	$1,471.10		$294.22
27306	Incision of thigh tendon		T	0049	22.3967	$1,471.10		$294.22
27307	Incision of thigh tendons		T	0049	22.3967	$1,471.10		$294.22
27310	Exploration of knee joint		T	0050	29.4401	$1,933.74		$386.75
27323	Biopsy, thigh soft tissues		T	0020	7.9864	$524.58		$104.92
27324	Biopsy, thigh soft tissues		T	0022	21.7477	$1,428.48	$354.45	$285.70
27325	Neurectomy, hamstring		T	0220	18.4356	$1,210.92		$242.19
27326	Neurectomy, popliteal		T	0220	18.4356	$1,210.92		$242.19
27327	Removal of thigh lesion		T	0022	21.7477	$1,428.48	$354.45	$285.70
27328	Removal of thigh lesion		T	0022	21.7477	$1,428.48	$354.45	$285.70
27329	Remove tumor, thigh/knee		T	0022	21.7477	$1,428.48	$354.45	$285.70
27330	Biopsy, knee joint lining		T	0050	29.4401	$1,933.74		$386.75
27331	Explore/treat knee joint		T	0050	29.4401	$1,933.74		$386.75
27332	Removal of knee cartilage		T	0050	29.4401	$1,933.74		$386.75
27333	Removal of knee cartilage		T	0050	29.4401	$1,933.74		$386.75
27334	Remove knee joint lining		T	0050	29.4401	$1,933.74		$386.75
27335	Remove knee joint lining		T	0050	29.4401	$1,933.74		$386.75
27340	Removal of kneecap bursa		T	0049	22.3967	$1,471.10		$294.22
27345	Removal of knee cyst		T	0049	22.3967	$1,471.10		$294.22
27347	Remove knee cyst		T	0049	22.3967	$1,471.10		$294.22
27350	Removal of kneecap		T	0050	29.4401	$1,933.74		$386.75
27355	Remove femur lesion		T	0050	29.4401	$1,933.74		$386.75
27356	Remove femur lesion/graft		T	0050	29.4401	$1,933.74		$386.75
27357	Remove femur lesion/graft		T	0050	29.4401	$1,933.74		$386.75
27358	Remove femur lesion/fixation		T	0050	29.4401	$1,933.74		$386.75
27360	Partial removal, leg bone(s)		T	0050	29.4401	$1,933.74		$386.75
27365	Extensive leg surgery		C					
27370	Injection for knee x-ray		N					
27372	Removal of foreign body		T	0022	21.7477	$1,428.48	$354.45	$285.70
27380	Repair of kneecap tendon		T	0049	22.3967	$1,471.10		$294.22

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
27381	Repair/graft kneecap tendon		T	0049	22.3967	$1,471.10		$294.22
27385	Repair of thigh muscle		T	0049	22.3967	$1,471.10		$294.22
27386	Repair/graft of thigh muscle		T	0049	22.3967	$1,471.10		$294.22
27390	Incision of thigh tendon		T	0049	22.3967	$1,471.10		$294.22
27391	Incision of thigh tendons		T	0049	22.3967	$1,471.10		$294.22
27392	Incision of thigh tendons		T	0049	22.3967	$1,471.10		$294.22
27393	Lengthening of thigh tendon		T	0050	29.4401	$1,933.74		$386.75
27394	Lengthening of thigh tendons		T	0050	29.4401	$1,933.74		$386.75
27395	Lengthening of thigh tendons		T	0051	45.4359	$2,984.41		$596.89
27396	Transplant of thigh tendon		T	0050	29.4401	$1,933.74		$386.75
27397	Transplants of thigh tendons		T	0051	45.4359	$2,984.41		$596.89
27400	Revise thigh muscles/tendons		T	0051	45.4359	$2,984.41		$596.89
27403	Repair of knee cartilage		T	0050	29.4401	$1,933.74		$386.75
27405	Repair of knee ligament		T	0051	45.4359	$2,984.41		$596.89
27407	Repair of knee ligament		T	0052	85.4915	$5,615.42		$1,123.09
27409	Repair of knee ligaments		T	0051	45.4359	$2,984.41		$596.89
27412	Autochondrocyte implant knee		T	0042	49.2291	$3,233.56	$804.74	$646.72
27415	Osteochondral knee allograft		T	0042	49.2291	$3,233.56	$804.74	$646.72
27416	Osteochondral knee autograft		T	0051	45.4359	$2,984.41		$596.89
27418	Repair degenerated kneecap		T	0051	45.4359	$2,984.41		$596.89
27420	Revision of unstable kneecap		T	0051	45.4359	$2,984.41		$596.89
27422	Revision of unstable kneecap		T	0051	45.4359	$2,984.41		$596.89
27424	Revision/removal of kneecap		T	0051	45.4359	$2,984.41		$596.89
27425	Lat retinacular release open		T	0050	29.4401	$1,933.74		$386.75
27427	Reconstruction, knee		T	0051	45.4359	$2,984.41		$596.89
27428	Reconstruction, knee		T	0052	85.4915	$5,615.42		$1,123.09
27429	Reconstruction, knee		T	0052	85.4915	$5,615.42		$1,123.09
27430	Revision of thigh muscles		T	0051	45.4359	$2,984.41		$596.89
27435	Incision of knee joint		T	0051	45.4359	$2,984.41		$596.89
27437	Revise kneecap		T	0047	37.8828	$2,488.29	$537.03	$497.66
27438	Revise kneecap with implant		T	0048	52.8676	$3,472.56		$694.52

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
27440	Revision of knee joint		T	0047	37.8828	$2,488.29	$537.03	$497.66
27441	Revision of knee joint		T	0047	37.8828	$2,488.29	$537.03	$497.66
27442	Revision of knee joint		T	0047	37.8828	$2,488.29	$537.03	$497.66
27443	Revision of knee joint		T	0047	37.8828	$2,488.29	$537.03	$497.66
27445	Revision of knee joint		C					
27446	Revision of knee joint		T	0681	214.1624	$14,067.04		$2,813.41
27447	Total knee arthroplasty		C					
27448	Incision of thigh		C					
27450	Incision of thigh		C					
27454	Realignment of thigh bone		C					
27455	Realignment of knee		C					
27457	Realignment of knee		C					
27465	Shortening of thigh bone		C					
27466	Lengthening of thigh bone		C					
27468	Shorten/lengthen thighs		C					
27470	Repair of thigh		C					
27472	Repair/graft of thigh		C					
27475	Surgery to stop leg growth		T	0050	29.4401	$1,933.74		$386.75
27477	Surgery to stop leg growth		C					
27479	Surgery to stop leg growth	CH	T	0050	29.4401	$1,933.74		$386.75
27485	Surgery to stop leg growth		C					
27486	Revise/replace knee joint		C					
27487	Revise/replace knee joint		C					
27488	Removal of knee prosthesis		C					
27495	Reinforce thigh		C					
27496	Decompression of thigh/knee		T	0049	22.3967	$1,471.10		$294.22
27497	Decompression of thigh/knee		T	0049	22.3967	$1,471.10		$294.22
27498	Decompression of thigh/knee		T	0049	22.3967	$1,471.10		$294.22
27499	Decompression of thigh/knee		T	0049	22.3967	$1,471.10		$294.22
27500	Treatment of thigh fracture	CH	T	0138	6.0607	$398.09		$79.62
27501	Treatment of thigh fracture	CH	T	0129	1.5788	$103.70		$20.74

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
27502	Treatment of thigh fracture	CH	T	0139	20.4295	$1,341.89		$268.38
27503	Treatment of thigh fracture	CH	T	0129	1.5788	$103.70		$20.74
27506	Treatment of thigh fracture		C					
27507	Treatment of thigh fracture		C					
27508	Treatment of thigh fracture	CH	T	0129	1.5788	$103.70		$20.74
27509	Treatment of thigh fracture		T	0062	25.6821	$1,686.90	$372.87	$337.38
27510	Treatment of thigh fracture	CH	T	0138	6.0607	$398.09		$79.62
27511	Treatment of thigh fracture		C					
27513	Treatment of thigh fracture		C					
27514	Treatment of thigh fracture		C					
27516	Treat thigh fx growth plate	CH	T	0129	1.5788	$103.70		$20.74
27517	Treat thigh fx growth plate	CH	T	0129	1.5788	$103.70		$20.74
27519	Treat thigh fx growth plate		C					
27520	Treat kneecap fracture	CH	T	0129	1.5788	$103.70		$20.74
27524	Treat kneecap fracture		T	0063	42.5770	$2,796.63		$559.33
27530	Treat knee fracture	CH	T	0129	1.5788	$103.70		$20.74
27532	Treat knee fracture	CH	T	0139	20.4295	$1,341.89		$268.38
27535	Treat knee fracture		C					
27536	Treat knee fracture		C					
27538	Treat knee fracture(s)	CH	T	0129	1.5788	$103.70		$20.74
27540	Treat knee fracture		C					
27550	Treat knee dislocation	CH	T	0129	1.5788	$103.70		$20.74
27552	Treat knee dislocation		T	0045	15.5334	$1,020.30	$268.47	$204.06
27556	Treat knee dislocation		C					
27557	Treat knee dislocation		C					
27558	Treat knee dislocation		C					
27560	Treat kneecap dislocation	CH	T	0129	1.5788	$103.70		$20.74
27562	Treat kneecap dislocation		T	0045	15.5334	$1,020.30	$268.47	$204.06
27566	Treat kneecap dislocation		T	0063	42.5770	$2,796.63		$559.33
27570	Fixation of knee joint		T	0045	15.5334	$1,020.30	$268.47	$204.06
27580	Fusion of knee		C					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
27590	Amputate leg at thigh		C					
27591	Amputate leg at thigh		C					
27592	Amputate leg at thigh		C					
27594	Amputation follow-up surgery		T	0049	22.3967	$1,471.10		$294.22
27596	Amputation follow-up surgery		C					
27598	Amputate lower leg at knee		C					
27599	Leg surgery procedure	CH	T	0129	1.5788	$103.70		$20.74
27600	Decompression of lower leg		T	0049	22.3967	$1,471.10		$294.22
27601	Decompression of lower leg		T	0049	22.3967	$1,471.10		$294.22
27602	Decompression of lower leg		T	0049	22.3967	$1,471.10		$294.22
27603	Drain lower leg lesion		T	0008	19.5771	$1,285.90		$257.18
27604	Drain lower leg bursa		T	0049	22.3967	$1,471.10		$294.22
27605	Incision of achilles tendon		T	0055	21.6078	$1,419.29	$355.34	$283.86
27606	Incision of achilles tendon		T	0049	22.3967	$1,471.10		$294.22
27607	Treat lower leg bone lesion		T	0049	22.3967	$1,471.10		$294.22
27610	Explore/treat ankle joint		T	0050	29.4401	$1,933.74		$386.75
27612	Exploration of ankle joint		T	0050	29.4401	$1,933.74		$386.75
27613	Biopsy lower leg soft tissue		T	0020	7.9864	$524.58		$104.92
27614	Biopsy lower leg soft tissue		T	0022	21.7477	$1,428.48	$354.45	$285.70
27615	Remove tumor, lower leg		T	0050	29.4401	$1,933.74		$386.75
27618	Remove lower leg lesion		T	0021	15.8699	$1,042.40	$219.48	$208.48
27619	Remove lower leg lesion		T	0022	21.7477	$1,428.48	$354.45	$285.70
27620	Explore/treat ankle joint		T	0050	29.4401	$1,933.74		$386.75
27625	Remove ankle joint lining		T	0050	29.4401	$1,933.74		$386.75
27626	Remove ankle joint lining		T	0050	29.4401	$1,933.74		$386.75
27630	Removal of tendon lesion		T	0049	22.3967	$1,471.10		$294.22
27635	Remove lower leg bone lesion		T	0050	29.4401	$1,933.74		$386.75
27637	Remove/graft leg bone lesion		T	0050	29.4401	$1,933.74		$386.75
27638	Remove/graft leg bone lesion		T	0050	29.4401	$1,933.74		$386.75
27640	Partial removal of tibia		T	0051	45.4359	$2,984.41		$596.89
27641	Partial removal of fibula		T	0050	29.4401	$1,933.74		$386.75

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
27645	Extensive lower leg surgery		C					
27646	Extensive lower leg surgery		C					
27647	Extensive ankle/heel surgery		T	0051	45.4359	$2,984.41		$596.89
27648	Injection for ankle x-ray		N					
27650	Repair achilles tendon		T	0051	45.4359	$2,984.41		$596.89
27652	Repair/graft achilles tendon		T	0052	85.4915	$5,615.42		$1,123.09
27654	Repair of achilles tendon		T	0051	45.4359	$2,984.41		$596.89
27656	Repair leg fascia defect		T	0049	22.3967	$1,471.10		$294.22
27658	Repair of leg tendon, each		T	0049	22.3967	$1,471.10		$294.22
27659	Repair of leg tendon, each		T	0049	22.3967	$1,471.10		$294.22
27664	Repair of leg tendon, each		T	0049	22.3967	$1,471.10		$294.22
27665	Repair of leg tendon, each		T	0050	29.4401	$1,933.74		$386.75
27675	Repair lower leg tendons		T	0049	22.3967	$1,471.10		$294.22
27676	Repair lower leg tendons		T	0050	29.4401	$1,933.74		$386.75
27680	Release of lower leg tendon		T	0050	29.4401	$1,933.74		$386.75
27681	Release of lower leg tendons		T	0050	29.4401	$1,933.74		$386.75
27685	Revision of lower leg tendon		T	0050	29.4401	$1,933.74		$386.75
27686	Revise lower leg tendons		T	0050	29.4401	$1,933.74		$386.75
27687	Revision of calf tendon		T	0050	29.4401	$1,933.74		$386.75
27690	Revise lower leg tendon		T	0051	45.4359	$2,984.41		$596.89
27691	Revise lower leg tendon		T	0051	45.4359	$2,984.41		$596.89
27692	Revise additional leg tendon		T	0051	45.4359	$2,984.41		$596.89
27695	Repair of ankle ligament		T	0050	29.4401	$1,933.74		$386.75
27696	Repair of ankle ligaments		T	0050	29.4401	$1,933.74		$386.75
27698	Repair of ankle ligament		T	0050	29.4401	$1,933.74		$386.75
27700	Revision of ankle joint		T	0047	37.8828	$2,488.29	$537.03	$497.66
27702	Reconstruct ankle joint		C					
27703	Reconstruction, ankle joint		C					
27704	Removal of ankle implant		T	0049	22.3967	$1,471.10		$294.22
27705	Incision of tibia		T	0051	45.4359	$2,984.41		$596.89
27707	Incision of fibula		T	0049	22.3967	$1,471.10		$294.22

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
27709	Incision of tibia & fibula		T	0050	29.4401	$1,933.74		$386.75
27712	Realignment of lower leg		C					
27715	Revision of lower leg		C					
27720	Repair of tibia		T	0063	42.5770	$2,796.63		$559.33
27722	Repair/graft of tibia		T	0064	62.0926	$4,078.49	$835.79	$815.70
27724	Repair/graft of tibia		C					
27725	Repair of lower leg		C					
27726	Repair fibula nonunion		T	0062	25.6821	$1,686.90	$372.87	$337.38
27727	Repair of lower leg		C					
27730	Repair of tibia epiphysis		T	0050	29.4401	$1,933.74		$386.75
27732	Repair of fibula epiphysis		T	0050	29.4401	$1,933.74		$386.75
27734	Repair lower leg epiphyses		T	0050	29.4401	$1,933.74		$386.75
27740	Repair of leg epiphyses		T	0050	29.4401	$1,933.74		$386.75
27742	Repair of leg epiphyses		T	0051	45.4359	$2,984.41		$596.89
27745	Reinforce tibia		T	0052	85.4915	$5,615.42		$1,123.09
27750	Treatment of tibia fracture	CH	T	0129	1.5788	$103.70		$20.74
27752	Treatment of tibia fracture	CH	T	0139	20.4295	$1,341.89		$268.38
27756	Treatment of tibia fracture		T	0062	25.6821	$1,686.90	$372.87	$337.38
27758	Treatment of tibia fracture		T	0063	42.5770	$2,796.63		$559.33
27759	Treatment of tibia fracture		T	0064	62.0926	$4,078.49	$835.79	$815.70
27760	Cltx medial ankle fx	CH	T	0129	1.5788	$103.70		$20.74
27762	Cltx med ankle fx w/mnpj	CH	T	0139	20.4295	$1,341.89		$268.38
27766	Optx medial ankle fx		T	0063	42.5770	$2,796.63		$559.33
27767	Cltx post ankle fx	CH	T	0129	1.5788	$103.70		$20.74
27768	Cltx post ankle fx w/mnpj	CH	T	0129	1.5788	$103.70		$20.74
27769	Optx post ankle fx		T	0063	42.5770	$2,796.63		$559.33
27780	Treatment of fibula fracture	CH	T	0129	1.5788	$103.70		$20.74
27781	Treatment of fibula fracture	CH	T	0139	20.4295	$1,341.89		$268.38
27784	Treatment of fibula fracture		T	0063	42.5770	$2,796.63		$559.33
27786	Treatment of ankle fracture	CH	T	0129	1.5788	$103.70		$20.74
27788	Treatment of ankle fracture	CH	T	0129	1.5788	$103.70		$20.74

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
27792	Treatment of ankle fracture		T	0063	42.5770	$2,796.63		$559.33
27808	Treatment of ankle fracture	CH	T	0129	1.5788	$103.70		$20.74
27810	Treatment of ankle fracture	CH	T	0138	6.0607	$398.09		$79.62
27814	Treatment of ankle fracture		T	0063	42.5770	$2,796.63		$559.33
27816	Treatment of ankle fracture	CH	T	0129	1.5788	$103.70		$20.74
27818	Treatment of ankle fracture	CH	T	0138	6.0607	$398.09		$79.62
27822	Treatment of ankle fracture		T	0063	42.5770	$2,796.63		$559.33
27823	Treatment of ankle fracture		T	0064	62.0926	$4,078.49	$835.79	$815.70
27824	Treat lower leg fracture	CH	T	0129	1.5788	$103.70		$20.74
27825	Treat lower leg fracture	CH	T	0139	20.4295	$1,341.89		$268.38
27826	Treat lower leg fracture		T	0063	42.5770	$2,796.63		$559.33
27827	Treat lower leg fracture		T	0064	62.0926	$4,078.49	$835.79	$815.70
27828	Treat lower leg fracture		T	0064	62.0926	$4,078.49	$835.79	$815.70
27829	Treat lower leg joint		T	0063	42.5770	$2,796.63		$559.33
27830	Treat lower leg dislocation	CH	T	0129	1.5788	$103.70		$20.74
27831	Treat lower leg dislocation	CH	T	0139	20.4295	$1,341.89		$268.38
27832	Treat lower leg dislocation		T	0063	42.5770	$2,796.63		$559.33
27840	Treat ankle dislocation	CH	T	0138	6.0607	$398.09		$79.62
27842	Treat ankle dislocation		T	0045	15.5334	$1,020.30	$268.47	$204.06
27846	Treat ankle dislocation		T	0063	42.5770	$2,796.63		$559.33
27848	Treat ankle dislocation		T	0063	42.5770	$2,796.63		$559.33
27860	Fixation of ankle joint		T	0045	15.5334	$1,020.30	$268.47	$204.06
27870	Fusion of ankle joint, open		T	0052	85.4915	$5,615.42		$1,123.09
27871	Fusion of tibiofibular joint		T	0052	85.4915	$5,615.42		$1,123.09
27880	Amputation of lower leg		C					
27881	Amputation of lower leg		C					
27882	Amputation of lower leg		C					
27884	Amputation follow-up surgery		T	0049	22.3967	$1,471.10		$294.22
27886	Amputation follow-up surgery	CH	T	0049	22.3967	$1,471.10		$294.22
27888	Amputation of foot at ankle		C					
27889	Amputation of foot at ankle		T	0050	29.4401	$1,933.74		$386.75

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
27892	Decompression of leg		T	0049	22.3967	$1,471.10		$294.22
27893	Decompression of leg		T	0049	22.3967	$1,471.10		$294.22
27894	Decompression of leg		T	0049	22.3967	$1,471.10		$294.22
27899	Leg/ankle surgery procedure	CH	T	0129	1.5788	$103.70		$20.74
28001	Drainage of bursa of foot		T	0007	12.8052	$841.10		$168.22
28002	Treatment of foot infection		T	0049	22.3967	$1,471.10		$294.22
28003	Treatment of foot infection		T	0049	22.3967	$1,471.10		$294.22
28005	Treat foot bone lesion		T	0055	21.6078	$1,419.29	$355.34	$283.86
28008	Incision of foot fascia		T	0055	21.6078	$1,419.29	$355.34	$283.86
28010	Incision of toe tendon		T	0055	21.6078	$1,419.29	$355.34	$283.86
28011	Incision of toe tendons		T	0055	21.6078	$1,419.29	$355.34	$283.86
28020	Exploration of foot joint		T	0055	21.6078	$1,419.29	$355.34	$283.86
28022	Exploration of foot joint		T	0055	21.6078	$1,419.29	$355.34	$283.86
28024	Exploration of toe joint		T	0055	21.6078	$1,419.29	$355.34	$283.86
28035	Decompression of tibia nerve		T	0220	18.4356	$1,210.92		$242.19
28043	Excision of foot lesion		T	0022	21.7477	$1,428.48	$354.45	$285.70
28045	Excision of foot lesion		T	0055	21.6078	$1,419.29	$355.34	$283.86
28046	Resection of tumor, foot		T	0055	21.6078	$1,419.29	$355.34	$283.86
28050	Biopsy of foot joint lining		T	0055	21.6078	$1,419.29	$355.34	$283.86
28052	Biopsy of foot joint lining		T	0055	21.6078	$1,419.29	$355.34	$283.86
28054	Biopsy of toe joint lining		T	0055	21.6078	$1,419.29	$355.34	$283.86
28055	Neurectomy, foot		T	0220	18.4356	$1,210.92		$242.19
28060	Partial removal, foot fascia		T	0055	21.6078	$1,419.29	$355.34	$283.86
28062	Removal of foot fascia		T	0055	21.6078	$1,419.29	$355.34	$283.86
28070	Removal of foot joint lining		T	0055	21.6078	$1,419.29	$355.34	$283.86
28072	Removal of foot joint lining		T	0055	21.6078	$1,419.29	$355.34	$283.86
28080	Removal of foot lesion		T	0055	21.6078	$1,419.29	$355.34	$283.86
28086	Excise foot tendon sheath		T	0055	21.6078	$1,419.29	$355.34	$283.86
28088	Excise foot tendon sheath		T	0055	21.6078	$1,419.29	$355.34	$283.86
28090	Removal of foot lesion		T	0055	21.6078	$1,419.29	$355.34	$283.86
28092	Removal of toe lesions		T	0055	21.6078	$1,419.29	$355.34	$283.86

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
28100	Removal of ankle/heel lesion		T	0055	21.6078	$1,419.29	$355.34	$283.86
28102	Remove/graft foot lesion		T	0056	47.1767	$3,098.75		$619.75
28103	Remove/graft foot lesion		T	0056	47.1767	$3,098.75		$619.75
28104	Removal of foot lesion		T	0055	21.6078	$1,419.29	$355.34	$283.86
28106	Remove/graft foot lesion		T	0056	47.1767	$3,098.75		$619.75
28107	Remove/graft foot lesion		T	0056	47.1767	$3,098.75		$619.75
28108	Removal of toe lesions		T	0055	21.6078	$1,419.29	$355.34	$283.86
28110	Part removal of metatarsal		T	0055	21.6078	$1,419.29	$355.34	$283.86
28111	Part removal of metatarsal		T	0055	21.6078	$1,419.29	$355.34	$283.86
28112	Part removal of metatarsal		T	0055	21.6078	$1,419.29	$355.34	$283.86
28113	Part removal of metatarsal		T	0055	21.6078	$1,419.29	$355.34	$283.86
28114	Removal of metatarsal heads		T	0055	21.6078	$1,419.29	$355.34	$283.86
28116	Revision of foot		T	0055	21.6078	$1,419.29	$355.34	$283.86
28118	Removal of heel bone		T	0055	21.6078	$1,419.29	$355.34	$283.86
28119	Removal of heel spur		T	0055	21.6078	$1,419.29	$355.34	$283.86
28120	Part removal of ankle/heel		T	0055	21.6078	$1,419.29	$355.34	$283.86
28122	Partial removal of foot bone		T	0055	21.6078	$1,419.29	$355.34	$283.86
28124	Partial removal of toe		T	0055	21.6078	$1,419.29	$355.34	$283.86
28126	Partial removal of toe		T	0055	21.6078	$1,419.29	$355.34	$283.86
28130	Removal of ankle bone		T	0055	21.6078	$1,419.29	$355.34	$283.86
28140	Removal of metatarsal		T	0055	21.6078	$1,419.29	$355.34	$283.86
28150	Removal of toe		T	0055	21.6078	$1,419.29	$355.34	$283.86
28153	Partial removal of toe		T	0055	21.6078	$1,419.29	$355.34	$283.86
28160	Partial removal of toe		T	0055	21.6078	$1,419.29	$355.34	$283.86
28171	Extensive foot surgery		T	0055	21.6078	$1,419.29	$355.34	$283.86
28173	Extensive foot surgery		T	0055	21.6078	$1,419.29	$355.34	$283.86
28175	Extensive foot surgery		T	0055	21.6078	$1,419.29	$355.34	$283.86
28190	Removal of foot foreign body	CH	T	0020	7.9864	$524.58		$104.92
28192	Removal of foot foreign body		T	0021	15.8699	$1,042.40	$219.48	$208.48
28193	Removal of foot foreign body		T	0020	7.9864	$524.58		$104.92
28200	Repair of foot tendon		T	0055	21.6078	$1,419.29	$355.34	$283.86

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
28202	Repair/graft of foot tendon		T	0055	21.6078	$1,419.29	$355.34	$283.86
28208	Repair of foot tendon		T	0055	21.6078	$1,419.29	$355.34	$283.86
28210	Repair/graft of foot tendon		T	0056	47.1767	$3,098.75		$619.75
28220	Release of foot tendon		T	0055	21.6078	$1,419.29	$355.34	$283.86
28222	Release of foot tendons		T	0055	21.6078	$1,419.29	$355.34	$283.86
28225	Release of foot tendon		T	0055	21.6078	$1,419.29	$355.34	$283.86
28226	Release of foot tendons		T	0055	21.6078	$1,419.29	$355.34	$283.86
28230	Incision of foot tendon(s)		T	0055	21.6078	$1,419.29	$355.34	$283.86
28232	Incision of toe tendon		T	0055	21.6078	$1,419.29	$355.34	$283.86
28234	Incision of foot tendon		T	0055	21.6078	$1,419.29	$355.34	$283.86
28238	Revision of foot tendon		T	0056	47.1767	$3,098.75		$619.75
28240	Release of big toe		T	0055	21.6078	$1,419.29	$355.34	$283.86
28250	Revision of foot fascia		T	0055	21.6078	$1,419.29	$355.34	$283.86
28260	Release of midfoot joint		T	0055	21.6078	$1,419.29	$355.34	$283.86
28261	Revision of foot tendon		T	0055	21.6078	$1,419.29	$355.34	$283.86
28262	Revision of foot and ankle		T	0055	21.6078	$1,419.29	$355.34	$283.86
28264	Release of midfoot joint		T	0056	47.1767	$3,098.75		$619.75
28270	Release of foot contracture		T	0055	21.6078	$1,419.29	$355.34	$283.86
28272	Release of toe joint, each		T	0055	21.6078	$1,419.29	$355.34	$283.86
28280	Fusion of toes		T	0055	21.6078	$1,419.29	$355.34	$283.86
28285	Repair of hammertoe		T	0055	21.6078	$1,419.29	$355.34	$283.86
28286	Repair of hammertoe		T	0055	21.6078	$1,419.29	$355.34	$283.86
28288	Partial removal of foot bone		T	0055	21.6078	$1,419.29	$355.34	$283.86
28289	Repair hallux rigidus		T	0055	21.6078	$1,419.29	$355.34	$283.86
28290	Correction of bunion		T	0057	31.0283	$2,038.06	$475.91	$407.62
28292	Correction of bunion		T	0057	31.0283	$2,038.06	$475.91	$407.62
28293	Correction of bunion		T	0057	31.0283	$2,038.06	$475.91	$407.62
28294	Correction of bunion		T	0057	31.0283	$2,038.06	$475.91	$407.62
28296	Correction of bunion		T	0057	31.0283	$2,038.06	$475.91	$407.62
28297	Correction of bunion		T	0057	31.0283	$2,038.06	$475.91	$407.62
28298	Correction of bunion		T	0057	31.0283	$2,038.06	$475.91	$407.62

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
28299	Correction of bunion		T	0057	31.0283	$2,038.06	$475.91	$407.62
28300	Incision of heel bone		T	0056	47.1767	$3,098.75		$619.75
28302	Incision of ankle bone		T	0055	21.6078	$1,419.29	$355.34	$283.86
28304	Incision of midfoot bones		T	0056	47.1767	$3,098.75		$619.75
28305	Incise/graft midfoot bones		T	0056	47.1767	$3,098.75		$619.75
28306	Incision of metatarsal		T	0055	21.6078	$1,419.29	$355.34	$283.86
28307	Incision of metatarsal		T	0055	21.6078	$1,419.29	$355.34	$283.86
28308	Incision of metatarsal		T	0055	21.6078	$1,419.29	$355.34	$283.86
28309	Incision of metatarsals		T	0056	47.1767	$3,098.75		$619.75
28310	Revision of big toe		T	0055	21.6078	$1,419.29	$355.34	$283.86
28312	Revision of toe		T	0055	21.6078	$1,419.29	$355.34	$283.86
28313	Repair deformity of toe		T	0055	21.6078	$1,419.29	$355.34	$283.86
28315	Removal of sesamoid bone		T	0055	21.6078	$1,419.29	$355.34	$283.86
28320	Repair of foot bones		T	0056	47.1767	$3,098.75		$619.75
28322	Repair of metatarsals		T	0056	47.1767	$3,098.75		$619.75
28340	Resect enlarged toe tissue		T	0055	21.6078	$1,419.29	$355.34	$283.86
28341	Resect enlarged toe		T	0055	21.6078	$1,419.29	$355.34	$283.86
28344	Repair extra toe(s)		T	0055	21.6078	$1,419.29	$355.34	$283.86
28345	Repair webbed toe(s)		T	0055	21.6078	$1,419.29	$355.34	$283.86
28360	Reconstruct cleft foot		T	0056	47.1767	$3,098.75		$619.75
28400	Treatment of heel fracture	CH	T	0129	1.5788	$103.70		$20.74
28405	Treatment of heel fracture	CH	T	0139	20.4295	$1,341.89		$268.38
28406	Treatment of heel fracture		T	0062	25.6821	$1,686.90	$372.87	$337.38
28415	Treat heel fracture		T	0064	62.0926	$4,078.49	$835.79	$815.70
28420	Treat/graft heel fracture		T	0063	42.5770	$2,796.63		$559.33
28430	Treatment of ankle fracture	CH	T	0129	1.5788	$103.70		$20.74
28435	Treatment of ankle fracture	CH	T	0129	1.5788	$103.70		$20.74
28436	Treatment of ankle fracture		T	0062	25.6821	$1,686.90	$372.87	$337.38
28445	Treat ankle fracture		T	0063	42.5770	$2,796.63		$559.33
28446	Osteochondral talus autogrft		T	0056	47.1767	$3,098.75		$619.75
28450	Treat midfoot fracture, each	CH	T	0129	1.5788	$103.70		$20.74

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
28455	Treat midfoot fracture, each	CH	T	0129	1.5788	$103.70		$20.74
28456	Treat midfoot fracture		T	0062	25.6821	$1,686.90	$372.87	$337.38
28465	Treat midfoot fracture, each		T	0063	42.5770	$2,796.63		$559.33
28470	Treat metatarsal fracture	CH	T	0129	1.5788	$103.70		$20.74
28475	Treat metatarsal fracture	CH	T	0129	1.5788	$103.70		$20.74
28476	Treat metatarsal fracture		T	0062	25.6821	$1,686.90	$372.87	$337.38
28485	Treat metatarsal fracture		T	0063	42.5770	$2,796.63		$559.33
28490	Treat big toe fracture	CH	T	0129	1.5788	$103.70		$20.74
28495	Treat big toe fracture	CH	T	0129	1.5788	$103.70		$20.74
28496	Treat big toe fracture		T	0062	25.6821	$1,686.90	$372.87	$337.38
28505	Treat big toe fracture		T	0062	25.6821	$1,686.90	$372.87	$337.38
28510	Treatment of toe fracture	CH	T	0129	1.5788	$103.70		$20.74
28515	Treatment of toe fracture	CH	T	0129	1.5788	$103.70		$20.74
28525	Treat toe fracture		T	0062	25.6821	$1,686.90	$372.87	$337.38
28530	Treat sesamoid bone fracture	CH	T	0129	1.5788	$103.70		$20.74
28531	Treat sesamoid bone fracture		T	0062	25.6821	$1,686.90	$372.87	$337.38
28540	Treat foot dislocation	CH	T	0129	1.5788	$103.70		$20.74
28545	Treat foot dislocation		T	0062	25.6821	$1,686.90	$372.87	$337.38
28546	Treat foot dislocation		T	0062	25.6821	$1,686.90	$372.87	$337.38
28555	Repair foot dislocation		T	0063	42.5770	$2,796.63		$559.33
28570	Treat foot dislocation	CH	T	0138	6.0607	$398.09		$79.62
28575	Treat foot dislocation	CH	T	0139	20.4295	$1,341.89		$268.38
28576	Treat foot dislocation		T	0062	25.6821	$1,686.90	$372.87	$337.38
28585	Repair foot dislocation		T	0062	25.6821	$1,686.90	$372.87	$337.38
28600	Treat foot dislocation	CH	T	0129	1.5788	$103.70		$20.74
28605	Treat foot dislocation	CH	T	0129	1.5788	$103.70		$20.74
28606	Treat foot dislocation		T	0062	25.6821	$1,686.90	$372.87	$337.38
28615	Repair foot dislocation		T	0063	42.5770	$2,796.63		$559.33
28630	Treat toe dislocation	CH	T	0129	1.5788	$103.70		$20.74
28635	Treat toe dislocation		T	0045	15.5334	$1,020.30	$268.47	$204.06
28636	Treat toe dislocation		T	0062	25.6821	$1,686.90	$372.87	$337.38

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
28645	Repair toe dislocation		T	0062	25.6821	$1,686.90	$372.87	$337.38
28660	Treat toe dislocation	CH	T	0129	1.5788	$103.70		$20.74
28665	Treat toe dislocation		T	0045	15.5334	$1,020.30	$268.47	$204.06
28666	Treat toe dislocation		T	0062	25.6821	$1,686.90	$372.87	$337.38
28675	Repair of toe dislocation		T	0062	25.6821	$1,686.90	$372.87	$337.38
28705	Fusion of foot bones		T	0056	47.1767	$3,098.75		$619.75
28715	Fusion of foot bones		T	0052	85.4915	$5,615.42		$1,123.09
28725	Fusion of foot bones		T	0056	47.1767	$3,098.75		$619.75
28730	Fusion of foot bones		T	0056	47.1767	$3,098.75		$619.75
28735	Fusion of foot bones		T	0056	47.1767	$3,098.75		$619.75
28737	Revision of foot bones		T	0056	47.1767	$3,098.75		$619.75
28740	Fusion of foot bones		T	0056	47.1767	$3,098.75		$619.75
28750	Fusion of big toe joint		T	0056	47.1767	$3,098.75		$619.75
28755	Fusion of big toe joint		T	0055	21.6078	$1,419.29	$355.34	$283.86
28760	Fusion of big toe joint		T	0056	47.1767	$3,098.75		$619.75
28800	Amputation of midfoot		C					
28805	Amputation thru metatarsal		C					
28810	Amputation toe & metatarsal		T	0055	21.6078	$1,419.29	$355.34	$283.86
28820	Amputation of toe		T	0055	21.6078	$1,419.29	$355.34	$283.86
28825	Partial amputation of toe		T	0055	21.6078	$1,419.29	$355.34	$283.86
28890	High energy eswt, plantar f		T	0050	29.4401	$1,933.74		$386.75
28899	Foot/toes surgery procedure	CH	T	0129	1.5788	$103.70		$20.74
29000	Application of body cast		S	0058	1.1147	$73.22		$14.65
29010	Application of body cast		S	0426	2.4021	$157.78		$31.56
29015	Application of body cast		S	0426	2.4021	$157.78		$31.56
29020	Application of body cast		S	0058	1.1147	$73.22		$14.65
29025	Application of body cast		S	0058	1.1147	$73.22		$14.65
29035	Application of body cast		S	0426	2.4021	$157.78		$31.56
29040	Application of body cast		S	0058	1.1147	$73.22		$14.65
29044	Application of body cast		S	0426	2.4021	$157.78		$31.56
29046	Application of body cast		S	0426	2.4021	$157.78		$31.56

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29049	Application of figure eight		S	0058	1.1147	$73.22		$14.65
29055	Application of shoulder cast		S	0426	2.4021	$157.78		$31.56
29058	Application of shoulder cast		S	0058	1.1147	$73.22		$14.65
29065	Application of long arm cast		S	0426	2.4021	$157.78		$31.56
29075	Application of forearm cast		S	0426	2.4021	$157.78		$31.56
29085	Apply hand/wrist cast		S	0058	1.1147	$73.22		$14.65
29086	Apply finger cast		S	0058	1.1147	$73.22		$14.65
29105	Apply long arm splint		S	0058	1.1147	$73.22		$14.65
29125	Apply forearm splint		S	0058	1.1147	$73.22		$14.65
29126	Apply forearm splint		S	0058	1.1147	$73.22		$14.65
29130	Application of finger splint		S	0058	1.1147	$73.22		$14.65
29131	Application of finger splint		S	0058	1.1147	$73.22		$14.65
29200	Strapping of chest		S	0058	1.1147	$73.22		$14.65
29220	Strapping of low back		S	0058	1.1147	$73.22		$14.65
29240	Strapping of shoulder		S	0058	1.1147	$73.22		$14.65
29260	Strapping of elbow or wrist		S	0058	1.1147	$73.22		$14.65
29280	Strapping of hand or finger		S	0058	1.1147	$73.22		$14.65
29305	Application of hip cast		S	0426	2.4021	$157.78		$31.56
29325	Application of hip casts		S	0426	2.4021	$157.78		$31.56
29345	Application of long leg cast		S	0426	2.4021	$157.78		$31.56
29355	Application of long leg cast		S	0426	2.4021	$157.78		$31.56
29358	Apply long leg cast brace		S	0426	2.4021	$157.78		$31.56
29365	Application of long leg cast		S	0426	2.4021	$157.78		$31.56
29405	Apply short leg cast		S	0426	2.4021	$157.78		$31.56
29425	Apply short leg cast		S	0426	2.4021	$157.78		$31.56
29435	Apply short leg cast		S	0426	2.4021	$157.78		$31.56
29440	Addition of walker to cast		S	0058	1.1147	$73.22		$14.65
29445	Apply rigid leg cast		S	0426	2.4021	$157.78		$31.56
29450	Application of leg cast		S	0058	1.1147	$73.22		$14.65
29505	Application, long leg splint		S	0058	1.1147	$73.22		$14.65
29515	Application lower leg splint		S	0058	1.1147	$73.22		$14.65

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
29520	Strapping of hip		S	0058	1.1147	$73.22		$14.65
29530	Strapping of knee		S	0058	1.1147	$73.22		$14.65
29540	Strapping of ankle and/or ft		S	0058	1.1147	$73.22		$14.65
29550	Strapping of toes		S	0058	1.1147	$73.22		$14.65
29580	Application of paste boot		S	0058	1.1147	$73.22		$14.65
29590	Application of foot splint		S	0058	1.1147	$73.22		$14.65
29700	Removal/revision of cast		S	0058	1.1147	$73.22		$14.65
29705	Removal/revision of cast		S	0058	1.1147	$73.22		$14.65
29710	Removal/revision of cast		S	0426	2.4021	$157.78		$31.56
29715	Removal/revision of cast		S	0058	1.1147	$73.22		$14.65
29720	Repair of body cast		S	0058	1.1147	$73.22		$14.65
29730	Windowing of cast		S	0058	1.1147	$73.22		$14.65
29740	Wedging of cast		S	0058	1.1147	$73.22		$14.65
29750	Wedging of clubfoot cast		S	0058	1.1147	$73.22		$14.65
29799	Casting/strapping procedure		S	0058	1.1147	$73.22		$14.65
29800	Jaw arthroscopy/surgery		T	0041	29.4350	$1,933.41		$386.69
29804	Jaw arthroscopy/surgery		T	0041	29.4350	$1,933.41		$386.69
29805	Shoulder arthroscopy, dx		T	0041	29.4350	$1,933.41		$386.69
29806	Shoulder arthroscopy/surgery		T	0042	49.2291	$3,233.56	$804.74	$646.72
29807	Shoulder arthroscopy/surgery		T	0042	49.2291	$3,233.56	$804.74	$646.72
29819	Shoulder arthroscopy/surgery		T	0042	49.2291	$3,233.56	$804.74	$646.72
29820	Shoulder arthroscopy/surgery		T	0042	49.2291	$3,233.56	$804.74	$646.72
29821	Shoulder arthroscopy/surgery		T	0042	49.2291	$3,233.56	$804.74	$646.72
29822	Shoulder arthroscopy/surgery		T	0041	29.4350	$1,933.41		$386.69
29823	Shoulder arthroscopy/surgery		T	0042	49.2291	$3,233.56	$804.74	$646.72
29824	Shoulder arthroscopy/surgery		T	0041	29.4350	$1,933.41		$386.69
29825	Shoulder arthroscopy/surgery		T	0042	49.2291	$3,233.56	$804.74	$646.72
29826	Shoulder arthroscopy/surgery		T	0042	49.2291	$3,233.56	$804.74	$646.72
29827	Arthroscop rotator cuff repr		T	0042	49.2291	$3,233.56	$804.74	$646.72
29828	Arthroscopy biceps tenodesis		T	0042	49.2291	$3,233.56	$804.74	$646.72
29830	Elbow arthroscopy		T	0041	29.4350	$1,933.41		$386.69

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
29834	Elbow arthroscopy/surgery		T	0041	29.4350	$1,933.41		$386.69
29835	Elbow arthroscopy/surgery		T	0041	29.4350	$1,933.41		$386.69
29836	Elbow arthroscopy/surgery		T	0041	29.4350	$1,933.41		$386.69
29837	Elbow arthroscopy/surgery		T	0041	29.4350	$1,933.41		$386.69
29838	Elbow arthroscopy/surgery		T	0041	29.4350	$1,933.41		$386.69
29840	Wrist arthroscopy		T	0041	29.4350	$1,933.41		$386.69
29843	Wrist arthroscopy/surgery		T	0041	29.4350	$1,933.41		$386.69
29844	Wrist arthroscopy/surgery		T	0041	29.4350	$1,933.41		$386.69
29845	Wrist arthroscopy/surgery		T	0041	29.4350	$1,933.41		$386.69
29846	Wrist arthroscopy/surgery		T	0041	29.4350	$1,933.41		$386.69
29847	Wrist arthroscopy/surgery		T	0042	49.2291	$3,233.56	$804.74	$646.72
29848	Wrist endoscopy/surgery		T	0041	29.4350	$1,933.41		$386.69
29850	Knee arthroscopy/surgery		T	0041	29.4350	$1,933.41		$386.69
29851	Knee arthroscopy/surgery		T	0042	49.2291	$3,233.56	$804.74	$646.72
29855	Tibial arthroscopy/surgery		T	0042	49.2291	$3,233.56	$804.74	$646.72
29856	Tibial arthroscopy/surgery		T	0042	49.2291	$3,233.56	$804.74	$646.72
29860	Hip arthroscopy, dx		T	0042	49.2291	$3,233.56	$804.74	$646.72
29861	Hip arthroscopy/surgery		T	0042	49.2291	$3,233.56	$804.74	$646.72
29862	Hip arthroscopy/surgery		T	0042	49.2291	$3,233.56	$804.74	$646.72
29863	Hip arthroscopy/surgery		T	0042	49.2291	$3,233.56	$804.74	$646.72
29866	Autgrft implnt, knee w/scope		T	0042	49.2291	$3,233.56	$804.74	$646.72
29867	Allgrft implnt, knee w/scope		T	0042	49.2291	$3,233.56	$804.74	$646.72
29868	Meniscal trnspl, knee w/scpe		T	0042	49.2291	$3,233.56	$804.74	$646.72
29870	Knee arthroscopy, dx		T	0041	29.4350	$1,933.41		$386.69
29871	Knee arthroscopy/drainage		T	0041	29.4350	$1,933.41		$386.69
29873	Knee arthroscopy/surgery		T	0041	29.4350	$1,933.41		$386.69
29874	Knee arthroscopy/surgery		T	0041	29.4350	$1,933.41		$386.69
29875	Knee arthroscopy/surgery		T	0041	29.4350	$1,933.41		$386.69
29876	Knee arthroscopy/surgery		T	0041	29.4350	$1,933.41		$386.69
29877	Knee arthroscopy/surgery		T	0041	29.4350	$1,933.41		$386.69
29879	Knee arthroscopy/surgery		T	0041	29.4350	$1,933.41		$386.69

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
29880	Knee arthroscopy/surgery		T	0041	29.4350	$1,933.41		$386.69
29881	Knee arthroscopy/surgery		T	0041	29.4350	$1,933.41		$386.69
29882	Knee arthroscopy/surgery		T	0041	29.4350	$1,933.41		$386.69
29883	Knee arthroscopy/surgery		T	0041	29.4350	$1,933.41		$386.69
29884	Knee arthroscopy/surgery		T	0041	29.4350	$1,933.41		$386.69
29885	Knee arthroscopy/surgery		T	0042	49.2291	$3,233.56	$804.74	$646.72
29886	Knee arthroscopy/surgery		T	0041	29.4350	$1,933.41		$386.69
29887	Knee arthroscopy/surgery		T	0041	29.4350	$1,933.41		$386.69
29888	Knee arthroscopy/surgery		T	0042	49.2291	$3,233.56	$804.74	$646.72
29889	Knee arthroscopy/surgery		T	0042	49.2291	$3,233.56	$804.74	$646.72
29891	Ankle arthroscopy/surgery		T	0042	49.2291	$3,233.56	$804.74	$646.72
29892	Ankle arthroscopy/surgery		T	0042	49.2291	$3,233.56	$804.74	$646.72
29893	Scope, plantar fasciotomy		T	0055	21.6078	$1,419.29	$355.34	$283.86
29894	Ankle arthroscopy/surgery		T	0041	29.4350	$1,933.41		$386.69
29895	Ankle arthroscopy/surgery		T	0041	29.4350	$1,933.41		$386.69
29897	Ankle arthroscopy/surgery		T	0041	29.4350	$1,933.41		$386.69
29898	Ankle arthroscopy/surgery		T	0041	29.4350	$1,933.41		$386.69
29899	Ankle arthroscopy/surgery		T	0042	49.2291	$3,233.56	$804.74	$646.72
29900	Mcp joint arthroscopy, dx		T	0041	29.4350	$1,933.41		$386.69
29901	Mcp joint arthroscopy, surg		T	0041	29.4350	$1,933.41		$386.69
29902	Mcp joint arthroscopy, surg		T	0041	29.4350	$1,933.41		$386.69
29904	Subtalar arthro w/fb rmvl		T	0041	29.4350	$1,933.41		$386.69
29905	Subtalar arthro w/exc		T	0041	29.4350	$1,933.41		$386.69
29906	Subtalar arthro w/deb		T	0041	29.4350	$1,933.41		$386.69
29907	Subtalar arthro w/fusion		T	0042	49.2291	$3,233.56	$804.74	$646.72
29999	Arthroscopy of joint		T	0041	29.4350	$1,933.41		$386.69
30000	Drainage of nose lesion		T	0251	3.1568	$207.35		$41.47
30020	Drainage of nose lesion		T	0251	3.1568	$207.35		$41.47
3006F	Cxr doc rev		M					
30100	Intranasal biopsy		T	0252	7.7504	$509.08	$109.16	$101.82
30110	Removal of nose polyp(s)		T	0253	17.1953	$1,129.46	$282.29	$225.90

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
30115	Removal of nose polyp(s)		T	0253	17.1953	$1,129.46	$282.29	$225.90
30117	Removal of intranasal lesion		T	0253	17.1953	$1,129.46	$282.29	$225.90
30118	Removal of intranasal lesion		T	0254	24.6341	$1,618.07		$323.62
3011F	Lipid panel doc rev		M					
30120	Revision of nose		T	0253	17.1953	$1,129.46	$282.29	$225.90
30124	Removal of nose lesion		T	0252	7.7504	$509.08	$109.16	$101.82
30125	Removal of nose lesion		T	0256	41.6247	$2,734.08		$546.82
30130	Excise inferior turbinate		T	0253	17.1953	$1,129.46	$282.29	$225.90
30140	Resect inferior turbinate		T	0254	24.6341	$1,618.07		$323.62
3014F	Screen mammo doc rev		M					
30150	Partial removal of nose		T	0256	41.6247	$2,734.08		$546.82
30160	Removal of nose		T	0256	41.6247	$2,734.08		$546.82
3017F	Colorectal ca screen doc rev		M					
30200	Injection treatment of nose		T	0252	7.7504	$509.08	$109.16	$101.82
3020F	Lvf assess		M					
30210	Nasal sinus therapy		T	0252	7.7504	$509.08	$109.16	$101.82
3021F	Lvef mod/sever deprs syst		M					
30220	Insert nasal septal button		T	0252	7.7504	$509.08	$109.16	$101.82
3022F	Lvef >=40% systolic		M					
3023F	Spirom doc rev		M					
3025F	Spirom fev/fvc<70% w copd		M					
3027F	Spirom fev/fvc>=70%/w/o copd		M					
3028F	O2 saturation doc rev		M					
30300	Remove nasal foreign body		X	0340	0.6481	$42.57		$8.52
30310	Remove nasal foreign body		T	0253	17.1953	$1,129.46	$282.29	$225.90
30320	Remove nasal foreign body		T	0253	17.1953	$1,129.46	$282.29	$225.90
3035F	O2 saturation<=88% /pao<=55		M					
3037F	O2 saturation >88% /pao>55		M					
30400	Reconstruction of nose		T	0256	41.6247	$2,734.08		$546.82
3040F	Fev<40% predicted value		M					
30410	Reconstruction of nose		T	0256	41.6247	$2,734.08		$546.82

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
30420	Reconstruction of nose		T	0256	41.6247	$2,734.08		$546.82
3042F	Fev>= 40% predicted value		M					
30430	Revision of nose		T	0254	24.6341	$1,618.07		$323.62
30435	Revision of nose		T	0256	41.6247	$2,734.08		$546.82
3044F	Hg a1c level lt 7.0%		M					
30450	Revision of nose		T	0256	41.6247	$2,734.08		$546.82
3045F	HG a1c level 7.0-9.0%		M					
30460	Revision of nose		T	0256	41.6247	$2,734.08		$546.82
30462	Revision of nose		T	0256	41.6247	$2,734.08		$546.82
30465	Repair nasal stenosis		T	0256	41.6247	$2,734.08		$546.82
3046F	Hemoglobin a1c level > 9.0%		M					
3048F	Ldl-c <100 mg/dl		M					
3049F	Ldl-c 100-129 mg/dl		M					
3050F	Ldl-c >= 130 mg/dl		M					
30520	Repair of nasal septum		T	0254	24.6341	$1,618.07		$323.62
30540	Repair nasal defect		T	0256	41.6247	$2,734.08		$546.82
30545	Repair nasal defect		T	0256	41.6247	$2,734.08		$546.82
30560	Release of nasal adhesions		T	0251	3.1568	$207.35		$41.47
30580	Repair upper jaw fistula		T	0256	41.6247	$2,734.08		$546.82
30600	Repair mouth/nose fistula		T	0256	41.6247	$2,734.08		$546.82
3060F	Pos microalbuminuria rev		M					
3061F	Neg microalbuminuria rev		M					
30620	Intranasal reconstruction		T	0256	41.6247	$2,734.08		$546.82
3062F	Pos macroalbuminuria rev		M					
30630	Repair nasal septum defect		T	0254	24.6341	$1,618.07		$323.62
3066F	Nephropathy doc tx		M					
3072F	Low risk for retinopathy		M					
3073F	Pre-surg eye measures docd		M					
3074F	Syst bp lt 130 mm hg		M					
3075F	Syst bp ge 130 - 139mm hg		M					
3077F	Syst bp >= 140 mm hg6 it		M					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
3078F	Diast bp < 80 mm hg		M					
3079F	Diast bp 80-89 mm hg		M					
30801	Ablate inf turbinate, superf		T	0252	7.7504	$509.08	$109.16	$101.82
30802	Cauterization, inner nose		T	0252	7.7504	$509.08	$109.16	$101.82
3080F	Diast bp >= 90 mm hg		M					
3082F	Kt/v lt 1.2		M					
3083F	Kt/v ge 1.2 and <1.7		M					
3084F	Kt/v ge 1.7		M					
3085F	Suicide risk assessed		M					
3088F	MDD, mild		M					
3089F	MDD, moderate		M					
30901	Control of nosebleed		T	0250	1.1335	$74.45	$25.10	$14.89
30903	Control of nosebleed		T	0250	1.1335	$74.45	$25.10	$14.89
30905	Control of nosebleed		T	0250	1.1335	$74.45	$25.10	$14.89
30906	Repeat control of nosebleed		T	0250	1.1335	$74.45	$25.10	$14.89
3090F	MDD, severe; w/o psych		M					
30915	Ligation, nasal sinus artery		T	0092	27.1216	$1,781.46		$356.30
3091F	Mdd, severe; w/ psych		M					
30920	Ligation, upper jaw artery		T	0092	27.1216	$1,781.46		$356.30
3092F	MDD, in remission		M					
30930	Ther fx, nasal inf turbinate		T	0253	17.1953	$1,129.46	$282.29	$225.90
3093F	Doc new diag 1st/addl mdd		M					
3095F	Central dexa results docd		M					
3096F	Central dexa ordered		M					
30999	Nasal surgery procedure	CH	T	0250	1.1335	$74.45	$25.10	$14.89
31000	Irrigation, maxillary sinus		T	0251	3.1568	$207.35		$41.47
31002	Irrigation, sphenoid sinus		T	0252	7.7504	$509.08	$109.16	$101.82
3100F	Image test ref carot diam		M					
31020	Exploration, maxillary sinus		T	0254	24.6341	$1,618.07		$323.62
31030	Exploration, maxillary sinus		T	0256	41.6247	$2,734.08		$546.82
31032	Explore sinus, remove polyps		T	0256	41.6247	$2,734.08		$546.82

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
31040	Exploration behind upper jaw		T	0254	24.6341	$1,618.07		$323.62
31050	Exploration, sphenoid sinus		T	0256	41.6247	$2,734.08		$546.82
31051	Sphenoid sinus surgery		T	0256	41.6247	$2,734.08		$546.82
31070	Exploration of frontal sinus		T	0254	24.6341	$1,618.07		$323.62
31075	Exploration of frontal sinus		T	0256	41.6247	$2,734.08		$546.82
31080	Removal of frontal sinus		T	0256	41.6247	$2,734.08		$546.82
31081	Removal of frontal sinus		T	0256	41.6247	$2,734.08		$546.82
31084	Removal of frontal sinus		T	0256	41.6247	$2,734.08		$546.82
31085	Removal of frontal sinus		T	0256	41.6247	$2,734.08		$546.82
31086	Removal of frontal sinus		T	0256	41.6247	$2,734.08		$546.82
31087	Removal of frontal sinus		T	0256	41.6247	$2,734.08		$546.82
31090	Exploration of sinuses		T	0256	41.6247	$2,734.08		$546.82
3110F	Pres/absn hmrhg/lesion docd		M					
3111F	Ct/mri brain done w/in 24hrs		M					
3112F	Ct/mri brain done gt 24 hrs		M					
31200	Removal of ethmoid sinus		T	0256	41.6247	$2,734.08		$546.82
31201	Removal of ethmoid sinus		T	0256	41.6247	$2,734.08		$546.82
31205	Removal of ethmoid sinus		T	0256	41.6247	$2,734.08		$546.82
3120F	12-lead ecg performed		M					
31225	Removal of upper jaw		C					
31230	Removal of upper jaw		C					
31231	Nasal endoscopy, dx		T	0072	1.7542	$115.22		$23.05
31233	Nasal/sinus endoscopy, dx		T	0072	1.7542	$115.22		$23.05
31235	Nasal/sinus endoscopy, dx		T	0074	17.9233	$1,177.27	$292.25	$235.46
31237	Nasal/sinus endoscopy, surg		T	0074	17.9233	$1,177.27	$292.25	$235.46
31238	Nasal/sinus endoscopy, surg		T	0074	17.9233	$1,177.27	$292.25	$235.46
31239	Nasal/sinus endoscopy, surg		T	0075	23.4400	$1,539.63	$445.92	$307.93
31240	Nasal/sinus endoscopy, surg		T	0074	17.9233	$1,177.27	$292.25	$235.46
31254	Revision of ethmoid sinus		T	0075	23.4400	$1,539.63	$445.92	$307.93
31255	Removal of ethmoid sinus		T	0075	23.4400	$1,539.63	$445.92	$307.93
31256	Exploration maxillary sinus		T	0075	23.4400	$1,539.63	$445.92	$307.93

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
31267	Endoscopy, maxillary sinus		T	0075	23.4400	$1,539.63	$445.92	$307.93
31276	Sinus endoscopy, surgical		T	0075	23.4400	$1,539.63	$445.92	$307.93
31287	Nasal/sinus endoscopy, surg		T	0075	23.4400	$1,539.63	$445.92	$307.93
31288	Nasal/sinus endoscopy, surg		T	0075	23.4400	$1,539.63	$445.92	$307.93
31290	Nasal/sinus endoscopy, surg		C					
31291	Nasal/sinus endoscopy, surg		C					
31292	Nasal/sinus endoscopy, surg		T	0075	23.4400	$1,539.63	$445.92	$307.93
31293	Nasal/sinus endoscopy, surg		T	0075	23.4400	$1,539.63	$445.92	$307.93
31294	Nasal/sinus endoscopy, surg		T	0075	23.4400	$1,539.63	$445.92	$307.93
31299	Sinus surgery procedure	CH	T	0250	1.1335	$74.45	$25.10	$14.89
31300	Removal of larynx lesion		T	0254	24.6341	$1,618.07		$323.62
3130F	Upper gi endoscopy performed		M					
31320	Diagnostic incision, larynx		T	0256	41.6247	$2,734.08		$546.82
3132F	Doc ref upper gi endoscopy		M					
31360	Removal of larynx		C					
31365	Removal of larynx		C					
31367	Partial removal of larynx		C					
31368	Partial removal of larynx		C					
31370	Partial removal of larynx		C					
31375	Partial removal of larynx		C					
31380	Partial removal of larynx		C					
31382	Partial removal of larynx		C					
31390	Removal of larynx & pharynx		C					
31395	Reconstruct larynx & pharynx		C					
31400	Revision of larynx		T	0256	41.6247	$2,734.08		$546.82
3140F	Upper gi endo shows barrtt's		M					
3141F	Upper gi endo not barrtt's		M					
31420	Removal of epiglottis		T	0256	41.6247	$2,734.08		$546.82
3142F	Barium swallow test ordered		M					
31500	Insert emergency airway		S	0094	2.4550	$161.25	$46.29	$32.25
31502	Change of windpipe airway		S	0078	1.4146	$92.92		$18.59

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
31505	Diagnostic laryngoscopy		T	0071	0.9326	$61.26		$12.26
3150F	Forceps esoph biopsy done		M					
31510	Laryngoscopy with biopsy		T	0074	17.9233	$1,177.27	$292.25	$235.46
31511	Remove foreign body, larynx		T	0072	1.7542	$115.22		$23.05
31512	Removal of larynx lesion		T	0074	17.9233	$1,177.27	$292.25	$235.46
31513	Injection into vocal cord		T	0072	1.7542	$115.22		$23.05
31515	Laryngoscopy for aspiration		T	0074	17.9233	$1,177.27	$292.25	$235.46
31520	Dx laryngoscopy, newborn		T	0072	1.7542	$115.22		$23.05
31525	Dx laryngoscopy excl nb		T	0074	17.9233	$1,177.27	$292.25	$235.46
31526	Dx laryngoscopy w/oper scope		T	0075	23.4400	$1,539.63	$445.92	$307.93
31527	Laryngoscopy for treatment		T	0075	23.4400	$1,539.63	$445.92	$307.93
31528	Laryngoscopy and dilation		T	0074	17.9233	$1,177.27	$292.25	$235.46
31529	Laryngoscopy and dilation		T	0074	17.9233	$1,177.27	$292.25	$235.46
31530	Laryngoscopy w/fb removal		T	0075	23.4400	$1,539.63	$445.92	$307.93
31531	Laryngoscopy w/fb & op scope		T	0075	23.4400	$1,539.63	$445.92	$307.93
31535	Laryngoscopy w/biopsy		T	0075	23.4400	$1,539.63	$445.92	$307.93
31536	Laryngoscopy w/bx & op scope		T	0075	23.4400	$1,539.63	$445.92	$307.93
31540	Laryngoscopy w/exc of tumor		T	0075	23.4400	$1,539.63	$445.92	$307.93
31541	Laryngscop w/tumr exc + scope		T	0075	23.4400	$1,539.63	$445.92	$307.93
31545	Remove vc lesion w/scope		T	0075	23.4400	$1,539.63	$445.92	$307.93
31546	Remove vc lesion scope/graft		T	0075	23.4400	$1,539.63	$445.92	$307.93
3155F	Cytogen test marrow b/4 tx		M					
31560	Laryngoscop w/arytenoidectom		T	0075	23.4400	$1,539.63	$445.92	$307.93
31561	Larynscop, remve cart + scop		T	0075	23.4400	$1,539.63	$445.92	$307.93
31570	Laryngoscope w/vc inj		T	0074	17.9233	$1,177.27	$292.25	$235.46
31571	Laryngoscop w/vc inj + scope		T	0075	23.4400	$1,539.63	$445.92	$307.93
31575	Diagnostic laryngoscopy		T	0072	1.7542	$115.22		$23.05
31576	Laryngoscopy with biopsy		T	0075	23.4400	$1,539.63	$445.92	$307.93
31577	Remove foreign body, larynx		T	0073	4.3638	$286.63	$69.15	$57.33
31578	Removal of larynx lesion		T	0075	23.4400	$1,539.63	$445.92	$307.93
31579	Diagnostic laryngoscopy		T	0073	4.3638	$286.63	$69.15	$57.33

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
31580	Revision of larynx		T	0256	41.6247	$2,734.08		$546.82
31582	Revision of larynx		T	0256	41.6247	$2,734.08		$546.82
31584	Treat larynx fracture		C					
31587	Revision of larynx		C					
31588	Revision of larynx		T	0256	41.6247	$2,734.08		$546.82
31590	Reinnervate larynx		T	0256	41.6247	$2,734.08		$546.82
31595	Larynx nerve surgery		T	0256	41.6247	$2,734.08		$546.82
31599	Larynx surgery procedure	CH	T	0250	1.1335	$74.45	$25.10	$14.89
31600	Incision of windpipe		T	0254	24.6341	$1,618.07		$323.62
31601	Incision of windpipe		T	0254	24.6341	$1,618.07		$323.62
31603	Incision of windpipe		T	0252	7.7504	$509.08	$109.16	$101.82
31605	Incision of windpipe		T	0252	7.7504	$509.08	$109.16	$101.82
3160F	Doc fe+ stores b/4 epo thx		M					
31610	Incision of windpipe		T	0254	24.6341	$1,618.07		$323.62
31611	Surgery/speech prosthesis		T	0254	24.6341	$1,618.07		$323.62
31612	Puncture/clear windpipe		T	0254	24.6341	$1,618.07		$323.62
31613	Repair windpipe opening		T	0254	24.6341	$1,618.07		$323.62
31614	Repair windpipe opening		T	0256	41.6247	$2,734.08		$546.82
31615	Visualization of windpipe		T	0076	10.2410	$672.67	$189.82	$134.54
31620	Endobronchial us add-on		N					
31622	Dx bronchoscope/wash		T	0076	10.2410	$672.67	$189.82	$134.54
31623	Dx bronchoscope/brush		T	0076	10.2410	$672.67	$189.82	$134.54
31624	Dx bronchoscope/lavage		T	0076	10.2410	$672.67	$189.82	$134.54
31625	Bronchoscopy w/biopsy(s)		T	0076	10.2410	$672.67	$189.82	$134.54
31628	Bronchoscopy/lung bx, each		T	0076	10.2410	$672.67	$189.82	$134.54
31629	Bronchoscopy/needle bx, each		T	0076	10.2410	$672.67	$189.82	$134.54
31630	Bronchoscopy dilate/fx repr		T	0415	25.1730	$1,653.46	$459.92	$330.70
31631	Bronchoscopy, dilate w/stent		T	0415	25.1730	$1,653.46	$459.92	$330.70
31632	Bronchoscopy/lung bx, add'l		T	0076	10.2410	$672.67	$189.82	$134.54
31633	Bronchoscopy/needle bx add'l		T	0076	10.2410	$672.67	$189.82	$134.54
31635	Bronchoscopy w/fb removal		T	0076	10.2410	$672.67	$189.82	$134.54

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
31636	Bronchoscopy, bronch stents		T	0415	25.1730	$1,653.46	$459.92	$330.70
31637	Bronchoscopy, stent add-on		T	0076	10.2410	$672.67	$189.82	$134.54
31638	Bronchoscopy, revise stent		T	0415	25.1730	$1,653.46	$459.92	$330.70
31640	Bronchoscopy w/tumor excise		T	0415	25.1730	$1,653.46	$459.92	$330.70
31641	Bronchoscopy, treat blockage		T	0415	25.1730	$1,653.46	$459.92	$330.70
31643	Diag bronchoscope/catheter		T	0076	10.2410	$672.67	$189.82	$134.54
31645	Bronchoscopy, clear airways		T	0076	10.2410	$672.67	$189.82	$134.54
31646	Bronchoscopy, reclear airway		T	0076	10.2410	$672.67	$189.82	$134.54
31656	Bronchoscopy, inj for x-ray		T	0076	10.2410	$672.67	$189.82	$134.54
3170F	Flow cyto done b/4 tx		M					
31715	Injection for bronchus x-ray		N					
31717	Bronchial brush biopsy		T	0073	4.3638	$286.63	$69.15	$57.33
31720	Clearance of airways		S	0077	0.3971	$26.08	$7.74	$5.22
31725	Clearance of airways		C					
31730	Intro, windpipe wire/tube		T	0073	4.3638	$286.63	$69.15	$57.33
31750	Repair of windpipe		T	0256	41.6247	$2,734.08		$546.82
31755	Repair of windpipe		T	0256	41.6247	$2,734.08		$546.82
31760	Repair of windpipe		C					
31766	Reconstruction of windpipe		C					
31770	Repair/graft of bronchus		C					
31775	Reconstruct bronchus		C					
31780	Reconstruct windpipe		C					
31781	Reconstruct windpipe		C					
31785	Remove windpipe lesion		T	0254	24.6341	$1,618.07		$323.62
31786	Remove windpipe lesion		C					
31800	Repair of windpipe injury		C					
31805	Repair of windpipe injury		C					
31820	Closure of windpipe lesion		T	0253	17.1953	$1,129.46	$282.29	$225.90
31825	Repair of windpipe defect		T	0254	24.6341	$1,618.07		$323.62
31830	Revise windpipe scar		T	0254	24.6341	$1,618.07		$323.62
31899	Airways surgical procedure		T	0076	10.2410	$672.67	$189.82	$134.54

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
3200F	Barium swallow test not req		M					
32035	Exploration of chest		C					
32036	Exploration of chest		C					
32095	Biopsy through chest wall		C					
32100	Exploration/biopsy of chest		C					
3210F	Grp a strep test performed		M					
32110	Explore/repair chest		C					
32120	Re-exploration of chest		C					
32124	Explore chest free adhesions		C					
32140	Removal of lung lesion(s)		C					
32141	Remove/treat lung lesions		C					
32150	Removal of lung lesion(s)		C					
32151	Remove lung foreign body		C					
3215F	Pt immunity to hep A docd		M					
32160	Open chest heart massage		C					
3216F	Pt immunity to hep B docd		M					
3218F	RNA tstng hep C docd-done		M					
32200	Drain, open, lung lesion		C					
32201	Drain, percut, lung lesion		T	0070	5.3627	$352.24		$70.45
3220F	Hep C quant rna tstng docd		M					
32215	Treat chest lining		C					
32220	Release of lung		C					
32225	Partial release of lung		C					
3230F	Note hring tst w/in 6 mon		M					
32310	Removal of chest lining		C					
32320	Free/remove chest lining		C					
32400	Needle biopsy chest lining		T	0685	9.6161	$631.62		$126.33
32402	Open biopsy chest lining		C					
32405	Biopsy, lung or mediastinum		T	0685	9.6161	$631.62		$126.33
32420	Puncture/clear lung		T	0070	5.3627	$352.24		$70.45
32421	Thoracentesis for aspiration		T	0070	5.3627	$352.24		$70.45

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
32422	Thoracentesis w/tube insert		T	0070	5.3627	$352.24		$70.45
32440	Removal of lung		C					
32442	Sleeve pneumonectomy		C					
32445	Removal of lung		C					
32480	Partial removal of lung		C					
32482	Bilobectomy		C					
32484	Segmentectomy		C					
32486	Sleeve lobectomy		C					
32488	Completion pneumonectomy		C					
32491	Lung volume reduction		C					
32500	Partial removal of lung		C					
32501	Repair bronchus add-on		C					
32503	Resect apical lung tumor		C					
32504	Resect apical lung tum/chest		C					
32540	Removal of lung lesion		C					
32550	Insert pleural cath		T	0652	29.6599	$1,948.18		$389.64
32551	Insertion of chest tube		T	0070	5.3627	$352.24		$70.45
32560	Treat lung lining chemically		T	0070	5.3627	$352.24		$70.45
32601	Thoracoscopy, diagnostic		T	0069	33.8939	$2,226.29	$591.64	$445.26
32602	Thoracoscopy, diagnostic		T	0069	33.8939	$2,226.29	$591.64	$445.26
32603	Thoracoscopy, diagnostic		T	0069	33.8939	$2,226.29	$591.64	$445.26
32604	Thoracoscopy, diagnostic		T	0069	33.8939	$2,226.29	$591.64	$445.26
32605	Thoracoscopy, diagnostic		T	0069	33.8939	$2,226.29	$591.64	$445.26
32606	Thoracoscopy, diagnostic		T	0069	33.8939	$2,226.29	$591.64	$445.26
3260F	Pt cat/pn cat/hist grd docd		M					
32650	Thoracoscopy, surgical		C					
32651	Thoracoscopy, surgical		C					
32652	Thoracoscopy, surgical		C					
32653	Thoracoscopy, surgical		C					
32654	Thoracoscopy, surgical		C					
32655	Thoracoscopy, surgical		C					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
32656	Thoracoscopy, surgical		C					
32657	Thoracoscopy, surgical		C					
32658	Thoracoscopy, surgical		C					
32659	Thoracoscopy, surgical		C					
3265F	RNA tstng HepC vir ord/docd		M					
32660	Thoracoscopy, surgical		C					
32661	Thoracoscopy, surgical		C					
32662	Thoracoscopy, surgical		C					
32663	Thoracoscopy, surgical		C					
32664	Thoracoscopy, surgical		C					
32665	Thoracoscopy, surgical		C					
3266F	HepC gn tstng docd b/4txmnt		M					
3268F	PSA/T/GLSC docd b/4 txmnt		M					
3269F	Bone scn b/4 txmnt/aftr Dx		M					
3270F	No bone scn b/4 txmnt/aftrDx		M					
3271F	Low risk prostate cancer		M					
3272F	Med risk prostate cancer		M					
3273F	High risk prostate cancer		M					
3274F	Prost Cncr rsk not lw/md/hgh		M					
3278F	Serum lvls CA/iPTH/lpd ord		M					
3279F	Hgb lvl >/=13 g/dL		M					
32800	Repair lung hernia		C					
3280F	Hgb lvl 11-12.9 g/dL		M					
32810	Close chest after drainage		C					
32815	Close bronchial fistula		C					
3281F	Hgb lvl <11 g/dL		M					
32820	Reconstruct injured chest		C					
3284F	IOP down >15% of pre-svc lvl		M					
32850	Donor pneumonectomy		C					
32851	Lung transplant, single		C					
32852	Lung transplant with bypass		C					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
32853	Lung transplant, double		C					
32854	Lung transplant with bypass		C					
32855	Prepare donor lung, single		C					
32856	Prepare donor lung, double		C					
3285F	IOP down <15% of pre-svc lvl		M					
3288F	Fall risk assessment docd		M					
32900	Removal of rib(s)		C					
32905	Revise & repair chest wall		C					
32906	Revise & repair chest wall		C					
3290F	Pt=D(Rh)- and unsensitized		M					
3291F	Pt=D(Rh)+or sensitized		M					
3292F	HIV tstng asked/docd/revwd		M					
32940	Revision of lung		C					
32960	Therapeutic pneumothorax		T	0070	5.3627	$352.24		$70.45
32997	Total lung lavage		C					
32998	Perq rf ablate tx, pul tumor		T	0423	46.0975	$3,027.87		$605.58
32999	Chest surgery procedure		T	0070	5.3627	$352.24		$70.45
3300F	AJCC stage docd b/4 thxpy		M					
33010	Drainage of heart sac		T	0070	5.3627	$352.24		$70.45
33011	Repeat drainage of heart sac		T	0070	5.3627	$352.24		$70.45
33015	Incision of heart sac		C					
3301F	Cancer stage docd metast		M					
33020	Incision of heart sac		C					
33025	Incision of heart sac		C					
3302F	AJCC stage 0 docd		M					
33030	Partial removal of heart sac		C					
33031	Partial removal of heart sac		C					
3303F	AJCC stage IA docd		M					
3304F	AJCC stage IB docd		M					
33050	Removal of heart sac lesion		C					
3305F	AJCC stage IC docd		M					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
3306F	AJCC stage IIA docd		M					
3307F	AJCC stage IIB docd		M					
3308F	AJCC stage IIC docd		M					
3309F	AJCC stage IIIA docd		M					
3310F	AJCC stage IIIB docd		M					
3311F	AJCC stage IIIC docd		M					
33120	Removal of heart lesion		C					
3312F	Ajcc stage iv docd		M					
33130	Removal of heart lesion		C					
3313F	AJCC stage IVB doc'd		E					
33140	Heart revascularize (tmr)		C					
33141	Heart tmr w/other procedure		C					
3314F	AJCC stage IVC doc'd		E					
3315F	ER +or PR +breast cancer		M					
3316F	ER- or PR- breast cancer		M					
3317F	Path rpt malig cancer docd		M					
3318F	Path rpt malig cancer docd		M					
3319F	X-ray/CT/Ultrsnd et al ordd		M					
33202	Insert epicard eltrd, open		C					
33203	Insert epicard eltrd, endo		C					
33206	Insertion of heart pacemaker		T	0089	114.6104	$7,528.07	$1,634.44	$1,505.62
33207	Insertion of heart pacemaker		T	0089	114.6104	$7,528.07	$1,634.44	$1,505.62
33208	Insertion of heart pacemaker		T	0655	141.3486	$9,284.34		$1,856.87
3320F	No Xray/CT/ et al ordd		M					
33210	Insertion of heart electrode		T	0106	49.6204	$3,259.27		$651.86
33211	Insertion of heart electrode		T	0106	49.6204	$3,259.27		$651.86
33212	Insertion of pulse generator		T	0090	94.7306	$6,222.28	$1,562.51	$1,244.46
33213	Insertion of pulse generator		T	0654	108.2256	$7,108.69		$1,421.74
33214	Upgrade of pacemaker system		T	0655	141.3486	$9,284.34		$1,856.87
33215	Reposition pacing-defib lead		T	0105	22.2934	$1,464.32		$292.87
33216	Insert lead pace-defib, one		T	0106	49.6204	$3,259.27		$651.86

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
33217	Insert lead pace-defib, dual		T	0106	49.6204	$3,259.27		$651.86
33218	Repair lead pace-defib, one		T	0105	22.2934	$1,464.32		$292.87
33220	Repair lead pace-defib, dual		T	0105	22.2934	$1,464.32		$292.87
33222	Revise pocket, pacemaker		T	0136	16.0086	$1,051.51		$210.31
33223	Revise pocket, pacing-defib		T	0136	16.0086	$1,051.51		$210.31
33224	Insert pacing lead & connect		T	0418	131.5909	$8,643.42		$1,728.69
33225	L ventric pacing lead add-on		T	0418	131.5909	$8,643.42		$1,728.69
33226	Reposition l ventric lead		T	0105	22.2934	$1,464.32		$292.87
33233	Removal of pacemaker system		T	0105	22.2934	$1,464.32		$292.87
33234	Removal of pacemaker system		T	0105	22.2934	$1,464.32		$292.87
33235	Removal pacemaker electrode		T	0105	22.2934	$1,464.32		$292.87
33236	Remove electrode/thoracotomy		C					
33237	Remove electrode/thoracotomy		C					
33238	Remove electrode/thoracotomy		C					
33240	Insert pulse generator		T	0107	327.1195	$21,486.52		$4,297.31
33241	Remove pulse generator		T	0105	22.2934	$1,464.32		$292.87
33243	Remove eltrd/thoracotomy		C					
33244	Remove eltrd, transven		T	0105	22.2934	$1,464.32		$292.87
33249	Eltrd/insert pace-defib		T	0108	406.8227	$26,721.74		$5,344.35
33250	Ablate heart dysrhythm focus		C					
33251	Ablate heart dysrhythm focus		C					
33254	Ablate atria, lmtd		C					
33255	Ablate atria w/o bypass, ext		C					
33256	Ablate atria w/bypass, exten		C					
33257	Ablate atria, lmtd, add-on		C					
33258	Ablate atria, x10sv, add-on		C					
33259	Ablate atria w/bypass add-on		C					
3325F	Preop asses 4 cataract surg		M					
33261	Ablate heart dysrhythm focus		C					
33265	Ablate atria, lmtd, endo		C					
33266	Ablate atria, x10sv, endo		C					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
33282	Implant pat-active ht record		S	0680	71.5537	$4,699.93		$939.99
33284	Remove pat-active ht record		T	0020	7.9864	$524.58		$104.92
33300	Repair of heart wound		C					
33305	Repair of heart wound		C					
3330F	Imaging study ordered (BkP)		M					
33310	Exploratory heart surgery		C					
33315	Exploratory heart surgery		C					
3331F	Bk imaging tst not ordered		M					
33320	Repair major blood vessel(s)		C					
33321	Repair major vessel		C					
33322	Repair major blood vessel(s)		C					
33330	Insert major vessel graft		C					
33332	Insert major vessel graft		C					
33335	Insert major vessel graft		C					
33400	Repair of aortic valve		C					
33401	Valvuloplasty, open		C					
33403	Valvuloplasty, w/cp bypass		C					
33404	Prepare heart-aorta conduit		C					
33405	Replacement of aortic valve		C					
33406	Replacement of aortic valve		C					
3340F	Mammo assess inc xray docd		M					
33410	Replacement of aortic valve		C					
33411	Replacement of aortic valve		C					
33412	Replacement of aortic valve		C					
33413	Replacement of aortic valve		C					
33414	Repair of aortic valve		C					
33415	Revision, subvalvular tissue		C					
33416	Revise ventricle muscle		C					
33417	Repair of aortic valve		C					
3341F	Mammo assess negative docd		M					
33420	Revision of mitral valve		C					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
33422	Revision of mitral valve		C					
33425	Repair of mitral valve		C					
33426	Repair of mitral valve		C					
33427	Repair of mitral valve		C					
3342F	Mammo assess bengn docd		M					
33430	Replacement of mitral valve		C					
3343F	Mammo probably bengn docd		M					
3344F	Mammo assess susp docd		M					
3345F	Mammo assess hghlymalig doc		M					
33460	Revision of tricuspid valve		C					
33463	Valvuloplasty, tricuspid		C					
33464	Valvuloplasty, tricuspid		C					
33465	Replace tricuspid valve		C					
33468	Revision of tricuspid valve		C					
33470	Revision of pulmonary valve		C					
33471	Valvotomy, pulmonary valve		C					
33472	Revision of pulmonary valve		C					
33474	Revision of pulmonary valve		C					
33475	Replacement, pulmonary valve		C					
33476	Revision of heart chamber		C					
33478	Revision of heart chamber		C					
33496	Repair, prosth valve clot		C					
33500	Repair heart vessel fistula		C					
33501	Repair heart vessel fistula		C					
33502	Coronary artery correction		C					
33503	Coronary artery graft		C					
33504	Coronary artery graft		C					
33505	Repair artery w/tunnel		C					
33506	Repair artery, translocation		C					
33507	Repair art, intramural		C					
33508	Endoscopic vein harvest		N					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
3350F	Mammo bx proven malig docd		M					
33510	CABG, vein, single		C					
33511	CABG, vein, two		C					
33512	CABG, vein, three		C					
33513	CABG, vein, four		C					
33514	CABG, vein, five		C					
33516	Cabg, vein, six or more		C					
33517	CABG, artery-vein, single		C					
33518	CABG, artery-vein, two		C					
33519	CABG, artery-vein, three		C					
33521	CABG, artery-vein, four		C					
33522	CABG, artery-vein, five		C					
33523	Cabg, art-vein, six or more		C					
33530	Coronary artery, bypass/reop		C					
33533	CABG, arterial, single		C					
33534	CABG, arterial, two		C					
33535	CABG, arterial, three		C					
33536	Cabg, arterial, four or more		C					
33542	Removal of heart lesion		C					
33545	Repair of heart damage		C					
33548	Restore/remodel, ventricle		C					
33572	Open coronary endarterectomy		C					
33600	Closure of valve		C					
33602	Closure of valve		C					
33606	Anastomosis/artery-aorta		C					
33608	Repair anomaly w/conduit		C					
33610	Repair by enlargement		C					
33611	Repair double ventricle		C					
33612	Repair double ventricle		C					
33615	Repair, modified fontan		C					
33617	Repair single ventricle		C					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
33619	Repair single ventricle		C					
33641	Repair heart septum defect		C					
33645	Revision of heart veins		C					
33647	Repair heart septum defects		C					
33660	Repair of heart defects		C					
33665	Repair of heart defects		C					
33670	Repair of heart chambers		C					
33675	Close mult vsd		C					
33676	Close mult vsd w/resection		C					
33677	CI mult vsd w/rem pul band		C					
33681	Repair heart septum defect		C					
33684	Repair heart septum defect		C					
33688	Repair heart septum defect		C					
33690	Reinforce pulmonary artery		C					
33692	Repair of heart defects		C					
33694	Repair of heart defects		C					
33697	Repair of heart defects		C					
33702	Repair of heart defects		C					
33710	Repair of heart defects		C					
33720	Repair of heart defect		C					
33722	Repair of heart defect		C					
33724	Repair venous anomaly		C					
33726	Repair pul venous stenosis		C					
33730	Repair heart-vein defect(s)		C					
33732	Repair heart-vein defect		C					
33735	Revision of heart chamber		C					
33736	Revision of heart chamber		C					
33737	Revision of heart chamber		C					
33750	Major vessel shunt		C					
33755	Major vessel shunt		C					
33762	Major vessel shunt		C					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
33764	Major vessel shunt & graft		C					
33766	Major vessel shunt		C					
33767	Major vessel shunt		C					
33768	Cavopulmonary shunting		C					
33770	Repair great vessels defect		C					
33771	Repair great vessels defect		C					
33774	Repair great vessels defect		C					
33775	Repair great vessels defect		C					
33776	Repair great vessels defect		C					
33777	Repair great vessels defect		C					
33778	Repair great vessels defect		C					
33779	Repair great vessels defect		C					
33780	Repair great vessels defect		C					
33781	Repair great vessels defect		C					
33786	Repair arterial trunk		C					
33788	Revision of pulmonary artery		C					
33800	Aortic suspension		C					
33802	Repair vessel defect		C					
33803	Repair vessel defect		C					
33813	Repair septal defect		C					
33814	Repair septal defect		C					
33820	Revise major vessel		C					
33822	Revise major vessel		C					
33824	Revise major vessel		C					
33840	Remove aorta constriction		C					
33845	Remove aorta constriction		C					
33851	Remove aorta constriction		C					
33852	Repair septal defect		C					
33853	Repair septal defect		C					
33860	Ascending aortic graft		C					
33861	Ascending aortic graft		C					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
33863	Ascending aortic graft		C					
33864	Ascending aortic graft		C					
33870	Transverse aortic arch graft		C					
33875	Thoracic aortic graft		C					
33877	Thoracoabdominal graft		C					
33880	Endovasc taa repr incl subcl		C					
33881	Endovasc taa repr w/o subcl		C					
33883	Insert endovasc prosth, taa		C					
33884	Endovasc prosth, taa, add-on		C					
33886	Endovasc prosth, delayed		C					
33889	Artery transpose/endovas taa		C					
33891	Car-car bp grft/endovas taa		C					
33910	Remove lung artery emboli		C					
33915	Remove lung artery emboli		C					
33916	Surgery of great vessel		C					
33917	Repair pulmonary artery		C					
33920	Repair pulmonary atresia		C					
33922	Transect pulmonary artery		C					
33924	Remove pulmonary shunt		C					
33925	Rpr pul art unifocal w/o cpb		C					
33926	Repr pul art, unifocal w/cpb		C					
33930	Removal of donor heart/lung		C					
33933	Prepare donor heart/lung		C					
33935	Transplantation, heart/lung		C					
33940	Removal of donor heart		C					
33944	Prepare donor heart		C					
33945	Transplantation of heart		C					
33960	External circulation assist		C					
33961	External circulation assist		C					
33967	Insert ia percut device		C					
33968	Remove aortic assist device		C					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
33970	Aortic circulation assist		C					
33971	Aortic circulation assist		C					
33973	Insert balloon device		C					
33974	Remove intra-aortic balloon		C					
33975	Implant ventricular device		C					
33976	Implant ventricular device		C					
33977	Remove ventricular device		C					
33978	Remove ventricular device		C					
33979	Insert intracorporeal device		C					
33980	Remove intracorporeal device		C					
33999	Cardiac surgery procedure		T	0070	5.3627	$352.24		$70.45
34001	Removal of artery clot		C					
34051	Removal of artery clot		C					
34101	Removal of artery clot		T	0088	40.2393	$2,643.08	$655.22	$528.62
34111	Removal of arm artery clot		T	0088	40.2393	$2,643.08	$655.22	$528.62
34151	Removal of artery clot		C					
34201	Removal of artery clot		T	0088	40.2393	$2,643.08	$655.22	$528.62
34203	Removal of leg artery clot		T	0088	40.2393	$2,643.08	$655.22	$528.62
34401	Removal of vein clot		C					
34421	Removal of vein clot		T	0088	40.2393	$2,643.08	$655.22	$528.62
34451	Removal of vein clot		C					
34471	Removal of vein clot		T	0088	40.2393	$2,643.08	$655.22	$528.62
34490	Removal of vein clot		T	0088	40.2393	$2,643.08	$655.22	$528.62
34501	Repair valve, femoral vein		T	0088	40.2393	$2,643.08	$655.22	$528.62
34502	Reconstruct vena cava		C					
34510	Transposition of vein valve		T	0088	40.2393	$2,643.08	$655.22	$528.62
34520	Cross-over vein graft		T	0088	40.2393	$2,643.08	$655.22	$528.62
34530	Leg vein fusion		T	0088	40.2393	$2,643.08	$655.22	$528.62
34800	Endovas aaa repr w/sm tube		C					
34802	Endovas aaa repr w/2-p part		C					
34803	Endovas aaa repr w/3-p part		C					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
34804	Endovas aaa repr w/1-p part		C					
34805	Endovas aaa repr w/long tube		C					
34806	Aneurysm press sensor add-on		C					
34808	Endovas iliac a device addon		C					
34812	Xpose for endoprosth, femorl		C					
34813	Femoral endovas graft add-on		C					
34820	Xpose for endoprosth, iliac		C					
34825	Endovasc extend prosth, init		C					
34826	Endovasc exten prosth, add'l		C					
34830	Open aortic tube prosth repr		C					
34831	Open aortoiliac prosth repr		C					
34832	Open aortofemor prosth repr		C					
34833	Xpose for endoprosth, iliac		C					
34834	Xpose, endoprosth, brachial		C					
34900	Endovasc iliac repr w/graft		C					
35001	Repair defect of artery		C					
35002	Repair artery rupture, neck		C					
35005	Repair defect of artery		C					
35011	Repair defect of artery		T	0653	45.5184	$2,989.83		$597.97
35013	Repair artery rupture, arm		C					
35021	Repair defect of artery		C					
35022	Repair artery rupture, chest		C					
35045	Repair defect of arm artery		C					
35081	Repair defect of artery		C					
35082	Repair artery rupture, aorta		C					
35091	Repair defect of artery		C					
35092	Repair artery rupture, aorta		C					
35102	Repair defect of artery		C					
35103	Repair artery rupture, groin		C					
35111	Repair defect of artery		C					
35112	Repair artery rupture,spleen		C					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
35121	Repair defect of artery		C					
35122	Repair artery rupture, belly		C					
35131	Repair defect of artery		C					
35132	Repair artery rupture, groin		C					
35141	Repair defect of artery		C					
35142	Repair artery rupture, thigh		C					
35151	Repair defect of artery		C					
35152	Repair artery rupture, knee		C					
35180	Repair blood vessel lesion		T	0093	27.2558	$1,790.27		$358.06
35182	Repair blood vessel lesion		C					
35184	Repair blood vessel lesion		T	0093	27.2558	$1,790.27		$358.06
35188	Repair blood vessel lesion		T	0088	40.2393	$2,643.08	$655.22	$528.62
35189	Repair blood vessel lesion		C					
35190	Repair blood vessel lesion		T	0093	27.2558	$1,790.27		$358.06
35201	Repair blood vessel lesion		T	0093	27.2558	$1,790.27		$358.06
35206	Repair blood vessel lesion		T	0093	27.2558	$1,790.27		$358.06
35207	Repair blood vessel lesion		T	0088	40.2393	$2,643.08	$655.22	$528.62
35211	Repair blood vessel lesion		C					
35216	Repair blood vessel lesion		C					
35221	Repair blood vessel lesion		C					
35226	Repair blood vessel lesion		T	0093	27.2558	$1,790.27		$358.06
35231	Repair blood vessel lesion		T	0093	27.2558	$1,790.27		$358.06
35236	Repair blood vessel lesion		T	0093	27.2558	$1,790.27		$358.06
35241	Repair blood vessel lesion		C					
35246	Repair blood vessel lesion		C					
35251	Repair blood vessel lesion		C					
35256	Repair blood vessel lesion		T	0093	27.2558	$1,790.27		$358.06
35261	Repair blood vessel lesion		T	0653	45.5184	$2,989.83		$597.97
35266	Repair blood vessel lesion		T	0653	45.5184	$2,989.83		$597.97
35271	Repair blood vessel lesion		C					
35276	Repair blood vessel lesion		C					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
35281	Repair blood vessel lesion		C					
35286	Repair blood vessel lesion		T	0653	45.5184	$2,989.83		$597.97
35301	Rechanneling of artery		C					
35302	Rechanneling of artery		C					
35303	Rechanneling of artery		C					
35304	Rechanneling of artery		C					
35305	Rechanneling of artery		C					
35306	Rechanneling of artery		C					
35311	Rechanneling of artery		C					
35321	Rechanneling of artery		T	0093	27.2558	$1,790.27		$358.06
35331	Rechanneling of artery		C					
35341	Rechanneling of artery		C					
35351	Rechanneling of artery		C					
35355	Rechanneling of artery		C					
35361	Rechanneling of artery		C					
35363	Rechanneling of artery		C					
35371	Rechanneling of artery		C					
35372	Rechanneling of artery		C					
35390	Reoperation, carotid add-on		C					
35400	Angioscopy		C					
35450	Repair arterial blockage		C					
35452	Repair arterial blockage		C					
35454	Repair arterial blockage		C					
35456	Repair arterial blockage		C					
35458	Repair arterial blockage		T	0083	48.2679	$3,170.43		$634.09
35459	Repair arterial blockage		T	0083	48.2679	$3,170.43		$634.09
35460	Repair venous blockage		T	0083	48.2679	$3,170.43		$634.09
35470	Repair arterial blockage		T	0083	48.2679	$3,170.43		$634.09
35471	Repair arterial blockage		T	0083	48.2679	$3,170.43		$634.09
35472	Repair arterial blockage		T	0083	48.2679	$3,170.43		$634.09
35473	Repair arterial blockage		T	0083	48.2679	$3,170.43		$634.09

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
35474	Repair arterial blockage		T	0083	48.2679	$3,170.43		$634.09
35475	Repair arterial blockage		T	0083	48.2679	$3,170.43		$634.09
35476	Repair venous blockage		T	0083	48.2679	$3,170.43		$634.09
35480	Atherectomy, open		C					
35481	Atherectomy, open		C					
35482	Atherectomy, open		C					
35483	Atherectomy, open		C					
35484	Atherectomy, open		T	0082	89.0122	$5,846.68		$1,169.34
35485	Atherectomy, open		T	0082	89.0122	$5,846.68		$1,169.34
35490	Atherectomy, percutaneous		T	0082	89.0122	$5,846.68		$1,169.34
35491	Atherectomy, percutaneous		T	0082	89.0122	$5,846.68		$1,169.34
35492	Atherectomy, percutaneous		T	0082	89.0122	$5,846.68		$1,169.34
35493	Atherectomy, percutaneous		T	0082	89.0122	$5,846.68		$1,169.34
35494	Atherectomy, percutaneous		T	0082	89.0122	$5,846.68		$1,169.34
35495	Atherectomy, percutaneous		T	0082	89.0122	$5,846.68		$1,169.34
35500	Harvest vein for bypass		T	0103	15.8354	$1,040.13		$208.03
35501	Artery bypass graft		C					
35506	Artery bypass graft		C					
35508	Artery bypass graft		C					
35509	Artery bypass graft		C					
35510	Artery bypass graft		C					
35511	Artery bypass graft		C					
35512	Artery bypass graft		C					
35515	Artery bypass graft		C					
35516	Artery bypass graft		C					
35518	Artery bypass graft		C					
35521	Artery bypass graft		C					
35522	Artery bypass graft		C					
35523	Artery bypass graft		C					
35525	Artery bypass graft		C					
35526	Artery bypass graft		C					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
35531	Artery bypass graft		C					
35533	Artery bypass graft		C					
35536	Artery bypass graft		C					
35537	Artery bypass graft		C					
35538	Artery bypass graft		C					
35539	Artery bypass graft		C					
35540	Artery bypass graft		C					
35548	Artery bypass graft		C					
35549	Artery bypass graft		C					
35551	Artery bypass graft		C					
35556	Artery bypass graft		C					
35558	Artery bypass graft		C					
35560	Artery bypass graft		C					
35563	Artery bypass graft		C					
35565	Artery bypass graft		C					
35566	Artery bypass graft		C					
35571	Artery bypass graft		C					
35572	Harvest femoropopliteal vein		N					
35583	Vein bypass graft		C					
35585	Vein bypass graft		C					
35587	Vein bypass graft		C					
35600	Harvest art for cabg add-on		C					
35601	Artery bypass graft		C					
35606	Artery bypass graft		C					
35612	Artery bypass graft		C					
35616	Artery bypass graft		C					
35621	Artery bypass graft		C					
35623	Bypass graft, not vein		C					
35626	Artery bypass graft		C					
35631	Artery bypass graft		C					
35636	Artery bypass graft		C					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
35637	Artery bypass graft		C					
35638	Artery bypass graft		C					
35642	Artery bypass graft		C					
35645	Artery bypass graft		C					
35646	Artery bypass graft		C					
35647	Artery bypass graft		C					
35650	Artery bypass graft		C					
35651	Artery bypass graft		C					
35654	Artery bypass graft		C					
35656	Artery bypass graft		C					
35661	Artery bypass graft		C					
35663	Artery bypass graft		C					
35665	Artery bypass graft		C					
35666	Artery bypass graft		C					
35671	Artery bypass graft		C					
35681	Composite bypass graft		C					
35682	Composite bypass graft		C					
35683	Composite bypass graft		C					
35685	Bypass graft patency/patch		T	0093	27.2558	$1,790.27		$358.06
35686	Bypass graft/av fist patency		T	0093	27.2558	$1,790.27		$358.06
35691	Arterial transposition		C					
35693	Arterial transposition		C					
35694	Arterial transposition		C					
35695	Arterial transposition		C					
35697	Reimplant artery each		C					
35700	Reoperation, bypass graft		C					
35701	Exploration, carotid artery		C					
35721	Exploration, femoral artery		C					
35741	Exploration popliteal artery		C					
35761	Exploration of artery/vein		T	0115	30.5339	$2,005.59		$401.12
35800	Explore neck vessels		C					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
35820	Explore chest vessels		C					
35840	Explore abdominal vessels		C					
35860	Explore limb vessels		T	0093	27.2558	$1,790.27		$358.06
35870	Repair vessel graft defect		C					
35875	Removal of clot in graft		T	0088	40.2393	$2,643.08	$655.22	$528.62
35876	Removal of clot in graft		T	0088	40.2393	$2,643.08	$655.22	$528.62
35879	Revise graft w/vein		T	0088	40.2393	$2,643.08	$655.22	$528.62
35881	Revise graft w/vein		T	0088	40.2393	$2,643.08	$655.22	$528.62
35883	Revise graft w/nonauto graft		T	0088	40.2393	$2,643.08	$655.22	$528.62
35884	Revise graft w/vein		T	0088	40.2393	$2,643.08	$655.22	$528.62
35901	Excision, graft, neck		C					
35903	Excision, graft, extremity		T	0115	30.5339	$2,005.59		$401.12
35905	Excision, graft, thorax		C					
35907	Excision, graft, abdomen		C					
36000	Place needle in vein		N					
36002	Pseudoaneurysm injection trt		S	0267	2.3495	$154.32	$60.50	$30.87
36005	Injection ext venography		N					
36010	Place catheter in vein		N					
36011	Place catheter in vein		N					
36012	Place catheter in vein		N					
36013	Place catheter in artery		N					
36014	Place catheter in artery		N					
36015	Place catheter in artery		N					
36100	Establish access to artery		N					
36120	Establish access to artery		N					
36140	Establish access to artery		N					
36145	Artery to vein shunt		N					
36160	Establish access to aorta		N					
36200	Place catheter in aorta		N					
36215	Place catheter in artery		N					
36216	Place catheter in artery		N					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
36217	Place catheter in artery		N					
36218	Place catheter in artery		N					
36245	Place catheter in artery		N					
36246	Place catheter in artery		N					
36247	Place catheter in artery		N					
36248	Place catheter in artery		N					
36260	Insertion of infusion pump		T	0623	29.5674	$1,942.11		$388.43
36261	Revision of infusion pump		T	0105	22.2934	$1,464.32		$292.87
36262	Removal of infusion pump		T	0105	22.2934	$1,464.32		$292.87
36299	Vessel injection procedure		N					
36400	Bl draw < 3 yrs fem/jugular		N					
36405	Bl draw < 3 yrs scalp vein		N					
36406	Bl draw < 3 yrs other vein		N					
36410	Non-routine bl draw > 3 yrs		N					
36415	Routine venipuncture		A					
36416	Capillary blood draw		N					
36420	Vein access cutdown < 1 yr	CH	X	0035	0.2298	$15.09		$3.02
36425	Vein access cutdown > 1 yr	CH	X	0035	0.2298	$15.09		$3.02
36430	Blood transfusion service		S	0110	3.3941	$222.94		$44.59
36440	Bl push transfuse, 2 yr or <		S	0110	3.3941	$222.94		$44.59
36450	Bl exchange/transfuse, nb		S	0110	3.3941	$222.94		$44.59
36455	Bl exchange/transfuse non-nb		S	0110	3.3941	$222.94		$44.59
36460	Transfusion service, fetal		S	0110	3.3941	$222.94		$44.59
36468	Injection(s), spider veins		T	0013	0.8332	$54.73		$10.95
36469	Injection(s), spider veins		T	0013	0.8332	$54.73		$10.95
36470	Injection therapy of vein		T	0013	0.8332	$54.73		$10.95
36471	Injection therapy of veins		T	0013	0.8332	$54.73		$10.95
36475	Endovenous rf, 1st vein		T	0091	43.1274	$2,832.78		$566.56
36476	Endovenous rf, vein add-on		T	0092	27.1216	$1,781.46		$356.30
36478	Endovenous laser, 1st vein		T	0092	27.1216	$1,781.46		$356.30
36479	Endovenous laser vein addon		T	0092	27.1216	$1,781.46		$356.30

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
36481	Insertion of catheter, vein		N					
36500	Insertion of catheter, vein		N					
36510	Insertion of catheter, vein		N					
36511	Apheresis wbc		S	0111	11.7199	$769.81	$198.40	$153.97
36512	Apheresis rbc		S	0111	11.7199	$769.81	$198.40	$153.97
36513	Apheresis platelets		S	0111	11.7199	$769.81	$198.40	$153.97
36514	Apheresis plasma		S	0111	11.7199	$769.81	$198.40	$153.97
36515	Apheresis, adsorp/reinfuse		S	0112	30.7556	$2,020.15	$433.29	$404.03
36516	Apheresis, selective		S	0112	30.7556	$2,020.15	$433.29	$404.03
36522	Photopheresis		S	0112	30.7556	$2,020.15	$433.29	$404.03
36555	Insert non-tunnel cv cath		T	0621	11.1392	$731.67		$146.34
36556	Insert non-tunnel cv cath		T	0621	11.1392	$731.67		$146.34
36557	Insert tunneled cv cath		T	0622	24.7775	$1,627.49		$325.50
36558	Insert tunneled cv cath		T	0622	24.7775	$1,627.49		$325.50
36560	Insert tunneled cv cath		T	0623	29.5674	$1,942.11		$388.43
36561	Insert tunneled cv cath		T	0623	29.5674	$1,942.11		$388.43
36563	Insert tunneled cv cath		T	0623	29.5674	$1,942.11		$388.43
36565	Insert tunneled cv cath		T	0623	29.5674	$1,942.11		$388.43
36566	Insert tunneled cv cath	CH	T	0623	29.5674	$1,942.11		$388.43
36568	Insert picc cath		T	0621	11.1392	$731.67		$146.34
36569	Insert picc cath		T	0621	11.1392	$731.67		$146.34
36570	Insert picvad cath		T	0622	24.7775	$1,627.49		$325.50
36571	Insert picvad cath		T	0622	24.7775	$1,627.49		$325.50
36575	Repair tunneled cv cath	CH	T	0121	4.5975	$301.98		$60.40
36576	Repair tunneled cv cath		T	0621	11.1392	$731.67		$146.34
36578	Replace tunneled cv cath		T	0622	24.7775	$1,627.49		$325.50
36580	Replace cvad cath		T	0621	11.1392	$731.67		$146.34
36581	Replace tunneled cv cath		T	0622	24.7775	$1,627.49		$325.50
36582	Replace tunneled cv cath		T	0623	29.5674	$1,942.11		$388.43
36583	Replace tunneled cv cath		T	0623	29.5674	$1,942.11		$388.43
36584	Replace picc cath		T	0621	11.1392	$731.67		$146.34

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
36585	Replace picvad cath		T	0622	24.7775	$1,627.49		$325.50
36589	Removal tunneled cv cath	CH	T	0121	4.5975	$301.98		$60.40
36590	Removal tunneled cv cath		T	0621	11.1392	$731.67		$146.34
36591	Draw blood off venous device		Q1	0624	0.6000	$39.41	$12.65	$7.89
36592	Collect blood from picc	CH	Q1	0624	0.6000	$39.41	$12.65	$7.89
36593	Declot vascular device		T	0676	2.4493	$160.88		$32.18
36595	Mech remov tunneled cv cath		T	0622	24.7775	$1,627.49		$325.50
36596	Mech remov tunneled cv cath		T	0621	11.1392	$731.67		$146.34
36597	Reposition venous catheter		T	0621	11.1392	$731.67		$146.34
36598	Inj w/fluor, eval cv device		T	0676	2.4493	$160.88		$32.18
36600	Withdrawal of arterial blood		Q1	0035	0.2298	$15.09		$3.02
36620	Insertion catheter, artery		N					
36625	Insertion catheter, artery		N					
36640	Insertion catheter, artery		T	0623	29.5674	$1,942.11		$388.43
36660	Insertion catheter, artery		C					
36680	Insert needle, bone cavity		T	0002	1.5340	$100.76		$20.16
36800	Insertion of cannula		T	0115	30.5339	$2,005.59		$401.12
36810	Insertion of cannula		T	0115	30.5339	$2,005.59		$401.12
36815	Insertion of cannula		T	0115	30.5339	$2,005.59		$401.12
36818	Av fuse, uppr arm, cephalic		T	0088	40.2393	$2,643.08	$655.22	$528.62
36819	Av fuse, uppr arm, basilic		T	0088	40.2393	$2,643.08	$655.22	$528.62
36820	Av fusion/forearm vein		T	0088	40.2393	$2,643.08	$655.22	$528.62
36821	Av fusion direct any site		T	0088	40.2393	$2,643.08	$655.22	$528.62
36822	Insertion of cannula(s)		C					
36823	Insertion of cannula(s)		C					
36825	Artery-vein autograft		T	0088	40.2393	$2,643.08	$655.22	$528.62
36830	Artery-vein nonautograft		T	0088	40.2393	$2,643.08	$655.22	$528.62
36831	Open thrombect av fistula		T	0088	40.2393	$2,643.08	$655.22	$528.62
36832	Av fistula revision, open		T	0088	40.2393	$2,643.08	$655.22	$528.62
36833	Av fistula revision		T	0088	40.2393	$2,643.08	$655.22	$528.62
36834	Repair A-V aneurysm		T	0088	40.2393	$2,643.08	$655.22	$528.62

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
36835	Artery to vein shunt		T	0115	30.5339	$2,005.59		$401.12
36838	Dist revas ligation, hemo		T	0088	40.2393	$2,643.08	$655.22	$528.62
36860	External cannula declotting		T	0676	2.4493	$160.88		$32.18
36861	Cannula declotting		T	0115	30.5339	$2,005.59		$401.12
36870	Percut thrombect av fistula		T	0653	45.5184	$2,989.83		$597.97
37140	Revision of circulation		C					
37145	Revision of circulation		C					
37160	Revision of circulation		C					
37180	Revision of circulation		C					
37181	Splice spleen/kidney veins		C					
37182	Insert hepatic shunt (tips)		C					
37183	Remove hepatic shunt (tips)		T	0229	90.7212	$5,958.93		$1,191.79
37184	Prim art mech thrombectomy		T	0088	40.2393	$2,643.08	$655.22	$528.62
37185	Prim art m-thrombect add-on		T	0088	40.2393	$2,643.08	$655.22	$528.62
37186	Sec art m-thrombect add-on		T	0088	40.2393	$2,643.08	$655.22	$528.62
37187	Venous mech thrombectomy		T	0088	40.2393	$2,643.08	$655.22	$528.62
37188	Venous m-thrombectomy add-on		T	0088	40.2393	$2,643.08	$655.22	$528.62
37195	Thrombolytic therapy, stroke		T	0676	2.4493	$160.88		$32.18
37200	Transcatheter biopsy		T	0623	29.5674	$1,942.11		$388.43
37201	Transcatheter therapy infuse		T	0103	15.8354	$1,040.13		$208.03
37202	Transcatheter therapy infuse		T	0103	15.8354	$1,040.13		$208.03
37203	Transcatheter retrieval		T	0623	29.5674	$1,942.11		$388.43
37204	Transcatheter occlusion		T	0082	89.0122	$5,846.68		$1,169.34
37205	Transcath iv stent, percut		T	0229	90.7212	$5,958.93		$1,191.79
37206	Transcath iv stent/perc addl		T	0229	90.7212	$5,958.93		$1,191.79
37207	Transcath iv stent, open		T	0229	90.7212	$5,958.93		$1,191.79
37208	Transcath iv stent/open addl		T	0229	90.7212	$5,958.93		$1,191.79
37209	Change iv cath at thromb tx		T	0623	29.5674	$1,942.11		$388.43
37210	Embolization uterine fibroid		T	0229	90.7212	$5,958.93		$1,191.79
37215	Transcath stent, cca w/eps		C					
37216	Transcath stent, cca w/o eps		E					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
37250	Iv us first vessel add-on		N					
37251	Iv us each add vessel add-on		N					
37500	Endoscopy ligate perf veins		T	0091	43.1274	$2,832.78		$566.56
37501	Vascular endoscopy procedure		T	0092	27.1216	$1,781.46		$356.30
37565	Ligation of neck vein		T	0093	27.2558	$1,790.27		$358.06
37600	Ligation of neck artery		T	0093	27.2558	$1,790.27		$358.06
37605	Ligation of neck artery		T	0091	43.1274	$2,832.78		$566.56
37606	Ligation of neck artery		T	0092	27.1216	$1,781.46		$356.30
37607	Ligation of a-v fistula		T	0092	27.1216	$1,781.46		$356.30
37609	Temporal artery procedure		T	0021	15.8699	$1,042.40	$219.48	$208.48
37615	Ligation of neck artery		T	0092	27.1216	$1,781.46		$356.30
37616	Ligation of chest artery		C					
37617	Ligation of abdomen artery		C					
37618	Ligation of extremity artery		C					
37620	Revision of major vein		T	0091	43.1274	$2,832.78		$566.56
37650	Revision of major vein		T	0092	27.1216	$1,781.46		$356.30
37660	Revision of major vein		C					
37700	Revise leg vein		T	0092	27.1216	$1,781.46		$356.30
37718	Ligate/strip short leg vein		T	0092	27.1216	$1,781.46		$356.30
37722	Ligate/strip long leg vein		T	0091	43.1274	$2,832.78		$566.56
37735	Removal of leg veins/lesion		T	0091	43.1274	$2,832.78		$566.56
37760	Ligation, leg veins, open		T	0092	27.1216	$1,781.46		$356.30
37765	Phleb veins extrem 10-20		T	0092	27.1216	$1,781.46		$356.30
37766	Phleb veins extrem 20+		T	0092	27.1216	$1,781.46		$356.30
37780	Revision of leg vein		T	0092	27.1216	$1,781.46		$356.30
37785	Ligate/divide/excise vein		T	0092	27.1216	$1,781.46		$356.30
37788	Revascularization, penis		C					
37790	Penile venous occlusion		T	0181	35.5509	$2,335.13	$621.82	$467.03
37799	Vascular surgery procedure		T	0103	15.8354	$1,040.13		$208.03
38100	Removal of spleen, total		C					
38101	Removal of spleen, partial		C					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
38102	Removal of spleen, total		C					
38115	Repair of ruptured spleen		C					
38120	Laparoscopy, splenectomy		T	0131	46.3867	$3,046.86	$1,001.89	$609.38
38129	Laparoscope proc, spleen		T	0130	37.5470	$2,466.24	$659.53	$493.25
38200	Injection for spleen x-ray		N					
38204	Bl donor search management		N					
38205	Harvest allogenic stem cells		S	0111	11.7199	$769.81	$198.40	$153.97
38206	Harvest auto stem cells		S	0111	11.7199	$769.81	$198.40	$153.97
38207	Cryopreserve stem cells		S	0110	3.3941	$222.94		$44.59
38208	Thaw preserved stem cells		S	0110	3.3941	$222.94		$44.59
38209	Wash harvest stem cells		S	0110	3.3941	$222.94		$44.59
38210	T-cell depletion of harvest		S	0393	6.0567	$397.83	$82.04	$79.57
38211	Tumor cell deplete of harvst		S	0393	6.0567	$397.83	$82.04	$79.57
38212	Rbc depletion of harvest		S	0393	6.0567	$397.83	$82.04	$79.57
38213	Platelet deplete of harvest		S	0393	6.0567	$397.83	$82.04	$79.57
38214	Volume deplete of harvest		S	0393	6.0567	$397.83	$82.04	$79.57
38215	Harvest stem cell concentrte		S	0393	6.0567	$397.83	$82.04	$79.57
38220	Bone marrow aspiration		T	0003	3.2496	$213.45		$42.69
38221	Bone marrow biopsy		T	0003	3.2496	$213.45		$42.69
38230	Bone marrow collection		S	0112	30.7556	$2,020.15	$433.29	$404.03
38240	Bone marrow/stem transplant		S	0112	30.7556	$2,020.15	$433.29	$404.03
38241	Bone marrow/stem transplant		S	0112	30.7556	$2,020.15	$433.29	$404.03
38242	Lymphocyte infuse transplant		S	0111	11.7199	$769.81	$198.40	$153.97
38300	Drainage, lymph node lesion		T	0007	12.8052	$841.10		$168.22
38305	Drainage, lymph node lesion		T	0008	19.5771	$1,285.90		$257.18
38308	Incision of lymph channels		T	0113	23.7542	$1,560.27		$312.06
38380	Thoracic duct procedure		C					
38381	Thoracic duct procedure		C					
38382	Thoracic duct procedure		C					
38500	Biopsy/removal, lymph nodes		T	0113	23.7542	$1,560.27		$312.06
38505	Needle biopsy, lymph nodes		T	0005	7.3814	$484.84		$96.97

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
38510	Biopsy/removal, lymph nodes		T	0113	23.7542	$1,560.27		$312.06
38520	Biopsy/removal, lymph nodes		T	0113	23.7542	$1,560.27		$312.06
38525	Biopsy/removal, lymph nodes		T	0113	23.7542	$1,560.27		$312.06
38530	Biopsy/removal, lymph nodes		T	0113	23.7542	$1,560.27		$312.06
38542	Explore deep node(s), neck		T	0114	47.1418	$3,096.46		$619.30
38550	Removal, neck/armpit lesion		T	0113	23.7542	$1,560.27		$312.06
38555	Removal, neck/armpit lesion		T	0113	23.7542	$1,560.27		$312.06
38562	Removal, pelvic lymph nodes		C					
38564	Removal, abdomen lymph nodes		C					
38570	Laparoscopy, lymph node biop		T	0131	46.3867	$3,046.86	$1,001.89	$609.38
38571	Laparoscopy, lymphadenectomy		T	0132	71.7816	$4,714.90	$1,239.22	$942.98
38572	Laparoscopy, lymphadenectomy		T	0131	46.3867	$3,046.86	$1,001.89	$609.38
38589	Laparoscope proc, lymphatic		T	0130	37.5470	$2,466.24	$659.53	$493.25
38700	Removal of lymph nodes, neck		T	0113	23.7542	$1,560.27		$312.06
38720	Removal of lymph nodes, neck		T	0113	23.7542	$1,560.27		$312.06
38724	Removal of lymph nodes, neck		C					
38740	Remove armpit lymph nodes		T	0114	47.1418	$3,096.46		$619.30
38745	Remove armpit lymph nodes		T	0114	47.1418	$3,096.46		$619.30
38746	Remove thoracic lymph nodes		C					
38747	Remove abdominal lymph nodes		C					
38760	Remove groin lymph nodes		T	0113	23.7542	$1,560.27		$312.06
38765	Remove groin lymph nodes		C					
38770	Remove pelvis lymph nodes		C					
38780	Remove abdomen lymph nodes		C					
38790	Inject for lymphatic x-ray		N					
38792	Identify sentinel node		Q1	0392	2.8090	$184.51	$49.22	$36.91
38794	Access thoracic lymph duct		N					
38999	Blood/lymph system procedure		S	0110	3.3941	$222.94		$44.59
39000	Exploration of chest		C					
39010	Exploration of chest		C					
39200	Removal chest lesion		C					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
39220	Removal chest lesion		C					
39400	Visualization of chest		T	0069	33.8939	$2,226.29	$591.64	$445.26
39499	Chest procedure		C					
39501	Repair diaphragm laceration		C					
39502	Repair paraesophageal hernia		C					
39503	Repair of diaphragm hernia		C					
39520	Repair of diaphragm hernia		C					
39530	Repair of diaphragm hernia		C					
39531	Repair of diaphragm hernia		C					
39540	Repair of diaphragm hernia		C					
39541	Repair of diaphragm hernia		C					
39545	Revision of diaphragm		C					
39560	Resect diaphragm, simple		C					
39561	Resect diaphragm, complex		C					
39599	Diaphragm surgery procedure		C					
4000F	Tobacco use txmnt counseling		M					
4001F	Tobacco use txmnt, pharmacol		M					
4002F	Statin therapy, rx		M					
4003F	Pt ed write/oral, pts w/ hf		M					
4005F	Pharm thx for op rxd		M					
4006F	Beta-blocker therapy rx		M					
4009F	Ace/arb inhibitor therapy rx		M					
4011F	Oral antiplatelet therapy rx		M					
4012F	Warfarin therapy rx		M					
4014F	Written discharge instr prvd		M					
4015F	Persist asthma medicine ctrl		M					
4016F	Anti-inflm/anlgsc agent rx		M					
4017F	Gi prophylaxis for nsaid rx		M					
4018F	Therapy exercise joint rx		M					
4019F	Doc recpt counsl vit d/calc+		M					
4025F	Inhaled bronchodilator rx		M					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
4030F	Oxygen therapy rx		M					
4033F	Pulmonary rehab rec		M					
4035F	Influenza imm rec		M					
4037F	Influenza imm order/admin		M					
4040F	Pneumoc vac/admin/rcvd		M					
4041F	Doc order cefazolin/cefurox		M					
4042F	Doc antibio not given		M					
4043F	Doc order given stop antibio		M					
4044F	Doc order given vte prophylx		M					
4045F	Empiric antibiotic rx		M					
4046F	Doc antibio given b/4 surg		M					
4047F	Doc antibio given b/4 surg		M					
4048F	Doc antibio given b/4 surg		M					
40490	Biopsy of lip		T	0251	3.1568	$207.35		$41.47
4049F	Doc order given stop antibio		M					
40500	Partial excision of lip		T	0253	17.1953	$1,129.46	$282.29	$225.90
4050F	Ht care plan doc		M					
40510	Partial excision of lip		T	0254	24.6341	$1,618.07		$323.62
4051F	Referred for an AV fistula		M					
40520	Partial excision of lip		T	0253	17.1953	$1,129.46	$282.29	$225.90
40525	Reconstruct lip with flap		T	0254	24.6341	$1,618.07		$323.62
40527	Reconstruct lip with flap		T	0254	24.6341	$1,618.07		$323.62
4052F	Hemodialysis via AV fistula		M					
40530	Partial removal of lip		T	0254	24.6341	$1,618.07		$323.62
4053F	Hemodialysis via AV graft		M					
4054F	Hemodialysis via catheter		M					
4055F	Pt rcvng periton dialysis		M					
4056F	Approp oral rehyd recommd		M					
4058F	Ped gastro ed given, caregvr		M					
4060F	Psych svcs provided		M					
4062F	Pt referral psych docd		M					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
4064F	Antidepressant rx		M					
40650	Repair lip		T	0252	7.7504	$509.08	$109.16	$101.82
40652	Repair lip		T	0252	7.7504	$509.08	$109.16	$101.82
40654	Repair lip		T	0252	7.7504	$509.08	$109.16	$101.82
4065F	Antipsychotic rx		M					
4066F	ECT provided		M					
4067F	Pt referral for ECT docd		M					
40700	Repair cleft lip/nasal		T	0256	41.6247	$2,734.08		$546.82
40701	Repair cleft lip/nasal		T	0256	41.6247	$2,734.08		$546.82
40702	Repair cleft lip/nasal		T	0256	41.6247	$2,734.08		$546.82
4070F	Dvt prophylx recvd day 2		M					
40720	Repair cleft lip/nasal		T	0256	41.6247	$2,734.08		$546.82
4073F	Oral antiplat thx rx dischrg		M					
4075F	Anticoag thx rx at dischrg		M					
40761	Repair cleft lip/nasal		T	0256	41.6247	$2,734.08		$546.82
4077F	Doc t-pa admin considered		M					
40799	Lip surgery procedure	CH	T	0250	1.1335	$74.45	$25.10	$14.89
4079F	Doc rehab svcs considered		M					
40800	Drainage of mouth lesion		T	0006	1.4267	$93.71		$18.75
40801	Drainage of mouth lesion		T	0252	7.7504	$509.08	$109.16	$101.82
40804	Removal, foreign body, mouth		X	0340	0.6481	$42.57		$8.52
40805	Removal, foreign body, mouth		T	0252	7.7504	$509.08	$109.16	$101.82
40806	Incision of lip fold		T	0251	3.1568	$207.35		$41.47
40808	Biopsy of mouth lesion		T	0251	3.1568	$207.35		$41.47
40810	Excision of mouth lesion		T	0253	17.1953	$1,129.46	$282.29	$225.90
40812	Excise/repair mouth lesion		T	0253	17.1953	$1,129.46	$282.29	$225.90
40814	Excise/repair mouth lesion		T	0253	17.1953	$1,129.46	$282.29	$225.90
40816	Excision of mouth lesion		T	0254	24.6341	$1,618.07		$323.62
40818	Excise oral mucosa for graft		T	0251	3.1568	$207.35		$41.47
40819	Excise lip or cheek fold		T	0252	7.7504	$509.08	$109.16	$101.82
40820	Treatment of mouth lesion		T	0253	17.1953	$1,129.46	$282.29	$225.90

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
40830	Repair mouth laceration		T	0251	3.1568	$207.35		$41.47
40831	Repair mouth laceration		T	0252	7.7504	$509.08	$109.16	$101.82
40840	Reconstruction of mouth		T	0254	24.6341	$1,618.07		$323.62
40842	Reconstruction of mouth		T	0254	24.6341	$1,618.07		$323.62
40843	Reconstruction of mouth		T	0254	24.6341	$1,618.07		$323.62
40844	Reconstruction of mouth		T	0256	41.6247	$2,734.08		$546.82
40845	Reconstruction of mouth		T	0256	41.6247	$2,734.08		$546.82
4084F	Aspirin recvd w/in 24 hrs		M					
40899	Mouth surgery procedure	CH	T	0250	1.1335	$74.45	$25.10	$14.89
4090F	Pt rcvng epo thxpy		M					
4095F	Pt not rcvng epo thxpy		M					
41000	Drainage of mouth lesion		T	0253	17.1953	$1,129.46	$282.29	$225.90
41005	Drainage of mouth lesion		T	0251	3.1568	$207.35		$41.47
41006	Drainage of mouth lesion		T	0254	24.6341	$1,618.07		$323.62
41007	Drainage of mouth lesion		T	0253	17.1953	$1,129.46	$282.29	$225.90
41008	Drainage of mouth lesion		T	0253	17.1953	$1,129.46	$282.29	$225.90
41009	Drainage of mouth lesion		T	0251	3.1568	$207.35		$41.47
4100F	Biphos thxpy vein ord/recvd		M					
41010	Incision of tongue fold		T	0252	7.7504	$509.08	$109.16	$101.82
41015	Drainage of mouth lesion		T	0251	3.1568	$207.35		$41.47
41016	Drainage of mouth lesion		T	0252	7.7504	$509.08	$109.16	$101.82
41017	Drainage of mouth lesion		T	0252	7.7504	$509.08	$109.16	$101.82
41018	Drainage of mouth lesion		T	0252	7.7504	$509.08	$109.16	$101.82
41019	Place needles h&n for rt		T	0254	24.6341	$1,618.07		$323.62
41100	Biopsy of tongue		T	0252	7.7504	$509.08	$109.16	$101.82
41105	Biopsy of tongue		T	0253	17.1953	$1,129.46	$282.29	$225.90
41108	Biopsy of floor of mouth		T	0252	7.7504	$509.08	$109.16	$101.82
4110F	Int mam art used for cabg		M					
41110	Excision of tongue lesion		T	0253	17.1953	$1,129.46	$282.29	$225.90
41112	Excision of tongue lesion		T	0253	17.1953	$1,129.46	$282.29	$225.90
41113	Excision of tongue lesion		T	0253	17.1953	$1,129.46	$282.29	$225.90

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
41114	Excision of tongue lesion		T	0254	24.6341	$1,618.07		$323.62
41115	Excision of tongue fold		T	0252	7.7504	$509.08	$109.16	$101.82
41116	Excision of mouth lesion		T	0253	17.1953	$1,129.46	$282.29	$225.90
41120	Partial removal of tongue		T	0254	24.6341	$1,618.07		$323.62
41130	Partial removal of tongue		C					
41135	Tongue and neck surgery		C					
41140	Removal of tongue		C					
41145	Tongue removal, neck surgery		C					
41150	Tongue, mouth, jaw surgery		C					
41153	Tongue, mouth, neck surgery		C					
41155	Tongue, jaw, & neck surgery		C					
4115F	Beta blckr admin w/in 24 hrs		M					
4120F	Antibiot rxd/given		M					
4124F	Antibiot not rxd/given		M					
41250	Repair tongue laceration	CH	T	0250	1.1335	$74.45	$25.10	$14.89
41251	Repair tongue laceration		T	0251	3.1568	$207.35		$41.47
41252	Repair tongue laceration		T	0252	7.7504	$509.08	$109.16	$101.82
4130F	Topical prep rx AOE		M					
4131F	Syst antimicrobial thx rx		M					
4132F	No syst antimicrobial thx rx		M					
4133F	Antihist/decong rx/recom		M					
4134F	No antihist/decong rx/recom		M					
4135F	Systemic corticosteroids rx		M					
4136F	Syst corticosteroids not rx		M					
41500	Fixation of tongue		T	0254	24.6341	$1,618.07		$323.62
4150F	Pt recvng antivir txmnt hepc		M					
41510	Tongue to lip surgery		T	0253	17.1953	$1,129.46	$282.29	$225.90
4151F	Pt not recvng antiv hep c		M					
41520	Reconstruction, tongue fold		T	0252	7.7504	$509.08	$109.16	$101.82
4152F	Docd pegintf/rib thxy consd		M					
4153F	Combo pegintf/rib rx		M					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
4154F	Hep A vac series recommended		M					
4155F	Hep A vac series prev recvd		M					
4156F	Hep B vac series recommended		M					
4157F	Hep B vac series prev recvd		M					
4158F	Pt edu re: alcoh drnkng done		M					
41599	Tongue and mouth surgery	CH	T	0250	1.1335	$74.45	$25.10	$14.89
4159F	Contrcp talk b/4 antiv txmnt		M					
4163F	Pt couns. 4 txmnt opt, prost		M					
4164F	Adjv hrmnl thxpy Rxd		M					
4165F	3D-CRT/IMRT received		M					
4167F	Hd Bed tilted 1st day vent		M					
4168F	Pt care ICU&vent w/in 24hrs		M					
4169F	No pt care ICU/vent in 24hrs		M					
4171F	Pt rcvng ESA thxpy		M					
4172F	Pt not rcvng ESA thxpy		M					
4174F	Couns potent Glauc impct		M					
4175F	Vis of >=20/40 w/in 90 days		M					
4176F	Talk re UV light pt/crgvr		M					
4177F	Talk pt/crgvr re AREDS prev		M					
4178F	AntiD glbln rcvd w/in 26wks		M					
4179F	Tamoxifen/AI prescribed		M					
41800	Drainage of gum lesion		T	0006	1.4267	$93.71		$18.75
41805	Removal foreign body, gum		T	0254	24.6341	$1,618.07		$323.62
41806	Removal foreign body,jawbone		T	0253	17.1953	$1,129.46	$282.29	$225.90
4180F	Adjv thxpyRxd/rcvd Stg3A-C		M					
4181F	Conformal radn thxpy rcvd		M					
41820	Excision, gum, each quadrant		T	0252	7.7504	$509.08	$109.16	$101.82
41821	Excision of gum flap		T	0252	7.7504	$509.08	$109.16	$101.82
41822	Excision of gum lesion		T	0253	17.1953	$1,129.46	$282.29	$225.90
41823	Excision of gum lesion		T	0254	24.6341	$1,618.07		$323.62
41825	Excision of gum lesion		T	0253	17.1953	$1,129.46	$282.29	$225.90

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
41826	Excision of gum lesion		T	0253	17.1953	$1,129.46	$282.29	$225.90
41827	Excision of gum lesion		T	0254	24.6341	$1,618.07		$323.62
41828	Excision of gum lesion		T	0253	17.1953	$1,129.46	$282.29	$225.90
4182F	No conformal radn thxpy		M					
41830	Removal of gum tissue		T	0253	17.1953	$1,129.46	$282.29	$225.90
41850	Treatment of gum lesion		T	0253	17.1953	$1,129.46	$282.29	$225.90
4185F	Continuous PPI or H2RA rcvd		M					
4186F	No Cont PPI or H2RA rcvd		M					
41870	Gum graft		T	0254	24.6341	$1,618.07		$323.62
41872	Repair gum		T	0253	17.1953	$1,129.46	$282.29	$225.90
41874	Repair tooth socket		T	0254	24.6341	$1,618.07		$323.62
4187F	Anti rheum DrugthxpyRxd/gvn		M					
4188F	Approp ACE/ARB tstng done		M					
41899	Dental surgery procedure	CH	T	0250	1.1335	$74.45	$25.10	$14.89
4189F	Approp digoxin tstng done		M					
4190F	Approp diuretic tstng done		M					
4191F	Approp anticonvuls tstng		M					
42000	Drainage mouth roof lesion		T	0251	3.1568	$207.35		$41.47
4200F	External beam to prost only		M					
4201F	Extrnl beam other than prost		M					
42100	Biopsy roof of mouth		T	0252	7.7504	$509.08	$109.16	$101.82
42104	Excision lesion, mouth roof		T	0253	17.1953	$1,129.46	$282.29	$225.90
42106	Excision lesion, mouth roof		T	0253	17.1953	$1,129.46	$282.29	$225.90
42107	Excision lesion, mouth roof		T	0254	24.6341	$1,618.07		$323.62
4210F	ACE/ARB thxpy for >= 6 mons		M					
42120	Remove palate/lesion		T	0256	41.6247	$2,734.08		$546.82
42140	Excision of uvula		T	0252	7.7504	$509.08	$109.16	$101.82
42145	Repair palate, pharynx/uvula		T	0254	24.6341	$1,618.07		$323.62
42160	Treatment mouth roof lesion		T	0253	17.1953	$1,129.46	$282.29	$225.90
42180	Repair palate		T	0251	3.1568	$207.35		$41.47
42182	Repair palate		T	0256	41.6247	$2,734.08		$546.82

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
42200	Reconstruct cleft palate		T	0256	41.6247	$2,734.08		$546.82
42205	Reconstruct cleft palate		T	0256	41.6247	$2,734.08		$546.82
4220F	Digoxin thxpy for >= 6 mons		M					
42210	Reconstruct cleft palate		T	0256	41.6247	$2,734.08		$546.82
42215	Reconstruct cleft palate		T	0256	41.6247	$2,734.08		$546.82
4221F	Diuretic thxpy for >= 6 mons		M					
42220	Reconstruct cleft palate		T	0256	41.6247	$2,734.08		$546.82
42225	Reconstruct cleft palate		T	0256	41.6247	$2,734.08		$546.82
42226	Lengthening of palate		T	0256	41.6247	$2,734.08		$546.82
42227	Lengthening of palate		T	0256	41.6247	$2,734.08		$546.82
42235	Repair palate		T	0253	17.1953	$1,129.46	$282.29	$225.90
42260	Repair nose to lip fistula		T	0254	24.6341	$1,618.07		$323.62
42280	Preparation, palate mold		T	0251	3.1568	$207.35		$41.47
42281	Insertion, palate prosthesis		T	0253	17.1953	$1,129.46	$282.29	$225.90
42299	Palate/uvula surgery	CH	T	0250	1.1335	$74.45	$25.10	$14.89
42300	Drainage of salivary gland		T	0253	17.1953	$1,129.46	$282.29	$225.90
42305	Drainage of salivary gland		T	0253	17.1953	$1,129.46	$282.29	$225.90
4230F	Anticonv thxpy for >= 6 mons		M					
42310	Drainage of salivary gland		T	0251	3.1568	$207.35		$41.47
42320	Drainage of salivary gland		T	0251	3.1568	$207.35		$41.47
42330	Removal of salivary stone		T	0253	17.1953	$1,129.46	$282.29	$225.90
42335	Removal of salivary stone		T	0253	17.1953	$1,129.46	$282.29	$225.90
42340	Removal of salivary stone		T	0253	17.1953	$1,129.46	$282.29	$225.90
42400	Biopsy of salivary gland		T	0005	7.3814	$484.84		$96.97
42405	Biopsy of salivary gland		T	0253	17.1953	$1,129.46	$282.29	$225.90
42408	Excision of salivary cyst		T	0253	17.1953	$1,129.46	$282.29	$225.90
42409	Drainage of salivary cyst		T	0253	17.1953	$1,129.46	$282.29	$225.90
4240F	Instr xrcz 4bk pn >12 weeks		M					
42410	Excise parotid gland/lesion		T	0256	41.6247	$2,734.08		$546.82
42415	Excise parotid gland/lesion		T	0256	41.6247	$2,734.08		$546.82
42420	Excise parotid gland/lesion		T	0256	41.6247	$2,734.08		$546.82

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
42425	Excise parotid gland/lesion		T	0256	41.6247	$2,734.08		$546.82
42426	Excise parotid gland/lesion		C					
4242F	Sprvsd xrcz bk pn >12 weeks		M					
42440	Excise submaxillary gland		T	0256	41.6247	$2,734.08		$546.82
42450	Excise sublingual gland		T	0254	24.6341	$1,618.07		$323.62
4245F	Pt instr resume nrml lifest		M					
4248F	Pt instr-no bd rest>= 4 days		M					
42500	Repair salivary duct		T	0254	24.6341	$1,618.07		$323.62
42505	Repair salivary duct		T	0256	41.6247	$2,734.08		$546.82
42507	Parotid duct diversion		T	0256	41.6247	$2,734.08		$546.82
42508	Parotid duct diversion		T	0256	41.6247	$2,734.08		$546.82
42509	Parotid duct diversion		T	0256	41.6247	$2,734.08		$546.82
4250F	Wrmng 4 surg - normothermia		M					
42510	Parotid duct diversion		T	0256	41.6247	$2,734.08		$546.82
42550	Injection for salivary x-ray		N					
42600	Closure of salivary fistula		T	0253	17.1953	$1,129.46	$282.29	$225.90
42650	Dilation of salivary duct		T	0252	7.7504	$509.08	$109.16	$101.82
42660	Dilation of salivary duct		T	0251	3.1568	$207.35		$41.47
42665	Ligation of salivary duct		T	0254	24.6341	$1,618.07		$323.62
42699	Salivary surgery procedure	CH	T	0250	1.1335	$74.45	$25.10	$14.89
42700	Drainage of tonsil abscess		T	0251	3.1568	$207.35		$41.47
42720	Drainage of throat abscess		T	0253	17.1953	$1,129.46	$282.29	$225.90
42725	Drainage of throat abscess		T	0256	41.6247	$2,734.08		$546.82
42800	Biopsy of throat	CH	T	0253	17.1953	$1,129.46	$282.29	$225.90
42802	Biopsy of throat		T	0253	17.1953	$1,129.46	$282.29	$225.90
42804	Biopsy of upper nose/throat		T	0253	17.1953	$1,129.46	$282.29	$225.90
42806	Biopsy of upper nose/throat		T	0254	24.6341	$1,618.07		$323.62
42808	Excise pharynx lesion		T	0253	17.1953	$1,129.46	$282.29	$225.90
42809	Remove pharynx foreign body		X	0340	0.6481	$42.57		$8.52
42810	Excision of neck cyst		T	0254	24.6341	$1,618.07		$323.62
42815	Excision of neck cyst		T	0256	41.6247	$2,734.08		$546.82

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42820	Remove tonsils and adenoids	CH	T	0254	24.6341	$1,618.07		$323.62
42821	Remove tonsils and adenoids	CH	T	0254	24.6341	$1,618.07		$323.62
42825	Removal of tonsils	CH	T	0254	24.6341	$1,618.07		$323.62
42826	Removal of tonsils	CH	T	0254	24.6341	$1,618.07		$323.62
42830	Removal of adenoids	CH	T	0254	24.6341	$1,618.07		$323.62
42831	Removal of adenoids	CH	T	0254	24.6341	$1,618.07		$323.62
42835	Removal of adenoids	CH	T	0254	24.6341	$1,618.07		$323.62
42836	Removal of adenoids	CH	T	0254	24.6341	$1,618.07		$323.62
42842	Extensive surgery of throat		T	0254	24.6341	$1,618.07		$323.62
42844	Extensive surgery of throat		T	0256	41.6247	$2,734.08		$546.82
42845	Extensive surgery of throat		C					
42860	Excision of tonsil tags	CH	T	0254	24.6341	$1,618.07		$323.62
42870	Excision of lingual tonsil	CH	T	0254	24.6341	$1,618.07		$323.62
42890	Partial removal of pharynx		T	0256	41.6247	$2,734.08		$546.82
42892	Revision of pharyngeal walls		T	0256	41.6247	$2,734.08		$546.82
42894	Revision of pharyngeal walls		C					
42900	Repair throat wound		T	0252	7.7504	$509.08	$109.16	$101.82
42950	Reconstruction of throat		T	0254	24.6341	$1,618.07		$323.62
42953	Repair throat, esophagus		C					
42955	Surgical opening of throat		T	0254	24.6341	$1,618.07		$323.62
42960	Control throat bleeding		T	0250	1.1335	$74.45	$25.10	$14.89
42961	Control throat bleeding		C					
42962	Control throat bleeding		T	0256	41.6247	$2,734.08		$546.82
42970	Control nose/throat bleeding		T	0250	1.1335	$74.45	$25.10	$14.89
42971	Control nose/throat bleeding		C					
42972	Control nose/throat bleeding		T	0253	17.1953	$1,129.46	$282.29	$225.90
42999	Throat surgery procedure	CH	T	0250	1.1335	$74.45	$25.10	$14.89
43020	Incision of esophagus		T	0252	7.7504	$509.08	$109.16	$101.82
43030	Throat muscle surgery		T	0253	17.1953	$1,129.46	$282.29	$225.90
43045	Incision of esophagus		C					
43100	Excision of esophagus lesion		C					

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43101	Excision of esophagus lesion		C					
43107	Removal of esophagus		C					
43108	Removal of esophagus		C					
43112	Removal of esophagus		C					
43113	Removal of esophagus		C					
43116	Partial removal of esophagus		C					
43117	Partial removal of esophagus		C					
43118	Partial removal of esophagus		C					
43121	Partial removal of esophagus		C					
43122	Partial removal of esophagus		C					
43123	Partial removal of esophagus		C					
43124	Removal of esophagus		C					
43130	Removal of esophagus pouch		T	0256	41.6247	$2,734.08		$546.82
43135	Removal of esophagus pouch		C					
43200	Esophagus endoscopy		T	0141	8.7109	$572.17	$143.38	$114.44
43201	Esoph scope w/submucous inj		T	0141	8.7109	$572.17	$143.38	$114.44
43202	Esophagus endoscopy, biopsy		T	0141	8.7109	$572.17	$143.38	$114.44
43204	Esoph scope w/sclerosis inj		T	0141	8.7109	$572.17	$143.38	$114.44
43205	Esophagus endoscopy/ligation		T	0141	8.7109	$572.17	$143.38	$114.44
43215	Esophagus endoscopy		T	0141	8.7109	$572.17	$143.38	$114.44
43216	Esophagus endoscopy/lesion		T	0141	8.7109	$572.17	$143.38	$114.44
43217	Esophagus endoscopy		T	0141	8.7109	$572.17	$143.38	$114.44
43219	Esophagus endoscopy		T	0384	25.7802	$1,693.35		$338.67
43220	Esoph endoscopy, dilation		T	0141	8.7109	$572.17	$143.38	$114.44
43226	Esoph endoscopy, dilation		T	0141	8.7109	$572.17	$143.38	$114.44
43227	Esoph endoscopy, repair		T	0141	8.7109	$572.17	$143.38	$114.44
43228	Esoph endoscopy, ablation		T	0422	26.4591	$1,737.94	$448.81	$347.59
43231	Esoph endoscopy w/us exam		T	0141	8.7109	$572.17	$143.38	$114.44
43232	Esoph endoscopy w/us fn bx		T	0141	8.7109	$572.17	$143.38	$114.44
43234	Upper GI endoscopy, exam		T	0141	8.7109	$572.17	$143.38	$114.44
43235	Uppr gi endoscopy, diagnosis		T	0141	8.7109	$572.17	$143.38	$114.44

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43236	Uppr gi scope w/submuc inj		T	0141	8.7109	$572.17	$143.38	$114.44
43237	Endoscopic us exam, esoph		T	0141	8.7109	$572.17	$143.38	$114.44
43238	Uppr gi endoscopy w/us fn bx		T	0141	8.7109	$572.17	$143.38	$114.44
43239	Upper GI endoscopy, biopsy		T	0141	8.7109	$572.17	$143.38	$114.44
43240	Esoph endoscope w/drain cyst		T	0141	8.7109	$572.17	$143.38	$114.44
43241	Upper GI endoscopy with tube		T	0141	8.7109	$572.17	$143.38	$114.44
43242	Uppr gi endoscopy w/us fn bx		T	0141	8.7109	$572.17	$143.38	$114.44
43243	Upper gi endoscopy & inject		T	0141	8.7109	$572.17	$143.38	$114.44
43244	Upper GI endoscopy/ligation		T	0141	8.7109	$572.17	$143.38	$114.44
43245	Uppr gi scope dilate strictr		T	0141	8.7109	$572.17	$143.38	$114.44
43246	Place gastrostomy tube		T	0141	8.7109	$572.17	$143.38	$114.44
43247	Operative upper GI endoscopy		T	0141	8.7109	$572.17	$143.38	$114.44
43248	Uppr gi endoscopy/guide wire		T	0141	8.7109	$572.17	$143.38	$114.44
43249	Esoph endoscopy, dilation		T	0141	8.7109	$572.17	$143.38	$114.44
43250	Upper GI endoscopy/tumor		T	0141	8.7109	$572.17	$143.38	$114.44
43251	Operative upper GI endoscopy		T	0141	8.7109	$572.17	$143.38	$114.44
43255	Operative upper GI endoscopy		T	0141	8.7109	$572.17	$143.38	$114.44
43256	Uppr gi endoscopy w/stent		T	0384	25.7802	$1,693.35		$338.67
43257	Uppr gi scope w/thrml txmnt		T	0422	26.4591	$1,737.94	$448.81	$347.59
43258	Operative upper GI endoscopy		T	0141	8.7109	$572.17	$143.38	$114.44
43259	Endoscopic ultrasound exam		T	0141	8.7109	$572.17	$143.38	$114.44
43260	Endo cholangiopancreatograph		T	0151	21.7949	$1,431.58		$286.32
43261	Endo cholangiopancreatograph		T	0151	21.7949	$1,431.58		$286.32
43262	Endo cholangiopancreatograph		T	0151	21.7949	$1,431.58		$286.32
43263	Endo cholangiopancreatograph		T	0151	21.7949	$1,431.58		$286.32
43264	Endo cholangiopancreatograph		T	0151	21.7949	$1,431.58		$286.32
43265	Endo cholangiopancreatograph		T	0151	21.7949	$1,431.58		$286.32
43267	Endo cholangiopancreatograph		T	0151	21.7949	$1,431.58		$286.32
43268	Endo cholangiopancreatograph		T	0384	25.7802	$1,693.35		$338.67
43269	Endo cholangiopancreatograph		T	0384	25.7802	$1,693.35		$338.67
43271	Endo cholangiopancreatograph		T	0151	21.7949	$1,431.58		$286.32

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
43272	Endo cholangiopancreatograph		T	0151	21.7949	$1,431.58		$286.32
43280	Laparoscopy, fundoplasty		T	0132	71.7816	$4,714.90	$1,239.22	$942.98
43289	Laparoscope proc, esoph		T	0130	37.5470	$2,466.24	$659.53	$493.25
43300	Repair of esophagus		C					
43305	Repair esophagus and fistula		C					
43310	Repair of esophagus		C					
43312	Repair esophagus and fistula		C					
43313	Esophagoplasty congenital		C					
43314	Tracheo-esophagoplasty cong		C					
43320	Fuse esophagus & stomach		C					
43324	Revise esophagus & stomach		C					
43325	Revise esophagus & stomach		C					
43326	Revise esophagus & stomach		C					
43330	Repair of esophagus		C					
43331	Repair of esophagus		C					
43340	Fuse esophagus & intestine		C					
43341	Fuse esophagus & intestine		C					
43350	Surgical opening, esophagus		C					
43351	Surgical opening, esophagus		C					
43352	Surgical opening, esophagus		C					
43360	Gastrointestinal repair		C					
43361	Gastrointestinal repair		C					
43400	Ligate esophagus veins		C					
43401	Esophagus surgery for veins		C					
43405	Ligate/staple esophagus		C					
43410	Repair esophagus wound		C					
43415	Repair esophagus wound		C					
43420	Repair esophagus opening	CH	T	0254	24.6341	$1,618.07		$323.62
43425	Repair esophagus opening		C					
43450	Dilate esophagus		T	0140	6.4892	$426.24	$91.40	$85.25
43453	Dilate esophagus		T	0140	6.4892	$426.24	$91.40	$85.25

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
43456	Dilate esophagus		T	0140	6.4892	$426.24	$91.40	$85.25
43458	Dilate esophagus		T	0141	8.7109	$572.17	$143.38	$114.44
43460	Pressure treatment esophagus		C					
43496	Free jejunum flap, microvasc		C					
43499	Esophagus surgery procedure		T	0141	8.7109	$572.17	$143.38	$114.44
43500	Surgical opening of stomach		C					
43501	Surgical repair of stomach		C					
43502	Surgical repair of stomach		C					
43510	Surgical opening of stomach		T	0141	8.7109	$572.17	$143.38	$114.44
43520	Incision of pyloric muscle		C					
43600	Biopsy of stomach		T	0141	8.7109	$572.17	$143.38	$114.44
43605	Biopsy of stomach		C					
43610	Excision of stomach lesion		C					
43611	Excision of stomach lesion		C					
43620	Removal of stomach		C					
43621	Removal of stomach		C					
43622	Removal of stomach		C					
43631	Removal of stomach, partial		C					
43632	Removal of stomach, partial		C					
43633	Removal of stomach, partial		C					
43634	Removal of stomach, partial		C					
43635	Removal of stomach, partial		C					
43640	Vagotomy & pylorus repair		C					
43641	Vagotomy & pylorus repair		C					
43644	Lap gastric bypass/roux-en-y		C					
43645	Lap gastr bypass incl smll i		C					
43647	Lap impl electrode, antrum		S	0061	80.4914	$5,287.00		$1,057.40
43648	Lap revise/remv eltrd antrum		T	0130	37.5470	$2,466.24	$659.53	$493.25
43651	Laparoscopy, vagus nerve		T	0132	71.7816	$4,714.90	$1,239.22	$942.98
43652	Laparoscopy, vagus nerve		T	0132	71.7816	$4,714.90	$1,239.22	$942.98
43653	Laparoscopy, gastrostomy		T	0131	46.3867	$3,046.86	$1,001.89	$609.38

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
43659	Laparoscope proc, stom		T	0130	37.5470	$2,466.24	$659.53	$493.25
43752	Nasal/orogastric w/stent		X	0272	1.2985	$85.29	$31.64	$17.06
43760	Change gastrostomy tube		T	0121	4.5975	$301.98		$60.40
43761	Reposition gastrostomy tube		T	0141	8.7109	$572.17	$143.38	$114.44
43770	Lap place gastr adj device		C					
43771	Lap revise gastr adj device		C					
43772	Lap rmvl gastr adj device		C					
43773	Lap replace gastr adj device		C					
43774	Lap rmvl gastr adj all parts		C					
43800	Reconstruction of pylorus		C					
43810	Fusion of stomach and bowel		C					
43820	Fusion of stomach and bowel		C					
43825	Fusion of stomach and bowel		C					
43830	Place gastrostomy tube		T	0422	26.4591	$1,737.94	$448.81	$347.59
43831	Place gastrostomy tube		T	0141	8.7109	$572.17	$143.38	$114.44
43832	Place gastrostomy tube		C					
43840	Repair of stomach lesion		C					
43842	V-band gastroplasty		E					
43843	Gastroplasty w/o v-band		C					
43845	Gastroplasty duodenal switch		C					
43846	Gastric bypass for obesity		C					
43847	Gastric bypass incl small i		C					
43848	Revision gastroplasty		C					
43850	Revise stomach-bowel fusion		C					
43855	Revise stomach-bowel fusion		C					
43860	Revise stomach-bowel fusion		C					
43865	Revise stomach-bowel fusion		C					
43870	Repair stomach opening		T	0141	8.7109	$572.17	$143.38	$114.44
43880	Repair stomach-bowel fistula		C					
43881	Impl/redo electrd, antrum		C					
43882	Revise/remove electrd antrum		C					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
43886	Revise gastric port, open		T	0137	20.8007	$1,366.27		$273.26
43887	Remove gastric port, open		T	0135	4.7503	$312.02		$62.41
43888	Change gastric port, open		T	0137	20.8007	$1,366.27		$273.26
43999	Stomach surgery procedure		T	0141	8.7109	$572.17	$143.38	$114.44
44005	Freeing of bowel adhesion		C					
44010	Incision of small bowel		C					
44015	Insert needle cath bowel		C					
44020	Explore small intestine		C					
44021	Decompress small bowel		C					
44025	Incision of large bowel		C					
44050	Reduce bowel obstruction		C					
44055	Correct malrotation of bowel		C					
44100	Biopsy of bowel		T	0141	8.7109	$572.17	$143.38	$114.44
44110	Excise intestine lesion(s)		C					
44111	Excision of bowel lesion(s)		C					
44120	Removal of small intestine		C					
44121	Removal of small intestine		C					
44125	Removal of small intestine		C					
44126	Enterectomy w/o taper, cong		C					
44127	Enterectomy w/taper, cong		C					
44128	Enterectomy cong, add-on		C					
44130	Bowel to bowel fusion		C					
44132	Enterectomy, cadaver donor		C					
44133	Enterectomy, live donor		C					
44135	Intestine transplnt, cadaver		C					
44136	Intestine transplant, live		C					
44137	Remove intestinal allograft		C					
44139	Mobilization of colon		C					
44140	Partial removal of colon		C					
44141	Partial removal of colon		C					
44143	Partial removal of colon		C					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
44144	Partial removal of colon		C					
44145	Partial removal of colon		C					
44146	Partial removal of colon		C					
44147	Partial removal of colon		C					
44150	Removal of colon		C					
44151	Removal of colon/ileostomy		C					
44155	Removal of colon/ileostomy		C					
44156	Removal of colon/ileostomy		C					
44157	Colectomy w/ileoanal anast		C					
44158	Colectomy w/neo-rectum pouch		C					
44160	Removal of colon		C					
44180	Lap, enterolysis		T	0131	46.3867	$3,046.86	$1,001.89	$609.38
44186	Lap, jejunostomy		T	0131	46.3867	$3,046.86	$1,001.89	$609.38
44187	Lap, ileo/jejuno-stomy		C					
44188	Lap, colostomy		C					
44202	Lap, enterectomy		C					
44203	Lap resect s/intestine, addl		C					
44204	Laparo partial colectomy		C					
44205	Lap colectomy part w/ileum		C					
44206	Lap part colectomy w/stoma		T	0132	71.7816	$4,714.90	$1,239.22	$942.98
44207	L colectomy/coloproctostomy		T	0132	71.7816	$4,714.90	$1,239.22	$942.98
44208	L colectomy/coloproctostomy		T	0132	71.7816	$4,714.90	$1,239.22	$942.98
44210	Laparo total proctocolectomy		C					
44211	Lap colectomy w/proctectomy		C					
44212	Laparo total proctocolectomy		C					
44213	Lap, mobil splenic fl add-on		T	0130	37.5470	$2,466.24	$659.53	$493.25
44227	Lap, close enterostomy		C					
44238	Laparoscope proc, intestine		T	0130	37.5470	$2,466.24	$659.53	$493.25
44300	Open bowel to skin		C					
44310	Ileostomy/jejunostomy		C					
44312	Revision of ileostomy		T	0137	20.8007	$1,366.27		$273.26

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
44314	Revision of ileostomy		C					
44316	Devise bowel pouch		C					
44320	Colostomy		C					
44322	Colostomy with biopsies		C					
44340	Revision of colostomy		T	0137	20.8007	$1,366.27		$273.26
44345	Revision of colostomy		C					
44346	Revision of colostomy		C					
44360	Small bowel endoscopy		T	0142	9.5559	$627.67	$152.78	$125.54
44361	Small bowel endoscopy/biopsy		T	0142	9.5559	$627.67	$152.78	$125.54
44363	Small bowel endoscopy		T	0142	9.5559	$627.67	$152.78	$125.54
44364	Small bowel endoscopy		T	0142	9.5559	$627.67	$152.78	$125.54
44365	Small bowel endoscopy		T	0142	9.5559	$627.67	$152.78	$125.54
44366	Small bowel endoscopy		T	0142	9.5559	$627.67	$152.78	$125.54
44369	Small bowel endoscopy		T	0142	9.5559	$627.67	$152.78	$125.54
44370	Small bowel endoscopy/stent		T	0384	25.7802	$1,693.35		$338.67
44372	Small bowel endoscopy		T	0142	9.5559	$627.67	$152.78	$125.54
44373	Small bowel endoscopy		T	0142	9.5559	$627.67	$152.78	$125.54
44376	Small bowel endoscopy		T	0142	9.5559	$627.67	$152.78	$125.54
44377	Small bowel endoscopy/biopsy		T	0142	9.5559	$627.67	$152.78	$125.54
44378	Small bowel endoscopy		T	0142	9.5559	$627.67	$152.78	$125.54
44379	S bowel endoscope w/stent		T	0384	25.7802	$1,693.35		$338.67
44380	Small bowel endoscopy		T	0142	9.5559	$627.67	$152.78	$125.54
44382	Small bowel endoscopy		T	0142	9.5559	$627.67	$152.78	$125.54
44383	Ileoscopy w/stent		T	0384	25.7802	$1,693.35		$338.67
44385	Endoscopy of bowel pouch		T	0143	9.0436	$594.02	$186.06	$118.81
44386	Endoscopy, bowel pouch/biop		T	0143	9.0436	$594.02	$186.06	$118.81
44388	Colonoscopy		T	0143	9.0436	$594.02	$186.06	$118.81
44389	Colonoscopy with biopsy		T	0143	9.0436	$594.02	$186.06	$118.81
44390	Colonoscopy for foreign body		T	0143	9.0436	$594.02	$186.06	$118.81
44391	Colonoscopy for bleeding		T	0143	9.0436	$594.02	$186.06	$118.81
44392	Colonoscopy & polypectomy		T	0143	9.0436	$594.02	$186.06	$118.81

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
44393	Colonoscopy, lesion removal		T	0143	9.0436	$594.02	$186.06	$118.81
44394	Colonoscopy w/snare		T	0143	9.0436	$594.02	$186.06	$118.81
44397	Colonoscopy w/stent		T	0384	25.7802	$1,693.35		$338.67
44500	Intro, gastrointestinal tube		T	0121	4.5975	$301.98		$60.40
44602	Suture, small intestine		C					
44603	Suture, small intestine		C					
44604	Suture, large intestine		C					
44605	Repair of bowel lesion		C					
44615	Intestinal stricturoplasty		C					
44620	Repair bowel opening		C					
44625	Repair bowel opening		C					
44626	Repair bowel opening		C					
44640	Repair bowel-skin fistula		C					
44650	Repair bowel fistula		C					
44660	Repair bowel-bladder fistula		C					
44661	Repair bowel-bladder fistula		C					
44680	Surgical revision, intestine		C					
44700	Suspend bowel w/prosthesis		C					
44701	Intraop colon lavage add-on		N					
44715	Prepare donor intestine		C					
44720	Prep donor intestine/venous		C					
44721	Prep donor intestine/artery		C					
44799	Unlisted procedure intestine		T	0153	23.2665	$1,528.24	$371.60	$305.65
44800	Excision of bowel pouch		C					
44820	Excision of mesentery lesion		C					
44850	Repair of mesentery		C					
44899	Bowel surgery procedure		C					
44900	Drain app abscess, open		C					
44901	Drain app abscess, percut		T	0037	13.5257	$888.42	$228.76	$177.69
44950	Appendectomy		C					
44955	Appendectomy add-on		C					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
44960	Appendectomy		C					
44970	Laparoscopy, appendectomy		T	0131	46.3867	$3,046.86	$1,001.89	$609.38
44979	Laparoscope proc, app		T	0130	37.5470	$2,466.24	$659.53	$493.25
45000	Drainage of pelvic abscess		T	0155	12.2474	$804.46		$160.90
45005	Drainage of rectal abscess		T	0155	12.2474	$804.46		$160.90
45020	Drainage of rectal abscess		T	0155	12.2474	$804.46		$160.90
45100	Biopsy of rectum		T	0149	23.3417	$1,533.18		$306.64
45108	Removal of anorectal lesion		T	0149	23.3417	$1,533.18		$306.64
45110	Removal of rectum		C					
45111	Partial removal of rectum		C					
45112	Removal of rectum		C					
45113	Partial proctectomy		C					
45114	Partial removal of rectum		C					
45116	Partial removal of rectum		C					
45119	Remove rectum w/reservoir		C					
45120	Removal of rectum		C					
45121	Removal of rectum and colon		C					
45123	Partial proctectomy		C					
45126	Pelvic exenteration		C					
45130	Excision of rectal prolapse		C					
45135	Excision of rectal prolapse		C					
45136	Excise ileoanal reservior		C					
45150	Excision of rectal stricture		T	0149	23.3417	$1,533.18		$306.64
45160	Excision of rectal lesion		T	0149	23.3417	$1,533.18		$306.64
45170	Excision of rectal lesion		T	0149	23.3417	$1,533.18		$306.64
45190	Destruction, rectal tumor		T	0149	23.3417	$1,533.18		$306.64
45300	Proctosigmoidoscopy dx		T	0146	5.5535	$364.78		$72.96
45303	Proctosigmoidoscopy dilate		T	0147	9.1698	$602.31		$120.47
45305	Proctosigmoidoscopy w/bx		T	0147	9.1698	$602.31		$120.47
45307	Proctosigmoidoscopy fb		T	0428	23.8940	$1,569.45		$313.89
45308	Proctosigmoidoscopy removal		T	0147	9.1698	$602.31		$120.47

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
45309	Proctosigmoidoscopy removal		T	0147	9.1698	$602.31		$120.47
45315	Proctosigmoidoscopy removal		T	0147	9.1698	$602.31		$120.47
45317	Proctosigmoidoscopy bleed		T	0147	9.1698	$602.31		$120.47
45320	Proctosigmoidoscopy ablate		T	0428	23.8940	$1,569.45		$313.89
45321	Proctosigmoidoscopy volvul		T	0428	23.8940	$1,569.45		$313.89
45327	Proctosigmoidoscopy w/stent		T	0384	25.7802	$1,693.35		$338.67
45330	Diagnostic sigmoidoscopy		T	0146	5.5535	$364.78		$72.96
45331	Sigmoidoscopy and biopsy		T	0146	5.5535	$364.78		$72.96
45332	Sigmoidoscopy w/fb removal		T	0146	5.5535	$364.78		$72.96
45333	Sigmoidoscopy & polypectomy		T	0147	9.1698	$602.31		$120.47
45334	Sigmoidoscopy for bleeding		T	0147	9.1698	$602.31		$120.47
45335	Sigmoidoscopy w/submuc inj		T	0146	5.5535	$364.78		$72.96
45337	Sigmoidoscopy & decompress		T	0146	5.5535	$364.78		$72.96
45338	Sigmoidoscopy w/tumr remove		T	0147	9.1698	$602.31		$120.47
45339	Sigmoidoscopy w/ablate tumr		T	0147	9.1698	$602.31		$120.47
45340	Sig w/balloon dilation		T	0147	9.1698	$602.31		$120.47
45341	Sigmoidoscopy w/ultrasound		T	0147	9.1698	$602.31		$120.47
45342	Sigmoidoscopy w/us guide bx		T	0147	9.1698	$602.31		$120.47
45345	Sigmoidoscopy w/stent		T	0384	25.7802	$1,693.35		$338.67
45355	Surgical colonoscopy		T	0143	9.0436	$594.02	$186.06	$118.81
45378	Diagnostic colonoscopy		T	0143	9.0436	$594.02	$186.06	$118.81
45379	Colonoscopy w/fb removal		T	0143	9.0436	$594.02	$186.06	$118.81
45380	Colonoscopy and biopsy		T	0143	9.0436	$594.02	$186.06	$118.81
45381	Colonoscopy, submucous inj		T	0143	9.0436	$594.02	$186.06	$118.81
45382	Colonoscopy/control bleeding		T	0143	9.0436	$594.02	$186.06	$118.81
45383	Lesion removal colonoscopy		T	0143	9.0436	$594.02	$186.06	$118.81
45384	Lesion remove colonoscopy		T	0143	9.0436	$594.02	$186.06	$118.81
45385	Lesion removal colonoscopy		T	0143	9.0436	$594.02	$186.06	$118.81
45386	Colonoscopy dilate stricture		T	0143	9.0436	$594.02	$186.06	$118.81
45387	Colonoscopy w/stent		T	0384	25.7802	$1,693.35		$338.67
45391	Colonoscopy w/endoscope us		T	0143	9.0436	$594.02	$186.06	$118.81

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
45392	Colonoscopy w/endoscopic fnb		T	0143	9.0436	$594.02	$186.06	$118.81
45395	Lap, removal of rectum		C					
45397	Lap, remove rectum w/pouch		C					
45400	Laparoscopic proc		C					
45402	Lap proctopexy w/sig resect		C					
45499	Laparoscope proc, rectum		T	0130	37.5470	$2,466.24	$659.53	$493.25
45500	Repair of rectum		T	0149	23.3417	$1,533.18		$306.64
45505	Repair of rectum		T	0150	31.2003	$2,049.36	$437.12	$409.88
45520	Treatment of rectal prolapse		T	0013	0.8332	$54.73		$10.95
45540	Correct rectal prolapse		C					
45541	Correct rectal prolapse		T	0150	31.2003	$2,049.36	$437.12	$409.88
45550	Repair rectum/remove sigmoid		C					
45560	Repair of rectocele		T	0150	31.2003	$2,049.36	$437.12	$409.88
45562	Exploration/repair of rectum		C					
45563	Exploration/repair of rectum		C					
45800	Repair rect/bladder fistula		C					
45805	Repair fistula w/colostomy		C					
45820	Repair rectourethral fistula		C					
45825	Repair fistula w/colostomy		C					
45900	Reduction of rectal prolapse		T	0148	5.7614	$378.43		$75.69
45905	Dilation of anal sphincter		T	0149	23.3417	$1,533.18		$306.64
45910	Dilation of rectal narrowing		T	0149	23.3417	$1,533.18		$306.64
45915	Remove rectal obstruction		T	0155	12.2474	$804.46		$160.90
45990	Surg dx exam, anorectal		T	0149	23.3417	$1,533.18		$306.64
45999	Rectum surgery procedure		T	0148	5.7614	$378.43		$75.69
46020	Placement of seton		T	0149	23.3417	$1,533.18		$306.64
46030	Removal of rectal marker		T	0148	5.7614	$378.43		$75.69
46040	Incision of rectal abscess		T	0149	23.3417	$1,533.18		$306.64
46045	Incision of rectal abscess		T	0149	23.3417	$1,533.18		$306.64
46050	Incision of anal abscess		T	0155	12.2474	$804.46		$160.90
46060	Incision of rectal abscess		T	0149	23.3417	$1,533.18		$306.64

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
46070	Incision of anal septum		T	0155	12.2474	$804.46		$160.90
46080	Incision of anal sphincter		T	0149	23.3417	$1,533.18		$306.64
46083	Incise external hemorrhoid		T	0164	2.2063	$144.92		$28.99
46200	Removal of anal fissure		T	0149	23.3417	$1,533.18		$306.64
46210	Removal of anal crypt		T	0149	23.3417	$1,533.18		$306.64
46211	Removal of anal crypts		T	0149	23.3417	$1,533.18		$306.64
46220	Removal of anal tag		T	0149	23.3417	$1,533.18		$306.64
46221	Ligation of hemorrhoid(s)		T	0148	5.7614	$378.43		$75.69
46230	Removal of anal tags		T	0149	23.3417	$1,533.18		$306.64
46250	Hemorrhoidectomy		T	0149	23.3417	$1,533.18		$306.64
46255	Hemorrhoidectomy		T	0149	23.3417	$1,533.18		$306.64
46257	Remove hemorrhoids & fissure		T	0149	23.3417	$1,533.18		$306.64
46258	Remove hemorrhoids & fistula		T	0149	23.3417	$1,533.18		$306.64
46260	Hemorrhoidectomy		T	0149	23.3417	$1,533.18		$306.64
46261	Remove hemorrhoids & fissure		T	0149	23.3417	$1,533.18		$306.64
46262	Remove hemorrhoids & fistula		T	0149	23.3417	$1,533.18		$306.64
46270	Removal of anal fistula		T	0149	23.3417	$1,533.18		$306.64
46275	Removal of anal fistula		T	0149	23.3417	$1,533.18		$306.64
46280	Removal of anal fistula		T	0149	23.3417	$1,533.18		$306.64
46285	Removal of anal fistula		T	0149	23.3417	$1,533.18		$306.64
46288	Repair anal fistula		T	0149	23.3417	$1,533.18		$306.64
46320	Removal of hemorrhoid clot		T	0149	23.3417	$1,533.18		$306.64
46500	Injection into hemorrhoid(s)		T	0155	12.2474	$804.46		$160.90
46505	Chemodenervation anal musc	CH	T	0155	12.2474	$804.46		$160.90
46600	Diagnostic anoscopy		X	0340	0.6481	$42.57		$8.52
46604	Anoscopy and dilation		T	0147	9.1698	$602.31		$120.47
46606	Anoscopy and biopsy		T	0146	5.5535	$364.78		$72.96
46608	Anoscopy, remove for body		T	0147	9.1698	$602.31		$120.47
46610	Anoscopy, remove lesion		T	0428	23.8940	$1,569.45		$313.89
46611	Anoscopy		T	0147	9.1698	$602.31		$120.47
46612	Anoscopy, remove lesions		T	0428	23.8940	$1,569.45		$313.89

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
46614	Anoscopy, control bleeding		T	0146	5.5535	$364.78		$72.96
46615	Anoscopy		T	0428	23.8940	$1,569.45		$313.89
46700	Repair of anal stricture		T	0149	23.3417	$1,533.18		$306.64
46705	Repair of anal stricture		C					
46706	Repr of anal fistula w/glue		T	0150	31.2003	$2,049.36	$437.12	$409.88
46710	Repr per/vag pouch sngl proc		C					
46712	Repr per/vag pouch dbl proc		C					
46715	Rep perf anoper fistu		C					
46716	Rep perf anoper/vestib fistu		C					
46730	Construction of absent anus		C					
46735	Construction of absent anus		C					
46740	Construction of absent anus		C					
46742	Repair of imperforated anus		C					
46744	Repair of cloacal anomaly		C					
46746	Repair of cloacal anomaly		C					
46748	Repair of cloacal anomaly		C					
46750	Repair of anal sphincter		T	0150	31.2003	$2,049.36	$437.12	$409.88
46751	Repair of anal sphincter		C					
46753	Reconstruction of anus		T	0149	23.3417	$1,533.18		$306.64
46754	Removal of suture from anus		T	0149	23.3417	$1,533.18		$306.64
46760	Repair of anal sphincter		T	0150	31.2003	$2,049.36	$437.12	$409.88
46761	Repair of anal sphincter		T	0150	31.2003	$2,049.36	$437.12	$409.88
46762	Implant artificial sphincter		T	0150	31.2003	$2,049.36	$437.12	$409.88
46900	Destruction, anal lesion(s)		T	0016	2.7062	$177.75		$35.55
46910	Destruction, anal lesion(s)		T	0017	20.6214	$1,354.50		$270.90
46916	Cryosurgery, anal lesion(s)		T	0015	1.5126	$99.35		$19.87
46917	Laser surgery, anal lesions		T	0017	20.6214	$1,354.50		$270.90
46922	Excision of anal lesion(s)		T	0017	20.6214	$1,354.50		$270.90
46924	Destruction, anal lesion(s)		T	0017	20.6214	$1,354.50		$270.90
46934	Destruction of hemorrhoids	CH	T	0148	5.7614	$378.43		$75.69
46935	Destruction of hemorrhoids	CH	T	0148	5.7614	$378.43		$75.69

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46936	Destruction of hemorrhoids		T	0149	23.3417	$1,533.18		$306.64
46937	Cryotherapy of rectal lesion		T	0149	23.3417	$1,533.18		$306.64
46938	Cryotherapy of rectal lesion		T	0150	31.2003	$2,049.36	$437.12	$409.88
46940	Treatment of anal fissure		T	0149	23.3417	$1,533.18		$306.64
46942	Treatment of anal fissure		T	0148	5.7614	$378.43		$75.69
46945	Ligation of hemorrhoids		T	0155	12.2474	$804.46		$160.90
46946	Ligation of hemorrhoids		T	0155	12.2474	$804.46		$160.90
46947	Hemorrhoidopexy by stapling		T	0150	31.2003	$2,049.36	$437.12	$409.88
46999	Anus surgery procedure		T	0148	5.7614	$378.43		$75.69
47000	Needle biopsy of liver		T	0685	9.6161	$631.62		$126.33
47001	Needle biopsy, liver add-on		N					
47010	Open drainage, liver lesion		C					
47011	Percut drain, liver lesion		T	0037	13.5257	$888.42	$228.76	$177.69
47015	Inject/aspirate liver cyst		C					
47100	Wedge biopsy of liver		C					
47120	Partial removal of liver		C					
47122	Extensive removal of liver		C					
47125	Partial removal of liver		C					
47130	Partial removal of liver		C					
47133	Removal of donor liver		C					
47135	Transplantation of liver		C					
47136	Transplantation of liver		C					
47140	Partial removal, donor liver		C					
47141	Partial removal, donor liver		C					
47142	Partial removal, donor liver		C					
47143	Prep donor liver, whole		C					
47144	Prep donor liver, 3-segment		C					
47145	Prep donor liver, lobe split		C					
47146	Prep donor liver/venous		C					
47147	Prep donor liver/arterial		C					
47300	Surgery for liver lesion		C					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
47350	Repair liver wound		C					
47360	Repair liver wound		C					
47361	Repair liver wound		C					
47362	Repair liver wound		C					
47370	Laparo ablate liver tumor rf		T	0132	71.7816	$4,714.90	$1,239.22	$942.98
47371	Laparo ablate liver cryosurg		T	0131	46.3867	$3,046.86	$1,001.89	$609.38
47379	Laparoscope procedure, liver		T	0130	37.5470	$2,466.24	$659.53	$493.25
47380	Open ablate liver tumor rf		C					
47381	Open ablate liver tumor cryo		C					
47382	Percut ablate liver rf		T	0423	46.0975	$3,027.87		$605.58
47399	Liver surgery procedure		T	0004	4.5254	$297.25		$59.45
47400	Incision of liver duct		C					
47420	Incision of bile duct		C					
47425	Incision of bile duct		C					
47460	Incise bile duct sphincter		C					
47480	Incision of gallbladder		C					
47490	Incision of gallbladder		T	0152	30.1057	$1,977.46		$395.50
47500	Injection for liver x-rays		N					
47505	Injection for liver x-rays		N					
47510	Insert catheter, bile duct		T	0152	30.1057	$1,977.46		$395.50
47511	Insert bile duct drain		T	0152	30.1057	$1,977.46		$395.50
47525	Change bile duct catheter		T	0427	15.5051	$1,018.44		$203.69
47530	Revise/reinsert bile tube		T	0427	15.5051	$1,018.44		$203.69
47550	Bile duct endoscopy add-on		C					
47552	Biliary endoscopy thru skin		T	0152	30.1057	$1,977.46		$395.50
47553	Biliary endoscopy thru skin		T	0152	30.1057	$1,977.46		$395.50
47554	Biliary endoscopy thru skin		T	0152	30.1057	$1,977.46		$395.50
47555	Biliary endoscopy thru skin		T	0152	30.1057	$1,977.46		$395.50
47556	Biliary endoscopy thru skin		T	0152	30.1057	$1,977.46		$395.50
47560	Laparoscopy w/cholangio		T	0130	37.5470	$2,466.24	$659.53	$493.25
47561	Laparo w/cholangio/biopsy		T	0130	37.5470	$2,466.24	$659.53	$493.25

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
47562	Laparoscopic cholecystectomy		T	0131	46.3867	$3,046.86	$1,001.89	$609.38
47563	Laparo cholecystectomy/graph		T	0131	46.3867	$3,046.86	$1,001.89	$609.38
47564	Laparo cholecystectomy/explr		T	0131	46.3867	$3,046.86	$1,001.89	$609.38
47570	Laparo cholecystoenterostomy		C					
47579	Laparoscope proc, biliary		T	0130	37.5470	$2,466.24	$659.53	$493.25
47600	Removal of gallbladder		C					
47605	Removal of gallbladder		C					
47610	Removal of gallbladder		C					
47612	Removal of gallbladder		C					
47620	Removal of gallbladder		C					
47630	Remove bile duct stone		T	0152	30.1057	$1,977.46		$395.50
47700	Exploration of bile ducts		C					
47701	Bile duct revision		C					
47711	Excision of bile duct tumor		C					
47712	Excision of bile duct tumor		C					
47715	Excision of bile duct cyst		C					
47720	Fuse gallbladder & bowel		C					
47721	Fuse upper gi structures		C					
47740	Fuse gallbladder & bowel		C					
47741	Fuse gallbladder & bowel		C					
47760	Fuse bile ducts and bowel		C					
47765	Fuse liver ducts & bowel		C					
47780	Fuse bile ducts and bowel		C					
47785	Fuse bile ducts and bowel		C					
47800	Reconstruction of bile ducts		C					
47801	Placement, bile duct support		C					
47802	Fuse liver duct & intestine		C					
47900	Suture bile duct injury		C					
47999	Bile tract surgery procedure		T	0152	30.1057	$1,977.46		$395.50
48000	Drainage of abdomen		C					
48001	Placement of drain, pancreas		C					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
48020	Removal of pancreatic stone		C					
48100	Biopsy of pancreas, open		C					
48102	Needle biopsy, pancreas		T	0685	9.6161	$631.62		$126.33
48105	Resect/debride pancreas		C					
48120	Removal of pancreas lesion		C					
48140	Partial removal of pancreas		C					
48145	Partial removal of pancreas		C					
48146	Pancreatectomy		C					
48148	Removal of pancreatic duct		C					
48150	Partial removal of pancreas		C					
48152	Pancreatectomy		C					
48153	Pancreatectomy		C					
48154	Pancreatectomy		C					
48155	Removal of pancreas		C					
48160	Pancreas removal/transplant		E					
48400	Injection, intraop add-on		C					
48500	Surgery of pancreatic cyst		C					
48510	Drain pancreatic pseudocyst		C					
48511	Drain pancreatic pseudocyst		T	0037	13.5257	$888.42	$228.76	$177.69
48520	Fuse pancreas cyst and bowel		C					
48540	Fuse pancreas cyst and bowel		C					
48545	Pancreatorrhaphy		C					
48547	Duodenal exclusion		C					
48548	Fuse pancreas and bowel		C					
48550	Donor pancreatectomy		E					
48551	Prep donor pancreas		C					
48552	Prep donor pancreas/venous		C					
48554	Transpl allograft pancreas		C					
48556	Removal, allograft pancreas		C					
48999	Pancreas surgery procedure		T	0004	4.5254	$297.25		$59.45
49000	Exploration of abdomen		C					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
49002	Reopening of abdomen		C					
49010	Exploration behind abdomen		C					
49020	Drain abdominal abscess		C					
49021	Drain abdominal abscess		T	0037	13.5257	$888.42	$228.76	$177.69
49040	Drain, open, abdom abscess		C					
49041	Drain, percut, abdom abscess		T	0037	13.5257	$888.42	$228.76	$177.69
49060	Drain, open, retrop abscess		C					
49061	Drain, percut, retroper absc		T	0037	13.5257	$888.42	$228.76	$177.69
49062	Drain to peritoneal cavity		C					
49080	Puncture, peritoneal cavity		T	0070	5.3627	$352.24		$70.45
49081	Removal of abdominal fluid		T	0070	5.3627	$352.24		$70.45
49180	Biopsy, abdominal mass		T	0685	9.6161	$631.62		$126.33
49203	Exc abd tum 5 cm or less		C					
49204	Exc abd tum over 5 cm		C					
49205	Exc abd tum over 10 cm		C					
49215	Excise sacral spine tumor		C					
49220	Multiple surgery, abdomen		C					
49250	Excision of umbilicus		T	0153	23.2665	$1,528.24	$371.60	$305.65
49255	Removal of omentum		C					
49320	Diag laparo separate proc		T	0130	37.5470	$2,466.24	$659.53	$493.25
49321	Laparoscopy, biopsy		T	0130	37.5470	$2,466.24	$659.53	$493.25
49322	Laparoscopy, aspiration		T	0130	37.5470	$2,466.24	$659.53	$493.25
49323	Laparo drain lymphocele		T	0130	37.5470	$2,466.24	$659.53	$493.25
49324	Lap insertion perm ip cath		T	0130	37.5470	$2,466.24	$659.53	$493.25
49325	Lap revision perm ip cath		T	0130	37.5470	$2,466.24	$659.53	$493.25
49326	Lap w/omentopexy add-on		T	0130	37.5470	$2,466.24	$659.53	$493.25
49329	Laparo proc, abdm/per/oment		T	0130	37.5470	$2,466.24	$659.53	$493.25
49400	Air injection into abdomen		N					
49402	Remove foreign body, adbomen		T	0153	23.2665	$1,528.24	$371.60	$305.65
49419	Insrt abdom cath for chemotx		T	0115	30.5339	$2,005.59		$401.12
49420	Insert abdom drain, temp		T	0652	29.6599	$1,948.18		$389.64

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
49421	Insert abdom drain, perm		T	0652	29.6599	$1,948.18		$389.64
49422	Remove perm cannula/catheter		T	0105	22.2934	$1,464.32		$292.87
49423	Exchange drainage catheter		T	0427	15.5051	$1,018.44		$203.69
49424	Assess cyst, contrast inject		N					
49425	Insert abdomen-venous drain		C					
49426	Revise abdomen-venous shunt		T	0153	23.2665	$1,528.24	$371.60	$305.65
49427	Injection, abdominal shunt		N					
49428	Ligation of shunt		C					
49429	Removal of shunt		T	0105	22.2934	$1,464.32		$292.87
49435	Insert subq exten to ip cath		T	0427	15.5051	$1,018.44		$203.69
49436	Embedded ip cath exit-site		T	0427	15.5051	$1,018.44		$203.69
49440	Place gastrostomy tube perc		T	0141	8.7109	$572.17	$143.38	$114.44
49441	Place duod/jej tube perc		T	0141	8.7109	$572.17	$143.38	$114.44
49442	Place cecostomy tube perc		T	0155	12.2474	$804.46		$160.90
49446	Change g-tube to g-j perc		T	0141	8.7109	$572.17	$143.38	$114.44
49450	Replace g/c tube perc		T	0121	4.5975	$301.98		$60.40
49451	Replace duod/jej tube perc		T	0121	4.5975	$301.98		$60.40
49452	Replace g-j tube perc		T	0121	4.5975	$301.98		$60.40
49460	Fix g/colon tube w/device		T	0121	4.5975	$301.98		$60.40
49465	Fluoro exam of g/colon tube		Q1	0276	1.3716	$90.09	$34.97	$18.02
49491	Rpr hern preemie reduc		T	0154	31.6898	$2,081.51	$464.85	$416.31
49492	Rpr ing hern premie, blocked		T	0154	31.6898	$2,081.51	$464.85	$416.31
49495	Rpr ing hernia baby, reduc		T	0154	31.6898	$2,081.51	$464.85	$416.31
49496	Rpr ing hernia baby, blocked		T	0154	31.6898	$2,081.51	$464.85	$416.31
49500	Rpr ing hernia, init, reduce		T	0154	31.6898	$2,081.51	$464.85	$416.31
49501	Rpr ing hernia, init blocked		T	0154	31.6898	$2,081.51	$464.85	$416.31
49505	Prp i/hern init reduc >5 yr		T	0154	31.6898	$2,081.51	$464.85	$416.31
49507	Prp i/hern init block >5 yr		T	0154	31.6898	$2,081.51	$464.85	$416.31
49520	Rerepair ing hernia, reduce		T	0154	31.6898	$2,081.51	$464.85	$416.31
49521	Rerepair ing hernia, blocked		T	0154	31.6898	$2,081.51	$464.85	$416.31
49525	Repair ing hernia, sliding		T	0154	31.6898	$2,081.51	$464.85	$416.31

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
49540	Repair lumbar hernia		T	0154	31.6898	$2,081.51	$464.85	$416.31
49550	Rpr rem hernia, init, reduce		T	0154	31.6898	$2,081.51	$464.85	$416.31
49553	Rpr fem hernia, init blocked		T	0154	31.6898	$2,081.51	$464.85	$416.31
49555	Rerepair fem hernia, reduce		T	0154	31.6898	$2,081.51	$464.85	$416.31
49557	Rerepair fem hernia, blocked		T	0154	31.6898	$2,081.51	$464.85	$416.31
49560	Rpr ventral hern init, reduc		T	0154	31.6898	$2,081.51	$464.85	$416.31
49561	Rpr ventral hern init, block		T	0154	31.6898	$2,081.51	$464.85	$416.31
49565	Rerepair ventrl hern, reduce		T	0154	31.6898	$2,081.51	$464.85	$416.31
49566	Rerepair ventrl hern, block		T	0154	31.6898	$2,081.51	$464.85	$416.31
49568	Hernia repair w/mesh		T	0154	31.6898	$2,081.51	$464.85	$416.31
49570	Rpr epigastric hern, reduce		T	0154	31.6898	$2,081.51	$464.85	$416.31
49572	Rpr epigastric hern, blocked		T	0154	31.6898	$2,081.51	$464.85	$416.31
49580	Rpr umbil hern, reduc < 5 yr		T	0154	31.6898	$2,081.51	$464.85	$416.31
49582	Rpr umbil hern, block < 5 yr		T	0154	31.6898	$2,081.51	$464.85	$416.31
49585	Rpr umbil hern, reduc > 5 yr		T	0154	31.6898	$2,081.51	$464.85	$416.31
49587	Rpr umbil hern, block > 5 yr		T	0154	31.6898	$2,081.51	$464.85	$416.31
49590	Repair spigelian hernia		T	0154	31.6898	$2,081.51	$464.85	$416.31
49600	Repair umbilical lesion		T	0154	31.6898	$2,081.51	$464.85	$416.31
49605	Repair umbilical lesion		C					
49606	Repair umbilical lesion		C					
49610	Repair umbilical lesion		C					
49611	Repair umbilical lesion		C					
49650	Laparo hernia repair initial		T	0131	46.3867	$3,046.86	$1,001.89	$609.38
49651	Laparo hernia repair recur		T	0131	46.3867	$3,046.86	$1,001.89	$609.38
49659	Laparo proc, hernia repair		T	0130	37.5470	$2,466.24	$659.53	$493.25
49900	Repair of abdominal wall		C					
49904	Omental flap, extra-abdom		C					
49905	Omental flap, intra-abdom		C					
49906	Free omental flap, microvasc		C					
49999	Abdomen surgery procedure		T	0153	23.2665	$1,528.24	$371.60	$305.65
50010	Exploration of kidney		C					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
50020	Renal abscess, open drain		T	0162	25.6811	$1,686.84		$337.37
50021	Renal abscess, percut drain		T	0037	13.5257	$888.42	$228.76	$177.69
50040	Drainage of kidney		C					
50045	Exploration of kidney		C					
5005F	Pt counsld on exam for moles		M					
50060	Removal of kidney stone		C					
50065	Incision of kidney		C					
50070	Incision of kidney		C					
50075	Removal of kidney stone		C					
50080	Removal of kidney stone		T	0429	45.9136	$3,015.79		$603.16
50081	Removal of kidney stone		T	0429	45.9136	$3,015.79		$603.16
50100	Revise kidney blood vessels		C					
5010F	Macul+ fndngs to dr mng dm		M					
50120	Exploration of kidney		C					
50125	Explore and drain kidney		C					
50130	Removal of kidney stone		C					
50135	Exploration of kidney		C					
5015F	Doc fx & test/txmnt for op		M					
50200	Biopsy of kidney		T	0685	9.6161	$631.62		$126.33
50205	Biopsy of kidney		C					
5020F	Txmnts 2 main Dr by 1 mon		M					
50220	Remove kidney, open		C					
50225	Removal kidney open, complex		C					
50230	Removal kidney open, radical		C					
50234	Removal of kidney & ureter		C					
50236	Removal of kidney & ureter		C					
50240	Partial removal of kidney		C					
50250	Cryoablate renal mass open		C					
50280	Removal of kidney lesion		C					
50290	Removal of kidney lesion		C					
50300	Remove cadaver donor kidney		C					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
50320	Remove kidney, living donor		C					
50323	Prep cadaver renal allograft		C					
50325	Prep donor renal graft		C					
50327	Prep renal graft/venous		C					
50328	Prep renal graft/arterial		C					
50329	Prep renal graft/ureteral		C					
50340	Removal of kidney		C					
50360	Transplantation of kidney		C					
50365	Transplantation of kidney		C					
50370	Remove transplanted kidney		C					
50380	Reimplantation of kidney		C					
50382	Change ureter stent, percut		T	0162	25.6811	$1,686.84		$337.37
50384	Remove ureter stent, percut		T	0161	18.9529	$1,244.90		$248.98
50385	Change stent via transureth		T	0161	18.9529	$1,244.90		$248.98
50386	Remove stent via transureth		T	0160	7.1684	$470.85		$94.17
50387	Change ext/int ureter stent		T	0427	15.5051	$1,018.44		$203.69
50389	Remove renal tube w/fluoro		T	0160	7.1684	$470.85		$94.17
50390	Drainage of kidney lesion		T	0685	9.6161	$631.62		$126.33
50391	Instll rx agnt into rnal tub		T	0126	1.0401	$68.32	$16.21	$13.67
50392	Insert kidney drain		T	0161	18.9529	$1,244.90		$248.98
50393	Insert ureteral tube		T	0162	25.6811	$1,686.84		$337.37
50394	Injection for kidney x-ray		N					
50395	Create passage to kidney		T	0161	18.9529	$1,244.90		$248.98
50396	Measure kidney pressure		T	0164	2.2063	$144.92		$28.99
50398	Change kidney tube		T	0427	15.5051	$1,018.44		$203.69
50400	Revision of kidney/ureter		C					
50405	Revision of kidney/ureter		C					
50500	Repair of kidney wound		C					
5050F	Plan 2 main Dr. by 1 month		M					
50520	Close kidney-skin fistula		C					
50525	Repair renal-abdomen fistula		C					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
50526	Repair renal-abdomen fistula		C					
50540	Revision of horseshoe kidney		C					
50541	Laparo ablate renal cyst		T	0130	37.5470	$2,466.24	$659.53	$493.25
50542	Laparo ablate renal mass		T	0132	71.7816	$4,714.90	$1,239.22	$942.98
50543	Laparo partial nephrectomy		T	0131	46.3867	$3,046.86	$1,001.89	$609.38
50544	Laparoscopy, pyeloplasty		T	0130	37.5470	$2,466.24	$659.53	$493.25
50545	Laparo radical nephrectomy		C					
50546	Laparoscopic nephrectomy		C					
50547	Laparo removal donor kidney		C					
50548	Laparo remove w/ureter		C					
50549	Laparoscope proc, renal		T	0130	37.5470	$2,466.24	$659.53	$493.25
50551	Kidney endoscopy		T	0160	7.1684	$470.85		$94.17
50553	Kidney endoscopy		T	0162	25.6811	$1,686.84		$337.37
50555	Kidney endoscopy & biopsy		T	0160	7.1684	$470.85		$94.17
50557	Kidney endoscopy & treatment		T	0162	25.6811	$1,686.84		$337.37
50561	Kidney endoscopy & treatment		T	0162	25.6811	$1,686.84		$337.37
50562	Renal scope w/tumor resect		T	0160	7.1684	$470.85		$94.17
50570	Kidney endoscopy		T	0160	7.1684	$470.85		$94.17
50572	Kidney endoscopy		T	0160	7.1684	$470.85		$94.17
50574	Kidney endoscopy & biopsy		T	0160	7.1684	$470.85		$94.17
50575	Kidney endoscopy		T	0163	36.4225	$2,392.38		$478.48
50576	Kidney endoscopy & treatment		T	0161	18.9529	$1,244.90		$248.98
50580	Kidney endoscopy & treatment		T	0161	18.9529	$1,244.90		$248.98
50590	Fragmenting of kidney stone		T	0169	42.4594	$2,788.90	$997.74	$557.78
50592	Perc rf ablate renal tumor		T	0423	46.0975	$3,027.87		$605.58
50593	Perc cryo ablate renal tum		T	0423	46.0975	$3,027.87		$605.58
50600	Exploration of ureter		C					
50605	Insert ureteral support		C					
5060F	Fndngs mammo 2pt w/in 3 days		M					
50610	Removal of ureter stone		C					
50620	Removal of ureter stone		C					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
5062F	Doc f2fmammo fndng in 3 days		M					
50630	Removal of ureter stone		C					
50650	Removal of ureter		C					
50660	Removal of ureter		C					
50684	Injection for ureter x-ray		N					
50686	Measure ureter pressure		T	0126	1.0401	$68.32	$16.21	$13.67
50688	Change of ureter tube/stent		T	0427	15.5051	$1,018.44		$203.69
50690	Injection for ureter x-ray		N					
50700	Revision of ureter		C					
50715	Release of ureter		C					
50722	Release of ureter		C					
50725	Release/revise ureter		C					
50727	Revise ureter	CH	T	0165	20.2632	$1,330.97		$266.20
50728	Revise ureter		C					
50740	Fusion of ureter & kidney		C					
50750	Fusion of ureter & kidney		C					
50760	Fusion of ureters		C					
50770	Splicing of ureters		C					
50780	Reimplant ureter in bladder		C					
50782	Reimplant ureter in bladder		C					
50783	Reimplant ureter in bladder		C					
50785	Reimplant ureter in bladder		C					
50800	Implant ureter in bowel		C					
50810	Fusion of ureter & bowel		C					
50815	Urine shunt to intestine		C					
50820	Construct bowel bladder		C					
50825	Construct bowel bladder		C					
50830	Revise urine flow		C					
50840	Replace ureter by bowel		C					
50845	Appendico-vesicostomy		C					
50860	Transplant ureter to skin		C					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
50900	Repair of ureter		C					
50920	Closure ureter/skin fistula		C					
50930	Closure ureter/bowel fistula		C					
50940	Release of ureter		C					
50945	Laparoscopy ureterolithotomy		T	0131	46.3867	$3,046.86	$1,001.89	$609.38
50947	Laparo new ureter/bladder		T	0131	46.3867	$3,046.86	$1,001.89	$609.38
50948	Laparo new ureter/bladder		T	0131	46.3867	$3,046.86	$1,001.89	$609.38
50949	Laparoscope proc, ureter		T	0130	37.5470	$2,466.24	$659.53	$493.25
50951	Endoscopy of ureter		T	0160	7.1684	$470.85		$94.17
50953	Endoscopy of ureter		T	0160	7.1684	$470.85		$94.17
50955	Ureter endoscopy & biopsy		T	0162	25.6811	$1,686.84		$337.37
50957	Ureter endoscopy & treatment		T	0162	25.6811	$1,686.84		$337.37
50961	Ureter endoscopy & treatment		T	0162	25.6811	$1,686.84		$337.37
50970	Ureter endoscopy		T	0160	7.1684	$470.85		$94.17
50972	Ureter endoscopy & catheter		T	0160	7.1684	$470.85		$94.17
50974	Ureter endoscopy & biopsy		T	0161	18.9529	$1,244.90		$248.98
50976	Ureter endoscopy & treatment		T	0161	18.9529	$1,244.90		$248.98
50980	Ureter endoscopy & treatment		T	0162	25.6811	$1,686.84		$337.37
51020	Incise & treat bladder		T	0162	25.6811	$1,686.84		$337.37
51030	Incise & treat bladder		T	0162	25.6811	$1,686.84		$337.37
51040	Incise & drain bladder		T	0162	25.6811	$1,686.84		$337.37
51045	Incise bladder/drain ureter		T	0160	7.1684	$470.85		$94.17
51050	Removal of bladder stone		T	0162	25.6811	$1,686.84		$337.37
51060	Removal of ureter stone		C					
51065	Remove ureter calculus		T	0162	25.6811	$1,686.84		$337.37
51080	Drainage of bladder abscess		T	0008	19.5771	$1,285.90		$257.18
51100	Drain bladder by needle		T	0164	2.2063	$144.92		$28.99
51101	Drain bladder by trocar/cath		T	0126	1.0401	$68.32	$16.21	$13.67
51102	Drain bl w/cath insertion		T	0165	20.2632	$1,330.97		$266.20
51500	Removal of bladder cyst		T	0154	31.6898	$2,081.51	$464.85	$416.31
51520	Removal of bladder lesion		T	0162	25.6811	$1,686.84		$337.37

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
51525	Removal of bladder lesion		C					
51530	Removal of bladder lesion		C					
51535	Repair of ureter lesion		T	0162	25.6811	$1,686.84		$337.37
51550	Partial removal of bladder		C					
51555	Partial removal of bladder		C					
51565	Revise bladder & ureter(s)		C					
51570	Removal of bladder		C					
51575	Removal of bladder & nodes		C					
51580	Remove bladder/revise tract		C					
51585	Removal of bladder & nodes		C					
51590	Remove bladder/revise tract		C					
51595	Remove bladder/revise tract		C					
51596	Remove bladder/create pouch		C					
51597	Removal of pelvic structures		C					
51600	Injection for bladder x-ray		N					
51605	Preparation for bladder xray		N					
51610	Injection for bladder x-ray		N					
51700	Irrigation of bladder		T	0164	2.2063	$144.92		$28.99
51701	Insert bladder catheter		X	0340	0.6481	$42.57		$8.52
51702	Insert temp bladder cath		X	0340	0.6481	$42.57		$8.52
51703	Insert bladder cath, complex		T	0126	1.0401	$68.32	$16.21	$13.67
51705	Change of bladder tube		T	0164	2.2063	$144.92		$28.99
51710	Change of bladder tube		T	0427	15.5051	$1,018.44		$203.69
51715	Endoscopic injection/implant		T	0168	30.5507	$2,006.69		$401.34
51720	Treatment of bladder lesion		T	0164	2.2063	$144.92		$28.99
51725	Simple cystometrogram		T	0156	3.1503	$206.92		$41.39
51726	Complex cystometrogram		T	0156	3.1503	$206.92		$41.39
51736	Urine flow measurement		T	0126	1.0401	$68.32	$16.21	$13.67
51741	Electro-uroflowmetry, first		T	0126	1.0401	$68.32	$16.21	$13.67
51772	Urethra pressure profile		T	0164	2.2063	$144.92		$28.99
51784	Anal/urinary muscle study		T	0126	1.0401	$68.32	$16.21	$13.67

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
51785	Anal/urinary muscle study		T	0164	2.2063	$144.92		$28.99
51792	Urinary reflex study		T	0126	1.0401	$68.32	$16.21	$13.67
51795	Urine voiding pressure study		T	0164	2.2063	$144.92		$28.99
51797	Intraabdominal pressure test		T	0164	2.2063	$144.92		$28.99
51798	Us urine capacity measure		X	0340	0.6481	$42.57		$8.52
51800	Revision of bladder/urethra		C					
51820	Revision of urinary tract		C					
51840	Attach bladder/urethra		C					
51841	Attach bladder/urethra		C					
51845	Repair bladder neck		C					
51860	Repair of bladder wound		C					
51865	Repair of bladder wound		C					
51880	Repair of bladder opening		T	0162	25.6811	$1,686.84		$337.37
51900	Repair bladder/vagina lesion		C					
51920	Close bladder-uterus fistula		C					
51925	Hysterectomy/bladder repair		C					
51940	Correction of bladder defect		C					
51960	Revision of bladder & bowel		C					
51980	Construct bladder opening		C					
51990	Laparo urethral suspension		T	0131	46.3867	$3,046.86	$1,001.89	$609.38
51992	Laparo sling operation		T	0131	46.3867	$3,046.86	$1,001.89	$609.38
51999	Laparoscope proc, bla		T	0130	37.5470	$2,466.24	$659.53	$493.25
52000	Cystoscopy		T	0160	7.1684	$470.85		$94.17
52001	Cystoscopy, removal of clots		T	0161	18.9529	$1,244.90		$248.98
52005	Cystoscopy & ureter catheter		T	0161	18.9529	$1,244.90		$248.98
52007	Cystoscopy and biopsy		T	0162	25.6811	$1,686.84		$337.37
52010	Cystoscopy & duct catheter		T	0160	7.1684	$470.85		$94.17
52204	Cystoscopy w/biopsy(s)		T	0161	18.9529	$1,244.90		$248.98
52214	Cystoscopy and treatment		T	0162	25.6811	$1,686.84		$337.37
52224	Cystoscopy and treatment		T	0162	25.6811	$1,686.84		$337.37
52234	Cystoscopy and treatment		T	0162	25.6811	$1,686.84		$337.37

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
52235	Cystoscopy and treatment		T	0162	25.6811	$1,686.84		$337.37
52240	Cystoscopy and treatment		T	0162	25.6811	$1,686.84		$337.37
52250	Cystoscopy and radiotracer		T	0162	25.6811	$1,686.84		$337.37
52260	Cystoscopy and treatment		T	0161	18.9529	$1,244.90		$248.98
52265	Cystoscopy and treatment		T	0160	7.1684	$470.85		$94.17
52270	Cystoscopy & revise urethra		T	0161	18.9529	$1,244.90		$248.98
52275	Cystoscopy & revise urethra		T	0162	25.6811	$1,686.84		$337.37
52276	Cystoscopy and treatment		T	0162	25.6811	$1,686.84		$337.37
52277	Cystoscopy and treatment		T	0162	25.6811	$1,686.84		$337.37
52281	Cystoscopy and treatment		T	0161	18.9529	$1,244.90		$248.98
52282	Cystoscopy, implant stent		T	0163	36.4225	$2,392.38		$478.48
52283	Cystoscopy and treatment		T	0162	25.6811	$1,686.84		$337.37
52285	Cystoscopy and treatment		T	0161	18.9529	$1,244.90		$248.98
52290	Cystoscopy and treatment		T	0161	18.9529	$1,244.90		$248.98
52300	Cystoscopy and treatment		T	0162	25.6811	$1,686.84		$337.37
52301	Cystoscopy and treatment		T	0162	25.6811	$1,686.84		$337.37
52305	Cystoscopy and treatment		T	0162	25.6811	$1,686.84		$337.37
52310	Cystoscopy and treatment		T	0161	18.9529	$1,244.90		$248.98
52315	Cystoscopy and treatment		T	0162	25.6811	$1,686.84		$337.37
52317	Remove bladder stone		T	0162	25.6811	$1,686.84		$337.37
52318	Remove bladder stone		T	0162	25.6811	$1,686.84		$337.37
52320	Cystoscopy and treatment		T	0162	25.6811	$1,686.84		$337.37
52325	Cystoscopy, stone removal		T	0162	25.6811	$1,686.84		$337.37
52327	Cystoscopy, inject material	CH	T	0163	36.4225	$2,392.38		$478.48
52330	Cystoscopy and treatment		T	0162	25.6811	$1,686.84		$337.37
52332	Cystoscopy and treatment		T	0162	25.6811	$1,686.84		$337.37
52334	Create passage to kidney		T	0162	25.6811	$1,686.84		$337.37
52341	Cysto w/ureter stricture tx		T	0162	25.6811	$1,686.84		$337.37
52342	Cysto w/up stricture tx		T	0162	25.6811	$1,686.84		$337.37
52343	Cysto w/renal stricture tx		T	0162	25.6811	$1,686.84		$337.37
52344	Cysto/uretero, stricture tx		T	0162	25.6811	$1,686.84		$337.37

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
52345	Cysto/uretero w/up stricture		T	0162	25.6811	$1,686.84		$337.37
52346	Cystouretero w/renal strict		T	0162	25.6811	$1,686.84		$337.37
52351	Cystouretero & or pyeloscope		T	0162	25.6811	$1,686.84		$337.37
52352	Cystouretero w/stone remove		T	0162	25.6811	$1,686.84		$337.37
52353	Cystouretero w/lithotripsy		T	0163	36.4225	$2,392.38		$478.48
52354	Cystouretero w/biopsy		T	0162	25.6811	$1,686.84		$337.37
52355	Cystouretero w/excise tumor		T	0162	25.6811	$1,686.84		$337.37
52400	Cystouretero w/congen repr		T	0162	25.6811	$1,686.84		$337.37
52402	Cystourethro cut ejacul duct		T	0162	25.6811	$1,686.84		$337.37
52450	Incision of prostate		T	0162	25.6811	$1,686.84		$337.37
52500	Revision of bladder neck		T	0162	25.6811	$1,686.84		$337.37
52601	Prostatectomy (TURP)		T	0163	36.4225	$2,392.38		$478.48
52606	Control postop bleeding		T	0162	25.6811	$1,686.84		$337.37
52612	Prostatectomy, first stage		T	0163	36.4225	$2,392.38		$478.48
52614	Prostatectomy, second stage		T	0163	36.4225	$2,392.38		$478.48
52620	Remove residual prostate		T	0163	36.4225	$2,392.38		$478.48
52630	Remove prostate regrowth		T	0163	36.4225	$2,392.38		$478.48
52640	Relieve bladder contracture		T	0162	25.6811	$1,686.84		$337.37
52647	Laser surgery of prostate		T	0429	45.9136	$3,015.79		$603.16
52648	Laser surgery of prostate		T	0429	45.9136	$3,015.79		$603.16
52649	2Prostate laser enucleation		T	0429	45.9136	$3,015.79		$603.16
52700	Drainage of prostate abscess		T	0162	25.6811	$1,686.84		$337.37
53000	Incision of urethra		T	0166	20.0824	$1,319.09		$263.82
53010	Incision of urethra		T	0166	20.0824	$1,319.09		$263.82
53020	Incision of urethra		T	0166	20.0824	$1,319.09		$263.82
53025	Incision of urethra		T	0166	20.0824	$1,319.09		$263.82
53040	Drainage of urethra abscess		T	0166	20.0824	$1,319.09		$263.82
53060	Drainage of urethra abscess		T	0166	20.0824	$1,319.09		$263.82
53080	Drainage of urinary leakage		T	0166	20.0824	$1,319.09		$263.82
53085	Drainage of urinary leakage		T	0166	20.0824	$1,319.09		$263.82
53200	Biopsy of urethra		T	0166	20.0824	$1,319.09		$263.82

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
53210	Removal of urethra		T	0168	30.5507	$2,006.69		$401.34
53215	Removal of urethra		T	0166	20.0824	$1,319.09		$263.82
53220	Treatment of urethra lesion		T	0168	30.5507	$2,006.69		$401.34
53230	Removal of urethra lesion		T	0168	30.5507	$2,006.69		$401.34
53235	Removal of urethra lesion		T	0166	20.0824	$1,319.09		$263.82
53240	Surgery for urethra pouch		T	0168	30.5507	$2,006.69		$401.34
53250	Removal of urethra gland		T	0166	20.0824	$1,319.09		$263.82
53260	Treatment of urethra lesion		T	0166	20.0824	$1,319.09		$263.82
53265	Treatment of urethra lesion		T	0166	20.0824	$1,319.09		$263.82
53270	Removal of urethra gland		T	0166	20.0824	$1,319.09		$263.82
53275	Repair of urethra defect		T	0166	20.0824	$1,319.09		$263.82
53400	Revise urethra, stage 1		T	0168	30.5507	$2,006.69		$401.34
53405	Revise urethra, stage 2		T	0168	30.5507	$2,006.69		$401.34
53410	Reconstruction of urethra		T	0168	30.5507	$2,006.69		$401.34
53415	Reconstruction of urethra		C					
53420	Reconstruct urethra, stage 1		T	0168	30.5507	$2,006.69		$401.34
53425	Reconstruct urethra, stage 2		T	0168	30.5507	$2,006.69		$401.34
53430	Reconstruction of urethra		T	0168	30.5507	$2,006.69		$401.34
53431	Reconstruct urethra/bladder		T	0168	30.5507	$2,006.69		$401.34
53440	Male sling procedure		S	0385	95.4091	$6,266.85		$1,253.37
53442	Remove/revise male sling		T	0168	30.5507	$2,006.69		$401.34
53444	Insert tandem cuff		S	0385	95.4091	$6,266.85		$1,253.37
53445	Insert uro/ves nck sphincter		S	0386	149.3352	$9,808.93		$1,961.79
53446	Remove uro sphincter		T	0168	30.5507	$2,006.69		$401.34
53447	Remove/replace ur sphincter		S	0386	149.3352	$9,808.93		$1,961.79
53448	Remov/replc ur sphinctr comp		C					
53449	Repair uro sphincter		T	0168	30.5507	$2,006.69		$401.34
53450	Revision of urethra		T	0168	30.5507	$2,006.69		$401.34
53460	Revision of urethra		T	0166	20.0824	$1,319.09		$263.82
53500	Urethrlys, transvag w/ scope		T	0168	30.5507	$2,006.69		$401.34
53502	Repair of urethra injury		T	0166	20.0824	$1,319.09		$263.82

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
53505	Repair of urethra injury		T	0168	30.5507	$2,006.69		$401.34
53510	Repair of urethra injury		T	0166	20.0824	$1,319.09		$263.82
53515	Repair of urethra injury		T	0168	30.5507	$2,006.69		$401.34
53520	Repair of urethra defect		T	0168	30.5507	$2,006.69		$401.34
53600	Dilate urethra stricture		T	0156	3.1503	$206.92		$41.39
53601	Dilate urethra stricture		T	0126	1.0401	$68.32	$16.21	$13.67
53605	Dilate urethra stricture		T	0161	18.9529	$1,244.90		$248.98
53620	Dilate urethra stricture		T	0165	20.2632	$1,330.97		$266.20
53621	Dilate urethra stricture		T	0164	2.2063	$144.92		$28.99
53660	Dilation of urethra		T	0126	1.0401	$68.32	$16.21	$13.67
53661	Dilation of urethra		T	0126	1.0401	$68.32	$16.21	$13.67
53665	Dilation of urethra		T	0166	20.0824	$1,319.09		$263.82
53850	Prostatic microwave thermotx		T	0429	45.9136	$3,015.79		$603.16
53852	Prostatic rf thermotx		T	0429	45.9136	$3,015.79		$603.16
53853	Prostatic water thermother		T	0162	25.6811	$1,686.84		$337.37
53899	Urology surgery procedure		T	0126	1.0401	$68.32	$16.21	$13.67
54000	Slitting of prepuce		T	0166	20.0824	$1,319.09		$263.82
54001	Slitting of prepuce		T	0166	20.0824	$1,319.09		$263.82
54015	Drain penis lesion		T	0008	19.5771	$1,285.90		$257.18
54050	Destruction, penis lesion(s)	CH	T	0013	0.8332	$54.73		$10.95
54055	Destruction, penis lesion(s)		T	0017	20.6214	$1,354.50		$270.90
54056	Cryosurgery, penis lesion(s)		T	0013	0.8332	$54.73		$10.95
54057	Laser surg, penis lesion(s)		T	0017	20.6214	$1,354.50		$270.90
54060	Excision of penis lesion(s)		T	0017	20.6214	$1,354.50		$270.90
54065	Destruction, penis lesion(s)		T	0017	20.6214	$1,354.50		$270.90
54100	Biopsy of penis		T	0021	15.8699	$1,042.40	$219.48	$208.48
54105	Biopsy of penis		T	0022	21.7477	$1,428.48	$354.45	$285.70
54110	Treatment of penis lesion		T	0181	35.5509	$2,335.13	$621.82	$467.03
54111	Treat penis lesion, graft		T	0181	35.5509	$2,335.13	$621.82	$467.03
54112	Treat penis lesion, graft		T	0181	35.5509	$2,335.13	$621.82	$467.03
54115	Treatment of penis lesion		T	0008	19.5771	$1,285.90		$257.18

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
54120	Partial removal of penis		T	0181	35.5509	$2,335.13	$621.82	$467.03
54125	Removal of penis		C					
54130	Remove penis & nodes		C					
54135	Remove penis & nodes		C					
54150	Circumcision w/regionl block		T	0183	22.8775	$1,502.69		$300.54
54160	Circumcision, neonate		T	0183	22.8775	$1,502.69		$300.54
54161	Circum 28 days or older		T	0183	22.8775	$1,502.69		$300.54
54162	Lysis penil circumic lesion		T	0183	22.8775	$1,502.69		$300.54
54163	Repair of circumcision		T	0183	22.8775	$1,502.69		$300.54
54164	Frenulotomy of penis		T	0183	22.8775	$1,502.69		$300.54
54200	Treatment of penis lesion		T	0164	2.2063	$144.92		$28.99
54205	Treatment of penis lesion		T	0181	35.5509	$2,335.13	$621.82	$467.03
54220	Treatment of penis lesion		T	0164	2.2063	$144.92		$28.99
54230	Prepare penis study		N					
54231	Dynamic cavernosometry		T	0165	20.2632	$1,330.97		$266.20
54235	Penile injection		T	0164	2.2063	$144.92		$28.99
54240	Penis study		T	0126	1.0401	$68.32	$16.21	$13.67
54250	Penis study		T	0164	2.2063	$144.92		$28.99
54300	Revision of penis		T	0181	35.5509	$2,335.13	$621.82	$467.03
54304	Revision of penis		T	0181	35.5509	$2,335.13	$621.82	$467.03
54308	Reconstruction of urethra		T	0181	35.5509	$2,335.13	$621.82	$467.03
54312	Reconstruction of urethra		T	0181	35.5509	$2,335.13	$621.82	$467.03
54316	Reconstruction of urethra		T	0181	35.5509	$2,335.13	$621.82	$467.03
54318	Reconstruction of urethra		T	0181	35.5509	$2,335.13	$621.82	$467.03
54322	Reconstruction of urethra		T	0181	35.5509	$2,335.13	$621.82	$467.03
54324	Reconstruction of urethra		T	0181	35.5509	$2,335.13	$621.82	$467.03
54326	Reconstruction of urethra		T	0181	35.5509	$2,335.13	$621.82	$467.03
54328	Revise penis/urethra		T	0181	35.5509	$2,335.13	$621.82	$467.03
54332	Revise penis/urethra	CH	T	0181	35.5509	$2,335.13	$621.82	$467.03
54336	Revise penis/urethra		C					
54340	Secondary urethral surgery		T	0181	35.5509	$2,335.13	$621.82	$467.03

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
54344	Secondary urethral surgery		T	0181	35.5509	$2,335.13	$621.82	$467.03
54348	Secondary urethral surgery		T	0181	35.5509	$2,335.13	$621.82	$467.03
54352	Reconstruct urethra/penis		T	0181	35.5509	$2,335.13	$621.82	$467.03
54360	Penis plastic surgery		T	0181	35.5509	$2,335.13	$621.82	$467.03
54380	Repair penis		T	0181	35.5509	$2,335.13	$621.82	$467.03
54385	Repair penis		T	0181	35.5509	$2,335.13	$621.82	$467.03
54390	Repair penis and bladder		C					
54400	Insert semi-rigid prosthesis		S	0385	95.4091	$6,266.85		$1,253.37
54401	Insert self-contd prosthesis		S	0386	149.3352	$9,808.93		$1,961.79
54405	Insert multi-comp penis pros		S	0386	149.3352	$9,808.93		$1,961.79
54406	Remove muti-comp penis pros		T	0181	35.5509	$2,335.13	$621.82	$467.03
54408	Repair multi-comp penis pros		T	0181	35.5509	$2,335.13	$621.82	$467.03
54410	Remove/replace penis prosth		S	0386	149.3352	$9,808.93		$1,961.79
54411	Remov/replc penis pros, comp		C					
54415	Remove self-contd penis pros		T	0181	35.5509	$2,335.13	$621.82	$467.03
54416	Remv/repl penis contain pros		S	0386	149.3352	$9,808.93		$1,961.79
54417	Remv/replc penis pros, compl		C					
54420	Revision of penis		T	0181	35.5509	$2,335.13	$621.82	$467.03
54430	Revision of penis		C					
54435	Revision of penis		T	0181	35.5509	$2,335.13	$621.82	$467.03
54440	Repair of penis		T	0181	35.5509	$2,335.13	$621.82	$467.03
54450	Preputial stretching		T	0156	3.1503	$206.92		$41.39
54500	Biopsy of testis		T	0037	13.5257	$888.42	$228.76	$177.69
54505	Biopsy of testis		T	0183	22.8775	$1,502.69		$300.54
54512	Excise lesion testis		T	0183	22.8775	$1,502.69		$300.54
54520	Removal of testis		T	0183	22.8775	$1,502.69		$300.54
54522	Orchiectomy, partial		T	0183	22.8775	$1,502.69		$300.54
54530	Removal of testis		T	0154	31.6898	$2,081.51	$464.85	$416.31
54535	Extensive testis surgery	CH	T	0181	35.5509	$2,335.13	$621.82	$467.03
54550	Exploration for testis		T	0154	31.6898	$2,081.51	$464.85	$416.31
54560	Exploration for testis		T	0183	22.8775	$1,502.69		$300.54

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
54600	Reduce testis torsion		T	0183	22.8775	$1,502.69		$300.54
54620	Suspension of testis		T	0183	22.8775	$1,502.69		$300.54
54640	Suspension of testis		T	0154	31.6898	$2,081.51	$464.85	$416.31
54650	Orchiopexy (Fowler-Stephens)		C					
54660	Revision of testis		T	0183	22.8775	$1,502.69		$300.54
54670	Repair testis injury		T	0183	22.8775	$1,502.69		$300.54
54680	Relocation of testis(es)		T	0183	22.8775	$1,502.69		$300.54
54690	Laparoscopy, orchiectomy		T	0131	46.3867	$3,046.86	$1,001.89	$609.38
54692	Laparoscopy, orchiopexy		T	0132	71.7816	$4,714.90	$1,239.22	$942.98
54699	Laparoscope proc, testis		T	0130	37.5470	$2,466.24	$659.53	$493.25
54700	Drainage of scrotum		T	0183	22.8775	$1,502.69		$300.54
54800	Biopsy of epididymis		T	0004	4.5254	$297.25		$59.45
54830	Remove epididymis lesion		T	0183	22.8775	$1,502.69		$300.54
54840	Remove epididymis lesion		T	0183	22.8775	$1,502.69		$300.54
54860	Removal of epididymis		T	0183	22.8775	$1,502.69		$300.54
54861	Removal of epididymis		T	0183	22.8775	$1,502.69		$300.54
54865	Explore epididymis		T	0183	22.8775	$1,502.69		$300.54
54900	Fusion of spermatic ducts		T	0183	22.8775	$1,502.69		$300.54
54901	Fusion of spermatic ducts		T	0183	22.8775	$1,502.69		$300.54
55000	Drainage of hydrocele		T	0004	4.5254	$297.25		$59.45
55040	Removal of hydrocele		T	0154	31.6898	$2,081.51	$464.85	$416.31
55041	Removal of hydroceles		T	0154	31.6898	$2,081.51	$464.85	$416.31
55060	Repair of hydrocele		T	0183	22.8775	$1,502.69		$300.54
55100	Drainage of scrotum abscess		T	0007	12.8052	$841.10		$168.22
55110	Explore scrotum		T	0183	22.8775	$1,502.69		$300.54
55120	Removal of scrotum lesion		T	0183	22.8775	$1,502.69		$300.54
55150	Removal of scrotum		T	0183	22.8775	$1,502.69		$300.54
55175	Revision of scrotum		T	0183	22.8775	$1,502.69		$300.54
55180	Revision of scrotum		T	0183	22.8775	$1,502.69		$300.54
55200	Incision of sperm duct		T	0183	22.8775	$1,502.69		$300.54
55250	Removal of sperm duct(s)		T	0183	22.8775	$1,502.69		$300.54

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55300	Prepare, sperm duct x-ray		N					
55400	Repair of sperm duct		T	0183	22.8775	$1,502.69		$300.54
55450	Ligation of sperm duct		T	0183	22.8775	$1,502.69		$300.54
55500	Removal of hydrocele		T	0183	22.8775	$1,502.69		$300.54
55520	Removal of sperm cord lesion		T	0183	22.8775	$1,502.69		$300.54
55530	Revise spermatic cord veins		T	0183	22.8775	$1,502.69		$300.54
55535	Revise spermatic cord veins		T	0154	31.6898	$2,081.51	$464.85	$416.31
55540	Revise hernia & sperm veins		T	0154	31.6898	$2,081.51	$464.85	$416.31
55550	Laparo ligate spermatic vein		T	0131	46.3867	$3,046.86	$1,001.89	$609.38
55559	Laparo proc, spermatic cord		T	0130	37.5470	$2,466.24	$659.53	$493.25
55600	Incise sperm duct pouch		T	0183	22.8775	$1,502.69		$300.54
55605	Incise sperm duct pouch		C					
55650	Remove sperm duct pouch		C					
55680	Remove sperm pouch lesion		T	0183	22.8775	$1,502.69		$300.54
55700	Biopsy of prostate		T	0184	11.8068	$775.52		$155.11
55705	Biopsy of prostate		T	0184	11.8068	$775.52		$155.11
55720	Drainage of prostate abscess		T	0162	25.6811	$1,686.84		$337.37
55725	Drainage of prostate abscess		T	0162	25.6811	$1,686.84		$337.37
55801	Removal of prostate		C					
55810	Extensive prostate surgery		C					
55812	Extensive prostate surgery		C					
55815	Extensive prostate surgery		C					
55821	Removal of prostate		C					
55831	Removal of prostate		C					
55840	Extensive prostate surgery		C					
55842	Extensive prostate surgery		C					
55845	Extensive prostate surgery		C					
55860	Surgical exposure, prostate		T	0165	20.2632	$1,330.97		$266.20
55862	Extensive prostate surgery		C					
55865	Extensive prostate surgery		C					
55866	Laparo radical prostatectomy		C					

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55870	Electroejaculation		T	0189	3.0399	$199.67		$39.94
55873	Cryoablate prostate		T	0674	120.7521	$7,931.48		$1,586.30
55875	Transperi needle place, pros		Q3	0163	36.4225	$2,392.38		$478.48
55876	Place rt device/marker, pros	CH	X	0310	13.7096	$900.50	$325.27	$180.10
55899	Genital surgery procedure		T	0126	1.0401	$68.32	$16.21	$13.67
55920	Place needles pelvic for rt		T	0153	23.2665	$1,528.24	$371.60	$305.65
55970	Sex transformation, M to F		E					
55980	Sex transformation, F to M		E					
56405	I & D of vulva/perineum		T	0189	3.0399	$199.67		$39.94
56420	Drainage of gland abscess		T	0188	1.4203	$93.29		$18.66
56440	Surgery for vulva lesion		T	0193	19.8841	$1,306.07		$261.22
56441	Lysis of labial lesion(s)		T	0193	19.8841	$1,306.07		$261.22
56442	Hymenotomy		T	0193	19.8841	$1,306.07		$261.22
56501	Destroy, vulva lesions, sim		T	0017	20.6214	$1,354.50		$270.90
56515	Destroy vulva lesion/s compl		T	0017	20.6214	$1,354.50		$270.90
56605	Biopsy of vulva/perineum		T	0189	3.0399	$199.67		$39.94
56606	Biopsy of vulva/perineum		T	0188	1.4203	$93.29		$18.66
56620	Partial removal of vulva		T	0193	19.8841	$1,306.07		$261.22
56625	Complete removal of vulva		T	0193	19.8841	$1,306.07		$261.22
56630	Extensive vulva surgery		C					
56631	Extensive vulva surgery		C					
56632	Extensive vulva surgery		C					
56633	Extensive vulva surgery		C					
56634	Extensive vulva surgery		C					
56637	Extensive vulva surgery		C					
56640	Extensive vulva surgery		C					
56700	Partial removal of hymen		T	0193	19.8841	$1,306.07		$261.22
56740	Remove vagina gland lesion		T	0193	19.8841	$1,306.07		$261.22
56800	Repair of vagina		T	0193	19.8841	$1,306.07		$261.22
56805	Repair clitoris		T	0193	19.8841	$1,306.07		$261.22
56810	Repair of perineum		T	0193	19.8841	$1,306.07		$261.22

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56820	Exam of vulva w/scope		T	0188	1.4203	$93.29		$18.66
56821	Exam/biopsy of vulva w/scope		T	0188	1.4203	$93.29		$18.66
57000	Exploration of vagina		T	0193	19.8841	$1,306.07		$261.22
57010	Drainage of pelvic abscess		T	0193	19.8841	$1,306.07		$261.22
57020	Drainage of pelvic fluid		T	0192	6.3303	$415.80		$83.16
57022	I & d vaginal hematoma, pp		T	0007	12.8052	$841.10		$168.22
57023	I & d vag hematoma, non-ob		T	0008	19.5771	$1,285.90		$257.18
57061	Destroy vag lesions, simple		T	0193	19.8841	$1,306.07		$261.22
57065	Destroy vag lesions, complex		T	0193	19.8841	$1,306.07		$261.22
57100	Biopsy of vagina		T	0192	6.3303	$415.80		$83.16
57105	Biopsy of vagina		T	0193	19.8841	$1,306.07		$261.22
57106	Remove vagina wall, partial		T	0193	19.8841	$1,306.07		$261.22
57107	Remove vagina tissue, part		T	0195	33.9125	$2,227.51	$483.80	$445.51
57109	Vaginectomy partial w/nodes		T	0195	33.9125	$2,227.51	$483.80	$445.51
57110	Remove vagina wall, complete		C					
57111	Remove vagina tissue, compl		C					
57112	Vaginectomy w/nodes, compl		C					
57120	Closure of vagina		T	0195	33.9125	$2,227.51	$483.80	$445.51
57130	Remove vagina lesion		T	0193	19.8841	$1,306.07		$261.22
57135	Remove vagina lesion		T	0193	19.8841	$1,306.07		$261.22
57150	Treat vagina infection		T	0188	1.4203	$93.29		$18.66
57155	Insert uteri tandems/ovoids		T	0192	6.3303	$415.80		$83.16
57160	Insert pessary/other device		T	0188	1.4203	$93.29		$18.66
57170	Fitting of diaphragm/cap		T	0191	0.1824	$11.98		$2.40
57180	Treat vaginal bleeding		T	0188	1.4203	$93.29		$18.66
57200	Repair of vagina		T	0193	19.8841	$1,306.07		$261.22
57210	Repair vagina/perineum		T	0193	19.8841	$1,306.07		$261.22
57220	Revision of urethra		T	0202	43.6282	$2,865.67	$981.50	$573.14
57230	Repair of urethral lesion		T	0195	33.9125	$2,227.51	$483.80	$445.51
57240	Repair bladder & vagina		T	0195	33.9125	$2,227.51	$483.80	$445.51
57250	Repair rectum & vagina		T	0195	33.9125	$2,227.51	$483.80	$445.51

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
57260	Repair of vagina		T	0195	33.9125	$2,227.51	$483.80	$445.51
57265	Extensive repair of vagina		T	0202	43.6282	$2,865.67	$981.50	$573.14
57267	Insert mesh/pelvic flr addon		T	0195	33.9125	$2,227.51	$483.80	$445.51
57268	Repair of bowel bulge		T	0195	33.9125	$2,227.51	$483.80	$445.51
57270	Repair of bowel pouch		C					
57280	Suspension of vagina		C					
57282	Colpopexy, extraperitoneal		T	0202	43.6282	$2,865.67	$981.50	$573.14
57283	Colpopexy, intraperitoneal		T	0202	43.6282	$2,865.67	$981.50	$573.14
57284	Repair paravag defect, open		T	0202	43.6282	$2,865.67	$981.50	$573.14
57285	Repair paravag defect, vag		T	0195	33.9125	$2,227.51	$483.80	$445.51
57287	Revise/remove sling repair		T	0195	33.9125	$2,227.51	$483.80	$445.51
57288	Repair bladder defect		T	0202	43.6282	$2,865.67	$981.50	$573.14
57289	Repair bladder & vagina		T	0195	33.9125	$2,227.51	$483.80	$445.51
57291	Construction of vagina		T	0195	33.9125	$2,227.51	$483.80	$445.51
57292	Construct vagina with graft		T	0195	33.9125	$2,227.51	$483.80	$445.51
57295	Revise vag graft via vagina		T	0193	19.8841	$1,306.07		$261.22
57296	Revise vag graft, open abd		C					
57300	Repair rectum-vagina fistula		T	0195	33.9125	$2,227.51	$483.80	$445.51
57305	Repair rectum-vagina fistula		C					
57307	Fistula repair & colostomy		C					
57308	Fistula repair, transperine		C					
57310	Repair urethrovaginal lesion		T	0202	43.6282	$2,865.67	$981.50	$573.14
57311	Repair urethrovaginal lesion		C					
57320	Repair bladder-vagina lesion		T	0195	33.9125	$2,227.51	$483.80	$445.51
57330	Repair bladder-vagina lesion		T	0195	33.9125	$2,227.51	$483.80	$445.51
57335	Repair vagina		T	0195	33.9125	$2,227.51	$483.80	$445.51
57400	Dilation of vagina		T	0193	19.8841	$1,306.07		$261.22
57410	Pelvic examination		T	0193	19.8841	$1,306.07		$261.22
57415	Remove vaginal foreign body		T	0193	19.8841	$1,306.07		$261.22
57420	Exam of vagina w/scope		T	0189	3.0399	$199.67		$39.94
57421	Exam/biopsy of vag w/scope		T	0189	3.0399	$199.67		$39.94

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
57423	Repair paravag defect, lap		T	0202	43.6282	$2,865.67	$981.50	$573.14
57425	Laparoscopy, surg, colpopexy		T	0130	37.5470	$2,466.24	$659.53	$493.25
57452	Exam of cervix w/scope		T	0189	3.0399	$199.67		$39.94
57454	Bx/curett of cervix w/scope		T	0189	3.0399	$199.67		$39.94
57455	Biopsy of cervix w/scope		T	0189	3.0399	$199.67		$39.94
57456	Endocerv curettage w/scope		T	0189	3.0399	$199.67		$39.94
57460	Bx of cervix w/scope, leep		T	0193	19.8841	$1,306.07		$261.22
57461	Conz of cervix w/scope, leep		T	0193	19.8841	$1,306.07		$261.22
57500	Biopsy of cervix		T	0192	6.3303	$415.80		$83.16
57505	Endocervical curettage		T	0192	6.3303	$415.80		$83.16
57510	Cauterization of cervix		T	0193	19.8841	$1,306.07		$261.22
57511	Cryocautery of cervix		T	0188	1.4203	$93.29		$18.66
57513	Laser surgery of cervix		T	0193	19.8841	$1,306.07		$261.22
57520	Conization of cervix		T	0193	19.8841	$1,306.07		$261.22
57522	Conization of cervix		T	0193	19.8841	$1,306.07		$261.22
57530	Removal of cervix		T	0195	33.9125	$2,227.51	$483.80	$445.51
57531	Removal of cervix, radical		C					
57540	Removal of residual cervix		C					
57545	Remove cervix/repair pelvis		C					
57550	Removal of residual cervix		T	0195	33.9125	$2,227.51	$483.80	$445.51
57555	Remove cervix/repair vagina		T	0195	33.9125	$2,227.51	$483.80	$445.51
57556	Remove cervix, repair bowel		T	0202	43.6282	$2,865.67	$981.50	$573.14
57558	D&c of cervical stump		T	0193	19.8841	$1,306.07		$261.22
57700	Revision of cervix		T	0193	19.8841	$1,306.07		$261.22
57720	Revision of cervix		T	0193	19.8841	$1,306.07		$261.22
57800	Dilation of cervical canal		T	0193	19.8841	$1,306.07		$261.22
58100	Biopsy of uterus lining		T	0188	1.4203	$93.29		$18.66
58110	Bx done w/colposcopy add-on		N					
58120	Dilation and curettage		T	0193	19.8841	$1,306.07		$261.22
58140	Myomectomy abdom method		C					
58145	Myomectomy vag method		T	0195	33.9125	$2,227.51	$483.80	$445.51

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
58146	Myomectomy abdom complex		C					
58150	Total hysterectomy		C					
58152	Total hysterectomy		C					
58180	Partial hysterectomy		C					
58200	Extensive hysterectomy		C					
58210	Extensive hysterectomy		C					
58240	Removal of pelvis contents		C					
58260	Vaginal hysterectomy		T	0195	33.9125	$2,227.51	$483.80	$445.51
58262	Vag hyst including t/o		T	0195	33.9125	$2,227.51	$483.80	$445.51
58263	Vag hyst w/t/o & vag repair		T	0195	33.9125	$2,227.51	$483.80	$445.51
58267	Vag hyst w/urinary repair		C					
58270	Vag hyst w/enterocele repair		T	0195	33.9125	$2,227.51	$483.80	$445.51
58275	Hysterectomy/revise vagina		C					
58280	Hysterectomy/revise vagina		C					
58285	Extensive hysterectomy		C					
58290	Vag hyst complex		T	0202	43.6282	$2,865.67	$981.50	$573.14
58291	Vag hyst incl t/o, complex		T	0202	43.6282	$2,865.67	$981.50	$573.14
58292	Vag hyst t/o & repair, compl		T	0202	43.6282	$2,865.67	$981.50	$573.14
58293	Vag hyst w/uro repair, compl		C					
58294	Vag hyst w/enterocele, compl		T	0202	43.6282	$2,865.67	$981.50	$573.14
58300	Insert intrauterine device		E					
58301	Remove intrauterine device		T	0188	1.4203	$93.29		$18.66
58321	Artificial insemination		T	0189	3.0399	$199.67		$39.94
58322	Artificial insemination		T	0189	3.0399	$199.67		$39.94
58323	Sperm washing		T	0189	3.0399	$199.67		$39.94
58340	Catheter for hysterography		N					
58345	Reopen fallopian tube		T	0193	19.8841	$1,306.07		$261.22
58346	Insert heyman uteri capsule		T	0193	19.8841	$1,306.07		$261.22
58350	Reopen fallopian tube		T	0195	33.9125	$2,227.51	$483.80	$445.51
58353	Endometr ablate, thermal		T	0195	33.9125	$2,227.51	$483.80	$445.51
58356	Endometrial cryoablation		T	0202	43.6282	$2,865.67	$981.50	$573.14

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
58400	Suspension of uterus		C					
58410	Suspension of uterus		C					
58520	Repair of ruptured uterus		C					
58540	Revision of uterus		C					
58541	Lsh, uterus 250 g or less	CH	T	0132	71.7816	$4,714.90	$1,239.22	$942.98
58542	Lsh w/t/o ut 250 g or less	CH	T	0132	71.7816	$4,714.90	$1,239.22	$942.98
58543	Lsh uterus above 250 g	CH	T	0132	71.7816	$4,714.90	$1,239.22	$942.98
58544	Lsh w/t/o uterus above 250 g	CH	T	0132	71.7816	$4,714.90	$1,239.22	$942.98
58545	Laparoscopic myomectomy		T	0130	37.5470	$2,466.24	$659.53	$493.25
58546	Laparo-myomectomy, complex		T	0131	46.3867	$3,046.86	$1,001.89	$609.38
58548	Lap radical hyst		C					
58550	Laparo-asst vag hysterectomy		T	0132	71.7816	$4,714.90	$1,239.22	$942.98
58552	Laparo-vag hyst incl t/o		T	0131	46.3867	$3,046.86	$1,001.89	$609.38
58553	Laparo-vag hyst, complex		T	0131	46.3867	$3,046.86	$1,001.89	$609.38
58554	Laparo-vag hyst w/t/o, compl		T	0131	46.3867	$3,046.86	$1,001.89	$609.38
58555	Hysteroscopy, dx, sep proc		T	0190	22.0023	$1,445.20	$424.28	$289.04
58558	Hysteroscopy, biopsy		T	0190	22.0023	$1,445.20	$424.28	$289.04
58559	Hysteroscopy, lysis		T	0190	22.0023	$1,445.20	$424.28	$289.04
58560	Hysteroscopy, resect septum		T	0387	36.4505	$2,394.21	$655.55	$478.85
58561	Hysteroscopy, remove myoma		T	0387	36.4505	$2,394.21	$655.55	$478.85
58562	Hysteroscopy, remove fb		T	0190	22.0023	$1,445.20	$424.28	$289.04
58563	Hysteroscopy, ablation		T	0387	36.4505	$2,394.21	$655.55	$478.85
58565	Hysteroscopy, sterilization		T	0202	43.6282	$2,865.67	$981.50	$573.14
58570	Tlh, uterus 250 g or less		T	0131	46.3867	$3,046.86	$1,001.89	$609.38
58571	Tlh w/t/o 250 g or less		T	0131	46.3867	$3,046.86	$1,001.89	$609.38
58572	Tlh, uterus over 250 g		T	0131	46.3867	$3,046.86	$1,001.89	$609.38
58573	Tlh w/t/o uterus over 250 g		T	0131	46.3867	$3,046.86	$1,001.89	$609.38
58578	Laparo proc, uterus		T	0130	37.5470	$2,466.24	$659.53	$493.25
58579	Hysteroscope procedure		T	0190	22.0023	$1,445.20	$424.28	$289.04
58600	Division of fallopian tube		T	0195	33.9125	$2,227.51	$483.80	$445.51
58605	Division of fallopian tube		C					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
58611	Ligate oviduct(s) add-on		C					
58615	Occlude fallopian tube(s)		T	0193	19.8841	$1,306.07		$261.22
58660	Laparoscopy, lysis		T	0131	46.3867	$3,046.86	$1,001.89	$609.38
58661	Laparoscopy, remove adnexa		T	0131	46.3867	$3,046.86	$1,001.89	$609.38
58662	Laparoscopy, excise lesions		T	0131	46.3867	$3,046.86	$1,001.89	$609.38
58670	Laparoscopy, tubal cautery		T	0131	46.3867	$3,046.86	$1,001.89	$609.38
58671	Laparoscopy, tubal block		T	0131	46.3867	$3,046.86	$1,001.89	$609.38
58672	Laparoscopy, fimbrioplasty		T	0131	46.3867	$3,046.86	$1,001.89	$609.38
58673	Laparoscopy, salpingostomy		T	0131	46.3867	$3,046.86	$1,001.89	$609.38
58679	Laparo proc, oviduct-ovary		T	0130	37.5470	$2,466.24	$659.53	$493.25
58700	Removal of fallopian tube		C					
58720	Removal of ovary/tube(s)		C					
58740	Revise fallopian tube(s)		C					
58750	Repair oviduct		C					
58752	Revise ovarian tube(s)		C					
58760	Remove tubal obstruction		C					
58770	Create new tubal opening		T	0195	33.9125	$2,227.51	$483.80	$445.51
58800	Drainage of ovarian cyst(s)		T	0193	19.8841	$1,306.07		$261.22
58805	Drainage of ovarian cyst(s)		T	0195	33.9125	$2,227.51	$483.80	$445.51
58820	Drain ovary abscess, open		T	0195	33.9125	$2,227.51	$483.80	$445.51
58822	Drain ovary abscess, percut		C					
58823	Drain pelvic abscess, percut		T	0193	19.8841	$1,306.07		$261.22
58825	Transposition, ovary(s)		C					
58900	Biopsy of ovary(s)		T	0193	19.8841	$1,306.07		$261.22
58920	Partial removal of ovary(s)		T	0195	33.9125	$2,227.51	$483.80	$445.51
58925	Removal of ovarian cyst(s)		T	0195	33.9125	$2,227.51	$483.80	$445.51
58940	Removal of ovary(s)		C					
58943	Removal of ovary(s)		C					
58950	Resect ovarian malignancy		C					
58951	Resect ovarian malignancy		C					
58952	Resect ovarian malignancy		C					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
58953	Tah, rad dissect for debulk		C					
58954	Tah rad debulk/lymph remove		C					
58956	Bso, omentectomy w/tah		C					
58957	Resect recurrent gyn mal		C					
58958	Resect recur gyn mal w/lym		C					
58960	Exploration of abdomen		C					
58970	Retrieval of oocyte		T	0189	3.0399	$199.67		$39.94
58974	Transfer of embryo		T	0189	3.0399	$199.67		$39.94
58976	Transfer of embryo		T	0189	3.0399	$199.67		$39.94
58999	Genital surgery procedure		T	0191	0.1824	$11.98		$2.40
59000	Amniocentesis, diagnostic		T	0189	3.0399	$199.67		$39.94
59001	Amniocentesis, therapeutic		T	0192	6.3303	$415.80		$83.16
59012	Fetal cord puncture,prenatal		T	0189	3.0399	$199.67		$39.94
59015	Chorion biopsy		T	0189	3.0399	$199.67		$39.94
59020	Fetal contract stress test		T	0188	1.4203	$93.29		$18.66
59025	Fetal non-stress test		T	0188	1.4203	$93.29		$18.66
59030	Fetal scalp blood sample		T	0189	3.0399	$199.67		$39.94
59050	Fetal monitor w/report		M					
59051	Fetal monitor/interpret only		B					
59070	Transabdom amnioinfus w/us		T	0189	3.0399	$199.67		$39.94
59072	Umbilical cord occlud w/us		T	0189	3.0399	$199.67		$39.94
59074	Fetal fluid drainage w/us		T	0189	3.0399	$199.67		$39.94
59076	Fetal shunt placement, w/us		T	0189	3.0399	$199.67		$39.94
59100	Remove uterus lesion		T	0195	33.9125	$2,227.51	$483.80	$445.51
59120	Treat ectopic pregnancy		C					
59121	Treat ectopic pregnancy		C					
59130	Treat ectopic pregnancy		C					
59135	Treat ectopic pregnancy		C					
59136	Treat ectopic pregnancy		C					
59140	Treat ectopic pregnancy		C					
59150	Treat ectopic pregnancy		T	0131	46.3867	$3,046.86	$1,001.89	$609.38

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
59151	Treat ectopic pregnancy		T	0131	46.3867	$3,046.86	$1,001.89	$609.38
59160	D & c after delivery		T	0193	19.8841	$1,306.07		$261.22
59200	Insert cervical dilator		T	0189	3.0399	$199.67		$39.94
59300	Episiotomy or vaginal repair		T	0193	19.8841	$1,306.07		$261.22
59320	Revision of cervix		T	0193	19.8841	$1,306.07		$261.22
59325	Revision of cervix		C					
59350	Repair of uterus		C					
59400	Obstetrical care		B					
59409	Obstetrical care		T	0193	19.8841	$1,306.07		$261.22
59410	Obstetrical care		B					
59412	Antepartum manipulation		T	0193	19.8841	$1,306.07		$261.22
59414	Deliver placenta		T	0193	19.8841	$1,306.07		$261.22
59425	Antepartum care only		B					
59426	Antepartum care only		B					
59430	Care after delivery		B					
59510	Cesarean delivery		B					
59514	Cesarean delivery only		C					
59515	Cesarean delivery		B					
59525	Remove uterus after cesarean		C					
59610	Vbac delivery		B					
59612	Vbac delivery only		T	0193	19.8841	$1,306.07		$261.22
59614	Vbac care after delivery		B					
59618	Attempted vbac delivery		B					
59620	Attempted vbac delivery only		C					
59622	Attempted vbac after care		B					
59812	Treatment of miscarriage		T	0193	19.8841	$1,306.07		$261.22
59820	Care of miscarriage		T	0193	19.8841	$1,306.07		$261.22
59821	Treatment of miscarriage		T	0193	19.8841	$1,306.07		$261.22
59830	Treat uterus infection		C					
59840	Abortion		T	0193	19.8841	$1,306.07		$261.22
59841	Abortion		T	0193	19.8841	$1,306.07		$261.22

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
59850	Abortion		C					
59851	Abortion		C					
59852	Abortion		C					
59855	Abortion		C					
59856	Abortion		C					
59857	Abortion		C					
59866	Abortion (mpr)		T	0189	3.0399	$199.67		$39.94
59870	Evacuate mole of uterus		T	0193	19.8841	$1,306.07		$261.22
59871	Remove cerclage suture		T	0193	19.8841	$1,306.07		$261.22
59897	Fetal invas px w/us	CH	T	0191	0.1824	$11.98		$2.40
59898	Laparo proc, ob care/deliver		T	0130	37.5470	$2,466.24	$659.53	$493.25
59899	Maternity care procedure		T	0191	0.1824	$11.98		$2.40
60000	Drain thyroid/tongue cyst		T	0252	7.7504	$509.08	$109.16	$101.82
6005F	Care level rationale doc		M					
60100	Biopsy of thyroid		T	0004	4.5254	$297.25		$59.45
6010F	Dysphag test done b/4 eating		M					
6015F	Dysphag test done b/4 eating		M					
60200	Remove thyroid lesion		T	0114	47.1418	$3,096.46		$619.30
6020F	Npo (nothing-mouth) ordered		M					
60210	Partial thyroid excision		T	0114	47.1418	$3,096.46		$619.30
60212	Partial thyroid excision		T	0114	47.1418	$3,096.46		$619.30
60220	Partial removal of thyroid		T	0114	47.1418	$3,096.46		$619.30
60225	Partial removal of thyroid		T	0114	47.1418	$3,096.46		$619.30
60240	Removal of thyroid		T	0114	47.1418	$3,096.46		$619.30
60252	Removal of thyroid		T	0256	41.6247	$2,734.08		$546.82
60254	Extensive thyroid surgery		C					
60260	Repeat thyroid surgery		T	0256	41.6247	$2,734.08		$546.82
60270	Removal of thyroid		C					
60271	Removal of thyroid		T	0256	41.6247	$2,734.08		$546.82
60280	Remove thyroid duct lesion		T	0114	47.1418	$3,096.46		$619.30
60281	Remove thyroid duct lesion		T	0114	47.1418	$3,096.46		$619.30

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
60300	Aspir/inj thyroid cyst		T	0004	4.5254	$297.25		$59.45
6030F	Max sterile barriers follwd		M					
6040F	Appro rad ds dvcs techs docd		M					
6045F	Radxps in end rprt4fluro pxd		M					
60500	Explore parathyroid glands		T	0256	41.6247	$2,734.08		$546.82
60502	Re-explore parathyroids		T	0256	41.6247	$2,734.08		$546.82
60505	Explore parathyroid glands		C					
60512	Autotransplant parathyroid		T	0022	21.7477	$1,428.48	$354.45	$285.70
60520	Removal of thymus gland		T	0256	41.6247	$2,734.08		$546.82
60521	Removal of thymus gland		C					
60522	Removal of thymus gland		C					
60540	Explore adrenal gland		C					
60545	Explore adrenal gland		C					
60600	Remove carotid body lesion		C					
60605	Remove carotid body lesion		C					
60650	Laparoscopy adrenalectomy		C					
60659	Laparo proc, endocrine		T	0130	37.5470	$2,466.24	$659.53	$493.25
60699	Endocrine surgery procedure		T	0114	47.1418	$3,096.46		$619.30
61000	Remove cranial cavity fluid	CH	T	0207	7.3510	$482.84		$96.57
61001	Remove cranial cavity fluid	CH	T	0207	7.3510	$482.84		$96.57
61020	Remove brain cavity fluid	CH	T	0207	7.3510	$482.84		$96.57
61026	Injection into brain canal	CH	T	0207	7.3510	$482.84		$96.57
61050	Remove brain canal fluid	CH	T	0207	7.3510	$482.84		$96.57
61055	Injection into brain canal	CH	T	0207	7.3510	$482.84		$96.57
61070	Brain canal shunt procedure		T	0121	4.5975	$301.98		$60.40
61105	Twist drill hole		C					
61107	Drill skull for implantation		C					
61108	Drill skull for drainage		C					
61120	Burr hole for puncture		C					
61140	Pierce skull for biopsy		C					
61150	Pierce skull for drainage		C					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
61151	Pierce skull for drainage		C					
61154	Pierce skull & remove clot		C					
61156	Pierce skull for drainage		C					
61210	Pierce skull, implant device		C					
61215	Insert brain-fluid device		T	0224	42.2017	$2,771.98		$554.40
61250	Pierce skull & explore		C					
61253	Pierce skull & explore		C					
61304	Open skull for exploration		C					
61305	Open skull for exploration		C					
61312	Open skull for drainage		C					
61313	Open skull for drainage		C					
61314	Open skull for drainage		C					
61315	Open skull for drainage		C					
61316	Implt cran bone flap to abdo		C					
61320	Open skull for drainage		C					
61321	Open skull for drainage		C					
61322	Decompressive craniotomy		C					
61323	Decompressive lobectomy		C					
61330	Decompress eye socket		T	0256	41.6247	$2,734.08		$546.82
61332	Explore/biopsy eye socket		C					
61333	Explore orbit/remove lesion		C					
61334	Explore orbit/remove object		T	0256	41.6247	$2,734.08		$546.82
61340	Subtemporal decompression		C					
61343	Incise skull (press relief)		C					
61345	Relieve cranial pressure		C					
61440	Incise skull for surgery		C					
61450	Incise skull for surgery		C					
61458	Incise skull for brain wound		C					
61460	Incise skull for surgery		C					
61470	Incise skull for surgery		C					
61480	Incise skull for surgery		C					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
61490	Incise skull for surgery		C					
61500	Removal of skull lesion		C					
61501	Remove infected skull bone		C					
61510	Removal of brain lesion		C					
61512	Remove brain lining lesion		C					
61514	Removal of brain abscess		C					
61516	Removal of brain lesion		C					
61517	Implt brain chemotx add-on		C					
61518	Removal of brain lesion		C					
61519	Remove brain lining lesion		C					
61520	Removal of brain lesion		C					
61521	Removal of brain lesion		C					
61522	Removal of brain abscess		C					
61524	Removal of brain lesion		C					
61526	Removal of brain lesion		C					
61530	Removal of brain lesion		C					
61531	Implant brain electrodes		C					
61533	Implant brain electrodes		C					
61534	Removal of brain lesion		C					
61535	Remove brain electrodes		C					
61536	Removal of brain lesion		C					
61537	Removal of brain tissue		C					
61538	Removal of brain tissue		C					
61539	Removal of brain tissue		C					
61540	Removal of brain tissue		C					
61541	Incision of brain tissue		C					
61542	Removal of brain tissue		C					
61543	Removal of brain tissue		C					
61544	Remove & treat brain lesion		C					
61545	Excision of brain tumor		C					
61546	Removal of pituitary gland		C					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
61548	Removal of pituitary gland		C					
61550	Release of skull seams		C					
61552	Release of skull seams		C					
61556	Incise skull/sutures		C					
61557	Incise skull/sutures		C					
61558	Excision of skull/sutures		C					
61559	Excision of skull/sutures		C					
61563	Excision of skull tumor		C					
61564	Excision of skull tumor		C					
61566	Removal of brain tissue		C					
61567	Incision of brain tissue		C					
61570	Remove foreign body, brain		C					
61571	Incise skull for brain wound		C					
61575	Skull base/brainstem surgery		C					
61576	Skull base/brainstem surgery		C					
61580	Craniofacial approach, skull		C					
61581	Craniofacial approach, skull		C					
61582	Craniofacial approach, skull		C					
61583	Craniofacial approach, skull		C					
61584	Orbitocranial approach/skull		C					
61585	Orbitocranial approach/skull		C					
61586	Resect nasopharynx, skull		C					
61590	Infratemporal approach/skull		C					
61591	Infratemporal approach/skull		C					
61592	Orbitocranial approach/skull		C					
61595	Transtemporal approach/skull		C					
61596	Transcochlear approach/skull		C					
61597	Transcondylar approach/skull		C					
61598	Transpetrosal approach/skull		C					
61600	Resect/excise cranial lesion		C					
61601	Resect/excise cranial lesion		C					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
61605	Resect/excise cranial lesion		C					
61606	Resect/excise cranial lesion		C					
61607	Resect/excise cranial lesion		C					
61608	Resect/excise cranial lesion		C					
61609	Transect artery, sinus		C					
61610	Transect artery, sinus		C					
61611	Transect artery, sinus		C					
61612	Transect artery, sinus		C					
61613	Remove aneurysm, sinus		C					
61615	Resect/excise lesion, skull		C					
61616	Resect/excise lesion, skull		C					
61618	Repair dura		C					
61619	Repair dura		C					
61623	Endovasc tempory vessel occl		T	0082	89.0122	$5,846.68		$1,169.34
61624	Transcath occlusion, cns		C					
61626	Transcath occlusion, non-cns		T	0082	89.0122	$5,846.68		$1,169.34
61630	Intracranial angioplasty		E					
61635	Intracran angioplsty w/stent		E					
61640	Dilate ic vasospasm, init		E					
61641	Dilate ic vasospasm add-on		E					
61642	Dilate ic vasospasm add-on		E					
61680	Intracranial vessel surgery		C					
61682	Intracranial vessel surgery		C					
61684	Intracranial vessel surgery		C					
61686	Intracranial vessel surgery		C					
61690	Intracranial vessel surgery		C					
61692	Intracranial vessel surgery		C					
61697	Brain aneurysm repr, complx		C					
61698	Brain aneurysm repr, complx		C					
61700	Brain aneurysm repr, simple		C					
61702	Inner skull vessel surgery		C					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
61703	Clamp neck artery		C					
61705	Revise circulation to head		C					
61708	Revise circulation to head		C					
61710	Revise circulation to head		C					
61711	Fusion of skull arteries		C					
61720	Incise skull/brain surgery		T	0221	36.1780	$2,376.32		$475.27
61735	Incise skull/brain surgery		C					
61750	Incise skull/brain biopsy		C					
61751	Brain biopsy w/ct/mr guide		C					
61760	Implant brain electrodes		C					
61770	Incise skull for treatment		T	0221	36.1780	$2,376.32		$475.27
61790	Treat trigeminal nerve		T	0220	18.4356	$1,210.92		$242.19
61791	Treat trigeminal tract		T	0203	14.6571	$962.74	$240.33	$192.55
61793	Focus radiation beam		B					
61795	Brain surgery using computer		N					
61850	Implant neuroelectrodes	CH	S	0061	80.4914	$5,287.00		$1,057.40
61860	Implant neuroelectrodes		C					
61863	Implant neuroelectrode		C					
61864	Implant neuroelectrde, addl		C					
61867	Implant neuroelectrode		C					
61868	Implant neuroelectrde, add'l		C					
61870	Implant neuroelectrodes		C					
61875	Implant neuroelectrodes		C					
61880	Revise/remove neuroelectrode		T	0687	19.4577	$1,278.06	$391.49	$255.62
61885	Insrt/redo neurostim 1 array		S	0039	182.4712	$11,985.44		$2,397.09
61886	Implant neurostim arrays		S	0315	269.8886	$17,727.36		$3,545.48
61888	Revise/remove neuroreceiver		T	0688	29.1033	$1,911.62	$762.66	$382.33
62000	Treat skull fracture		T	0254	24.6341	$1,618.07		$323.62
62005	Treat skull fracture		C					
62010	Treatment of head injury		C					
62100	Repair brain fluid leakage		C					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
62115	Reduction of skull defect		C					
62116	Reduction of skull defect		C					
62117	Reduction of skull defect		C					
62120	Repair skull cavity lesion		C					
62121	Incise skull repair		C					
62140	Repair of skull defect		C					
62141	Repair of skull defect		C					
62142	Remove skull plate/flap		C					
62143	Replace skull plate/flap		C					
62145	Repair of skull & brain		C					
62146	Repair of skull with graft		C					
62147	Repair of skull with graft		C					
62148	Retr bone flap to fix skull		C					
62160	Neuroendoscopy add-on		N					
62161	Dissect brain w/scope		C					
62162	Remove colloid cyst w/scope		C					
62163	Neuroendoscopy w/fb removal		C					
62164	Remove brain tumor w/scope		C					
62165	Remove pituit tumor w/scope		C					
62180	Establish brain cavity shunt		C					
62190	Establish brain cavity shunt		C					
62192	Establish brain cavity shunt		C					
62194	Replace/irrigate catheter	CH	T	0207	7.3510	$482.84		$96.57
62200	Establish brain cavity shunt		C					
62201	Brain cavity shunt w/scope		C					
62220	Establish brain cavity shunt		C					
62223	Establish brain cavity shunt		C					
62225	Replace/irrigate catheter		T	0427	15.5051	$1,018.44		$203.69
62230	Replace/revise brain shunt		T	0224	42.2017	$2,771.98		$554.40
62252	Csf shunt reprogram		S	0691	2.6410	$173.47	$50.49	$34.70
62256	Remove brain cavity shunt		C					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
62258	Replace brain cavity shunt		C					
62263	Epidural lysis mult sessions	CH	T	0207	7.3510	$482.84		$96.57
62264	Epidural lysis on single day		T	0203	14.6571	$962.74	$240.33	$192.55
62268	Drain spinal cord cyst	CH	T	0207	7.3510	$482.84		$96.57
62269	Needle biopsy, spinal cord		T	0685	9.6161	$631.62		$126.33
62270	Spinal fluid tap, diagnostic		T	0206	3.6940	$242.64	$52.09	$48.53
62272	Drain cerebro spinal fluid		T	0206	3.6940	$242.64	$52.09	$48.53
62273	Inject epidural patch		T	0206	3.6940	$242.64	$52.09	$48.53
62280	Treat spinal cord lesion		T	0207	7.3510	$482.84		$96.57
62281	Treat spinal cord lesion		T	0207	7.3510	$482.84		$96.57
62282	Treat spinal canal lesion		T	0207	7.3510	$482.84		$96.57
62284	Injection for myelogram		N					
62287	Percutaneous diskectomy		T	0221	36.1780	$2,376.32		$475.27
62290	Inject for spine disk x-ray		N					
62291	Inject for spine disk x-ray		N					
62292	Injection into disk lesion	CH	T	0207	7.3510	$482.84		$96.57
62294	Injection into spinal artery	CH	T	0207	7.3510	$482.84		$96.57
62310	Inject spine c/t		T	0207	7.3510	$482.84		$96.57
62311	Inject spine l/s (cd)		T	0207	7.3510	$482.84		$96.57
62318	Inject spine w/cath, c/t		T	0207	7.3510	$482.84		$96.57
62319	Inject spine w/cath l/s (cd)		T	0207	7.3510	$482.84		$96.57
62350	Implant spinal canal cath		T	0224	42.2017	$2,771.98		$554.40
62351	Implant spinal canal cath		T	0208	48.3964	$3,178.87		$635.78
62355	Remove spinal canal catheter		T	0203	14.6571	$962.74	$240.33	$192.55
62360	Insert spine infusion device		T	0224	42.2017	$2,771.98		$554.40
62361	Implant spine infusion pump		T	0227	184.6865	$12,130.95		$2,426.19
62362	Implant spine infusion pump		T	0227	184.6865	$12,130.95		$2,426.19
62365	Remove spine infusion device		T	0221	36.1780	$2,376.32		$475.27
62367	Analyze spine infusion pump	CH	S	0692	1.7241	$113.25		$22.65
62368	Analyze spine infusion pump		S	0691	2.6410	$173.47	$50.49	$34.70
63001	Removal of spinal lamina		T	0208	48.3964	$3,178.87		$635.78

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
63003	Removal of spinal lamina		T	0208	48.3964	$3,178.87		$635.78
63005	Removal of spinal lamina		T	0208	48.3964	$3,178.87		$635.78
63011	Removal of spinal lamina		T	0208	48.3964	$3,178.87		$635.78
63012	Removal of spinal lamina		T	0208	48.3964	$3,178.87		$635.78
63015	Removal of spinal lamina		T	0208	48.3964	$3,178.87		$635.78
63016	Removal of spinal lamina		T	0208	48.3964	$3,178.87		$635.78
63017	Removal of spinal lamina		T	0208	48.3964	$3,178.87		$635.78
63020	Neck spine disk surgery		T	0208	48.3964	$3,178.87		$635.78
63030	Low back disk surgery		T	0208	48.3964	$3,178.87		$635.78
63035	Spinal disk surgery add-on		T	0208	48.3964	$3,178.87		$635.78
63040	Laminotomy, single cervical		T	0208	48.3964	$3,178.87		$635.78
63042	Laminotomy, single lumbar		T	0208	48.3964	$3,178.87		$635.78
63043	Laminotomy, add'l cervical		C					
63044	Laminotomy, add'l lumbar		C					
63045	Removal of spinal lamina		T	0208	48.3964	$3,178.87		$635.78
63046	Removal of spinal lamina		T	0208	48.3964	$3,178.87		$635.78
63047	Removal of spinal lamina		T	0208	48.3964	$3,178.87		$635.78
63048	Remove spinal lamina add-on		T	0208	48.3964	$3,178.87		$635.78
63050	Cervical laminoplasty		C					
63051	C-laminoplasty w/graft/plate		C					
63055	Decompress spinal cord		T	0208	48.3964	$3,178.87		$635.78
63056	Decompress spinal cord		T	0208	48.3964	$3,178.87		$635.78
63057	Decompress spine cord add-on		T	0208	48.3964	$3,178.87		$635.78
63064	Decompress spinal cord		T	0208	48.3964	$3,178.87		$635.78
63066	Decompress spine cord add-on		T	0208	48.3964	$3,178.87		$635.78
63075	Neck spine disk surgery		T	0208	48.3964	$3,178.87		$635.78
63076	Neck spine disk surgery		C					
63077	Spine disk surgery, thorax		C					
63078	Spine disk surgery, thorax		C					
63081	Removal of vertebral body		C					
63082	Remove vertebral body add-on		C					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
63085	Removal of vertebral body		C					
63086	Remove vertebral body add-on		C					
63087	Removal of vertebral body		C					
63088	Remove vertebral body add-on		C					
63090	Removal of vertebral body		C					
63091	Remove vertebral body add-on		C					
63101	Removal of vertebral body		C					
63102	Removal of vertebral body		C					
63103	Remove vertebral body add-on		C					
63170	Incise spinal cord tract(s)		C					
63172	Drainage of spinal cyst		C					
63173	Drainage of spinal cyst		C					
63180	Revise spinal cord ligaments		C					
63182	Revise spinal cord ligaments		C					
63185	Incise spinal column/nerves		C					
63190	Incise spinal column/nerves		C					
63191	Incise spinal column/nerves		C					
63194	Incise spinal column & cord		C					
63195	Incise spinal column & cord		C					
63196	Incise spinal column & cord		C					
63197	Incise spinal column & cord		C					
63198	Incise spinal column & cord		C					
63199	Incise spinal column & cord		C					
63200	Release of spinal cord		C					
63250	Revise spinal cord vessels		C					
63251	Revise spinal cord vessels		C					
63252	Revise spinal cord vessels		C					
63265	Excise intraspinal lesion		C					
63266	Excise intraspinal lesion		C					
63267	Excise intraspinal lesion		C					
63268	Excise intraspinal lesion		C					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
63270	Excise intraspinal lesion		C					
63271	Excise intraspinal lesion		C					
63272	Excise intraspinal lesion		C					
63273	Excise intraspinal lesion		C					
63275	Biopsy/excise spinal tumor		C					
63276	Biopsy/excise spinal tumor		C					
63277	Biopsy/excise spinal tumor		C					
63278	Biopsy/excise spinal tumor		C					
63280	Biopsy/excise spinal tumor		C					
63281	Biopsy/excise spinal tumor		C					
63282	Biopsy/excise spinal tumor		C					
63283	Biopsy/excise spinal tumor		C					
63285	Biopsy/excise spinal tumor		C					
63286	Biopsy/excise spinal tumor		C					
63287	Biopsy/excise spinal tumor		C					
63290	Biopsy/excise spinal tumor		C					
63295	Repair of laminectomy defect		C					
63300	Removal of vertebral body		C					
63301	Removal of vertebral body		C					
63302	Removal of vertebral body		C					
63303	Removal of vertebral body		C					
63304	Removal of vertebral body		C					
63305	Removal of vertebral body		C					
63306	Removal of vertebral body		C					
63307	Removal of vertebral body		C					
63308	Remove vertebral body add-on		C					
63600	Remove spinal cord lesion		T	0220	18.4356	$1,210.92		$242.19
63610	Stimulation of spinal cord		T	0220	18.4356	$1,210.92		$242.19
63615	Remove lesion of spinal cord		T	0220	18.4356	$1,210.92		$242.19
63650	Implant neuroelectrodes		S	0040	64.4162	$4,231.11		$846.23
63655	Implant neuroelectrodes		S	0061	80.4914	$5,287.00		$1,057.40

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
63660	Revise/remove neuroelectrode		T	0687	19.4577	$1,278.06	$391.49	$255.62
63685	Insrt/redo spine n generator		S	0222	241.9400	$15,891.59		$3,178.32
63688	Revise/remove neuroreceiver		T	0688	29.1033	$1,911.62	$762.66	$382.33
63700	Repair of spinal herniation		C					
63702	Repair of spinal herniation		C					
63704	Repair of spinal herniation		C					
63706	Repair of spinal herniation		C					
63707	Repair spinal fluid leakage		C					
63709	Repair spinal fluid leakage		C					
63710	Graft repair of spine defect		C					
63740	Install spinal shunt		C					
63741	Install spinal shunt		T	0224	42.2017	$2,771.98		$554.40
63744	Revision of spinal shunt		T	0224	42.2017	$2,771.98		$554.40
63746	Removal of spinal shunt	CH	T	0203	14.6571	$962.74	$240.33	$192.55
64400	N block inj, trigeminal		T	0204	2.5055	$164.57	$40.13	$32.92
64402	N block inj, facial		T	0204	2.5055	$164.57	$40.13	$32.92
64405	N block inj, occipital		T	0206	3.6940	$242.64	$52.09	$48.53
64408	N block inj, vagus		T	0206	3.6940	$242.64	$52.09	$48.53
64410	N block inj, phrenic		T	0207	7.3510	$482.84		$96.57
64412	N block inj, spinal accessor		T	0207	7.3510	$482.84		$96.57
64413	N block inj, cervical plexus		T	0206	3.6940	$242.64	$52.09	$48.53
64415	N block inj, brachial plexus		T	0206	3.6940	$242.64	$52.09	$48.53
64416	N block cont infuse, b plex		T	0207	7.3510	$482.84		$96.57
64417	N block inj, axillary		T	0206	3.6940	$242.64	$52.09	$48.53
64418	N block inj, suprascapular		T	0206	3.6940	$242.64	$52.09	$48.53
64420	N block inj, intercost, sng		T	0206	3.6940	$242.64	$52.09	$48.53
64421	N block inj, intercost, mlt	CH	T	0207	7.3510	$482.84		$96.57
64425	N block inj, ilio-ing/hypogi		T	0206	3.6940	$242.64	$52.09	$48.53
64430	N block inj, pudendal		T	0207	7.3510	$482.84		$96.57
64435	N block inj, paracervical		T	0206	3.6940	$242.64	$52.09	$48.53
64445	N block inj, sciatic, sng		T	0206	3.6940	$242.64	$52.09	$48.53

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
64446	N blk inj, sciatic, cont inf		T	0203	14.6571	$962.74	$240.33	$192.55
64447	N block inj fem, single		T	0206	3.6940	$242.64	$52.09	$48.53
64448	N block inj fem, cont inf		T	0206	3.6940	$242.64	$52.09	$48.53
64449	N block inj, lumbar plexus		T	0207	7.3510	$482.84		$96.57
64450	N block, other peripheral		T	0206	3.6940	$242.64	$52.09	$48.53
64470	Inj paravertebral c/t		T	0207	7.3510	$482.84		$96.57
64472	Inj paravertebral c/t add-on		T	0206	3.6940	$242.64	$52.09	$48.53
64475	Inj paravertebral l/s		T	0207	7.3510	$482.84		$96.57
64476	Inj paravertebral l/s add-on		T	0204	2.5055	$164.57	$40.13	$32.92
64479	Inj foramen epidural c/t		T	0207	7.3510	$482.84		$96.57
64480	Inj foramen epidural add-on		T	0206	3.6940	$242.64	$52.09	$48.53
64483	Inj foramen epidural l/s		T	0207	7.3510	$482.84		$96.57
64484	Inj foramen epidural add-on		T	0206	3.6940	$242.64	$52.09	$48.53
64505	N block, spenopalatine gangl		T	0204	2.5055	$164.57	$40.13	$32.92
64508	N block, carotid sinus s/p		T	0204	2.5055	$164.57	$40.13	$32.92
64510	N block, stellate ganglion		T	0207	7.3510	$482.84		$96.57
64517	N block inj, hypogas plxs		T	0207	7.3510	$482.84		$96.57
64520	N block, lumbar/thoracic		T	0207	7.3510	$482.84		$96.57
64530	N block inj, celiac pelus		T	0207	7.3510	$482.84		$96.57
64550	Apply neurostimulator		A					
64553	Implant neuroelectrodes		S	0225	101.1630	$6,644.79		$1,328.96
64555	Implant neuroelectrodes		S	0040	64.4162	$4,231.11		$846.23
64560	Implant neuroelectrodes		S	0040	64.4162	$4,231.11		$846.23
64561	Implant neuroelectrodes		S	0040	64.4162	$4,231.11		$846.23
64565	Implant neuroelectrodes		S	0040	64.4162	$4,231.11		$846.23
64573	Implant neuroelectrodes		S	0225	101.1630	$6,644.79		$1,328.96
64575	Implant neuroelectrodes		S	0061	80.4914	$5,287.00		$1,057.40
64577	Implant neuroelectrodes		S	0061	80.4914	$5,287.00		$1,057.40
64580	Implant neuroelectrodes		S	0061	80.4914	$5,287.00		$1,057.40
64581	Implant neuroelectrodes		S	0061	80.4914	$5,287.00		$1,057.40
64585	Revise/remove neuroelectrode		T	0687	19.4577	$1,278.06	$391.49	$255.62

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
64590	Insrt/redo pn/gastr stimul		S	0039	182.4712	$11,985.44		$2,397.09
64595	Revise/rmv pn/gastr stimul		T	0688	29.1033	$1,911.62	$762.66	$382.33
64600	Injection treatment of nerve		T	0203	14.6571	$962.74	$240.33	$192.55
64605	Injection treatment of nerve		T	0203	14.6571	$962.74	$240.33	$192.55
64610	Injection treatment of nerve		T	0203	14.6571	$962.74	$240.33	$192.55
64612	Destroy nerve, face muscle		T	0204	2.5055	$164.57	$40.13	$32.92
64613	Destroy nerve, neck muscle	CH	T	0206	3.6940	$242.64	$52.09	$48.53
64614	Destroy nerve, extrem musc	CH	T	0206	3.6940	$242.64	$52.09	$48.53
64620	Injection treatment of nerve		T	0207	7.3510	$482.84		$96.57
64622	Destr paravertebrl nerve l/s		T	0203	14.6571	$962.74	$240.33	$192.55
64623	Destr paravertebral n add-on		T	0207	7.3510	$482.84		$96.57
64626	Destr paravertebrl nerve c/t		T	0203	14.6571	$962.74	$240.33	$192.55
64627	Destr paravertebral n add-on		T	0204	2.5055	$164.57	$40.13	$32.92
64630	Injection treatment of nerve		T	0207	7.3510	$482.84		$96.57
64640	Injection treatment of nerve		T	0207	7.3510	$482.84		$96.57
64650	Chemodenerv eccrine glands		T	0204	2.5055	$164.57	$40.13	$32.92
64653	Chemodenerv eccrine glands		T	0204	2.5055	$164.57	$40.13	$32.92
64680	Injection treatment of nerve		T	0203	14.6571	$962.74	$240.33	$192.55
64681	Injection treatment of nerve		T	0203	14.6571	$962.74	$240.33	$192.55
64702	Revise finger/toe nerve		T	0220	18.4356	$1,210.92		$242.19
64704	Revise hand/foot nerve		T	0220	18.4356	$1,210.92		$242.19
64708	Revise arm/leg nerve		T	0220	18.4356	$1,210.92		$242.19
64712	Revision of sciatic nerve		T	0220	18.4356	$1,210.92		$242.19
64713	Revision of arm nerve(s)		T	0220	18.4356	$1,210.92		$242.19
64714	Revise low back nerve(s)		T	0220	18.4356	$1,210.92		$242.19
64716	Revision of cranial nerve		T	0220	18.4356	$1,210.92		$242.19
64718	Revise ulnar nerve at elbow		T	0220	18.4356	$1,210.92		$242.19
64719	Revise ulnar nerve at wrist		T	0220	18.4356	$1,210.92		$242.19
64721	Carpal tunnel surgery		T	0220	18.4356	$1,210.92		$242.19
64722	Relieve pressure on nerve(s)		T	0220	18.4356	$1,210.92		$242.19
64726	Release foot/toe nerve		T	0220	18.4356	$1,210.92		$242.19

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
64727	Internal nerve revision		T	0220	18.4356	$1,210.92		$242.19
64732	Incision of brow nerve		T	0220	18.4356	$1,210.92		$242.19
64734	Incision of cheek nerve		T	0220	18.4356	$1,210.92		$242.19
64736	Incision of chin nerve		T	0220	18.4356	$1,210.92		$242.19
64738	Incision of jaw nerve		T	0220	18.4356	$1,210.92		$242.19
64740	Incision of tongue nerve		T	0220	18.4356	$1,210.92		$242.19
64742	Incision of facial nerve		T	0220	18.4356	$1,210.92		$242.19
64744	Incise nerve, back of head		T	0220	18.4356	$1,210.92		$242.19
64746	Incise diaphragm nerve		T	0220	18.4356	$1,210.92		$242.19
64752	Incision of vagus nerve		C					
64755	Incision of stomach nerves		C					
64760	Incision of vagus nerve		C					
64761	Incision of pelvis nerve		T	0220	18.4356	$1,210.92		$242.19
64763	Incise hip/thigh nerve		T	0220	18.4356	$1,210.92		$242.19
64766	Incise hip/thigh nerve		T	0221	36.1780	$2,376.32		$475.27
64771	Sever cranial nerve		T	0220	18.4356	$1,210.92		$242.19
64772	Incision of spinal nerve		T	0220	18.4356	$1,210.92		$242.19
64774	Remove skin nerve lesion		T	0220	18.4356	$1,210.92		$242.19
64776	Remove digit nerve lesion		T	0220	18.4356	$1,210.92		$242.19
64778	Digit nerve surgery add-on		T	0220	18.4356	$1,210.92		$242.19
64782	Remove limb nerve lesion		T	0220	18.4356	$1,210.92		$242.19
64783	Limb nerve surgery add-on		T	0220	18.4356	$1,210.92		$242.19
64784	Remove nerve lesion		T	0220	18.4356	$1,210.92		$242.19
64786	Remove sciatic nerve lesion		T	0221	36.1780	$2,376.32		$475.27
64787	Implant nerve end		T	0220	18.4356	$1,210.92		$242.19
64788	Remove skin nerve lesion		T	0220	18.4356	$1,210.92		$242.19
64790	Removal of nerve lesion		T	0220	18.4356	$1,210.92		$242.19
64792	Removal of nerve lesion		T	0221	36.1780	$2,376.32		$475.27
64795	Biopsy of nerve		T	0220	18.4356	$1,210.92		$242.19
64802	Remove sympathetic nerves		T	0220	18.4356	$1,210.92		$242.19
64804	Remove sympathetic nerves		T	0220	18.4356	$1,210.92		$242.19

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
64809	Remove sympathetic nerves		C					
64818	Remove sympathetic nerves		C					
64820	Remove sympathetic nerves		T	0220	18.4356	$1,210.92		$242.19
64821	Remove sympathetic nerves		T	0054	28.1744	$1,850.61		$370.13
64822	Remove sympathetic nerves		T	0054	28.1744	$1,850.61		$370.13
64823	Remove sympathetic nerves		T	0054	28.1744	$1,850.61		$370.13
64831	Repair of digit nerve		T	0221	36.1780	$2,376.32		$475.27
64832	Repair nerve add-on		T	0221	36.1780	$2,376.32		$475.27
64834	Repair of hand or foot nerve		T	0221	36.1780	$2,376.32		$475.27
64835	Repair of hand or foot nerve		T	0221	36.1780	$2,376.32		$475.27
64836	Repair of hand or foot nerve		T	0221	36.1780	$2,376.32		$475.27
64837	Repair nerve add-on		T	0221	36.1780	$2,376.32		$475.27
64840	Repair of leg nerve		T	0221	36.1780	$2,376.32		$475.27
64856	Repair/transpose nerve		T	0221	36.1780	$2,376.32		$475.27
64857	Repair arm/leg nerve		T	0221	36.1780	$2,376.32		$475.27
64858	Repair sciatic nerve		T	0221	36.1780	$2,376.32		$475.27
64859	Nerve surgery		T	0221	36.1780	$2,376.32		$475.27
64861	Repair of arm nerves		T	0221	36.1780	$2,376.32		$475.27
64862	Repair of low back nerves		T	0221	36.1780	$2,376.32		$475.27
64864	Repair of facial nerve		T	0221	36.1780	$2,376.32		$475.27
64865	Repair of facial nerve		T	0221	36.1780	$2,376.32		$475.27
64866	Fusion of facial/other nerve		C					
64868	Fusion of facial/other nerve		C					
64870	Fusion of facial/other nerve		T	0221	36.1780	$2,376.32		$475.27
64872	Subsequent repair of nerve		T	0221	36.1780	$2,376.32		$475.27
64874	Repair & revise nerve add-on		T	0221	36.1780	$2,376.32		$475.27
64876	Repair nerve/shorten bone		T	0221	36.1780	$2,376.32		$475.27
64885	Nerve graft, head or neck		T	0221	36.1780	$2,376.32		$475.27
64886	Nerve graft, head or neck		T	0221	36.1780	$2,376.32		$475.27
64890	Nerve graft, hand or foot		T	0221	36.1780	$2,376.32		$475.27
64891	Nerve graft, hand or foot		T	0221	36.1780	$2,376.32		$475.27

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
64892	Nerve graft, arm or leg		T	0221	36.1780	$2,376.32		$475.27
64893	Nerve graft, arm or leg		T	0221	36.1780	$2,376.32		$475.27
64895	Nerve graft, hand or foot		T	0221	36.1780	$2,376.32		$475.27
64896	Nerve graft, hand or foot		T	0221	36.1780	$2,376.32		$475.27
64897	Nerve graft, arm or leg		T	0221	36.1780	$2,376.32		$475.27
64898	Nerve graft, arm or leg		T	0221	36.1780	$2,376.32		$475.27
64901	Nerve graft add-on		T	0221	36.1780	$2,376.32		$475.27
64902	Nerve graft add-on		T	0221	36.1780	$2,376.32		$475.27
64905	Nerve pedicle transfer		T	0221	36.1780	$2,376.32		$475.27
64907	Nerve pedicle transfer		T	0221	36.1780	$2,376.32		$475.27
64910	Nerve repair w/allograft	CH	T	0221	36.1780	$2,376.32		$475.27
64911	Neurorraphy w/vein autograft	CH	T	0221	36.1780	$2,376.32		$475.27
64999	Nervous system surgery		T	0204	2.5055	$164.57	$40.13	$32.92
65091	Revise eye		T	0242	38.2210	$2,510.51	$597.36	$502.11
65093	Revise eye with implant		T	0242	38.2210	$2,510.51	$597.36	$502.11
65101	Removal of eye		T	0242	38.2210	$2,510.51	$597.36	$502.11
65103	Remove eye/insert implant		T	0242	38.2210	$2,510.51	$597.36	$502.11
65105	Remove eye/attach implant		T	0242	38.2210	$2,510.51	$597.36	$502.11
65110	Removal of eye		T	0242	38.2210	$2,510.51	$597.36	$502.11
65112	Remove eye/revise socket		T	0242	38.2210	$2,510.51	$597.36	$502.11
65114	Remove eye/revise socket		T	0242	38.2210	$2,510.51	$597.36	$502.11
65125	Revise ocular implant	CH	T	0241	25.4908	$1,674.34	$383.45	$334.87
65130	Insert ocular implant		T	0241	25.4908	$1,674.34	$383.45	$334.87
65135	Insert ocular implant		T	0241	25.4908	$1,674.34	$383.45	$334.87
65140	Attach ocular implant		T	0242	38.2210	$2,510.51	$597.36	$502.11
65150	Revise ocular implant		T	0241	25.4908	$1,674.34	$383.45	$334.87
65155	Reinsert ocular implant		T	0242	38.2210	$2,510.51	$597.36	$502.11
65175	Removal of ocular implant		T	0240	19.1444	$1,257.48	$309.52	$251.50
65205	Remove foreign body from eye		S	0698	0.9139	$60.03		$12.01
65210	Remove foreign body from eye		S	0698	0.9139	$60.03		$12.01
65220	Remove foreign body from eye		S	0698	0.9139	$60.03		$12.01

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
65222	Remove foreign body from eye		S	0698	0.9139	$60.03		$12.01
65235	Remove foreign body from eye		T	0233	16.3116	$1,071.41	$266.33	$214.29
65260	Remove foreign body from eye	CH	T	0235	5.8210	$382.35		$76.47
65265	Remove foreign body from eye		T	0237	22.0653	$1,449.34		$289.87
65270	Repair of eye wound		T	0240	19.1444	$1,257.48	$309.52	$251.50
65272	Repair of eye wound		T	0234	23.9886	$1,575.67	$511.31	$315.14
65273	Repair of eye wound		C					
65275	Repair of eye wound		T	0234	23.9886	$1,575.67	$511.31	$315.14
65280	Repair of eye wound	CH	T	0237	22.0653	$1,449.34		$289.87
65285	Repair of eye wound		T	0672	37.8896	$2,488.74		$497.75
65286	Repair of eye wound		T	0232	4.5980	$302.02	$75.66	$60.41
65290	Repair of eye socket wound		T	0243	24.5085	$1,609.82	$430.35	$321.97
65400	Removal of eye lesion		T	0233	16.3116	$1,071.41	$266.33	$214.29
65410	Biopsy of cornea		T	0233	16.3116	$1,071.41	$266.33	$214.29
65420	Removal of eye lesion		T	0233	16.3116	$1,071.41	$266.33	$214.29
65426	Removal of eye lesion		T	0234	23.9886	$1,575.67	$511.31	$315.14
65430	Corneal smear		S	0698	0.9139	$60.03		$12.01
65435	Curette/treat cornea		T	0239	7.8833	$517.81		$103.57
65436	Curette/treat cornea		T	0233	16.3116	$1,071.41	$266.33	$214.29
65450	Treatment of corneal lesion		S	0231	2.1019	$138.06		$27.62
65600	Revision of cornea		T	0240	19.1444	$1,257.48	$309.52	$251.50
65710	Corneal transplant		T	0244	37.6829	$2,475.16	$803.26	$495.04
65730	Corneal transplant		T	0244	37.6829	$2,475.16	$803.26	$495.04
65750	Corneal transplant		T	0244	37.6829	$2,475.16	$803.26	$495.04
65755	Corneal transplant		T	0244	37.6829	$2,475.16	$803.26	$495.04
65760	Revision of cornea		E					
65765	Revision of cornea		E					
65767	Corneal tissue transplant		E					
65770	Revise cornea with implant		T	0293	113.2439	$7,438.31		$1,487.67
65771	Radial keratotomy		E					
65772	Correction of astigmatism		T	0233	16.3116	$1,071.41	$266.33	$214.29

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
65775	Correction of astigmatism		T	0233	16.3116	$1,071.41	$266.33	$214.29
65780	Ocular reconst, transplant		T	0244	37.6829	$2,475.16	$803.26	$495.04
65781	Ocular reconst, transplant		T	0244	37.6829	$2,475.16	$803.26	$495.04
65782	Ocular reconst, transplant		T	0244	37.6829	$2,475.16	$803.26	$495.04
65800	Drainage of eye		T	0233	16.3116	$1,071.41	$266.33	$214.29
65805	Drainage of eye		T	0233	16.3116	$1,071.41	$266.33	$214.29
65810	Drainage of eye		T	0234	23.9886	$1,575.67	$511.31	$315.14
65815	Drainage of eye		T	0234	23.9886	$1,575.67	$511.31	$315.14
65820	Relieve inner eye pressure		T	0232	4.5980	$302.02	$75.66	$60.41
65850	Incision of eye		T	0234	23.9886	$1,575.67	$511.31	$315.14
65855	Laser surgery of eye		T	0247	5.3324	$350.25	$104.31	$70.05
65860	Incise inner eye adhesions		T	0247	5.3324	$350.25	$104.31	$70.05
65865	Incise inner eye adhesions		T	0233	16.3116	$1,071.41	$266.33	$214.29
65870	Incise inner eye adhesions		T	0234	23.9886	$1,575.67	$511.31	$315.14
65875	Incise inner eye adhesions		T	0234	23.9886	$1,575.67	$511.31	$315.14
65880	Incise inner eye adhesions		T	0233	16.3116	$1,071.41	$266.33	$214.29
65900	Remove eye lesion		T	0233	16.3116	$1,071.41	$266.33	$214.29
65920	Remove implant of eye		T	0234	23.9886	$1,575.67	$511.31	$315.14
65930	Remove blood clot from eye		T	0234	23.9886	$1,575.67	$511.31	$315.14
66020	Injection treatment of eye		T	0233	16.3116	$1,071.41	$266.33	$214.29
66030	Injection treatment of eye		T	0232	4.5980	$302.02	$75.66	$60.41
66130	Remove eye lesion		T	0234	23.9886	$1,575.67	$511.31	$315.14
66150	Glaucoma surgery		T	0234	23.9886	$1,575.67	$511.31	$315.14
66155	Glaucoma surgery		T	0234	23.9886	$1,575.67	$511.31	$315.14
66160	Glaucoma surgery		T	0234	23.9886	$1,575.67	$511.31	$315.14
66165	Glaucoma surgery		T	0234	23.9886	$1,575.67	$511.31	$315.14
66170	Glaucoma surgery		T	0234	23.9886	$1,575.67	$511.31	$315.14
66172	Incision of eye		T	0234	23.9886	$1,575.67	$511.31	$315.14
66180	Implant eye shunt		T	0673	40.1189	$2,635.17	$649.56	$527.04
66185	Revise eye shunt		T	0673	40.1189	$2,635.17	$649.56	$527.04
66220	Repair eye lesion		T	0672	37.8896	$2,488.74		$497.75

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
66225	Repair/graft eye lesion		T	0673	40.1189	$2,635.17	$649.56	$527.04
66250	Follow-up surgery of eye		T	0233	16.3116	$1,071.41	$266.33	$214.29
66500	Incision of iris		T	0232	4.5980	$302.02	$75.66	$60.41
66505	Incision of iris		T	0232	4.5980	$302.02	$75.66	$60.41
66600	Remove iris and lesion		T	0234	23.9886	$1,575.67	$511.31	$315.14
66605	Removal of iris		T	0234	23.9886	$1,575.67	$511.31	$315.14
66625	Removal of iris		T	0232	4.5980	$302.02	$75.66	$60.41
66630	Removal of iris		T	0234	23.9886	$1,575.67	$511.31	$315.14
66635	Removal of iris		T	0234	23.9886	$1,575.67	$511.31	$315.14
66680	Repair iris & ciliary body		T	0234	23.9886	$1,575.67	$511.31	$315.14
66682	Repair iris & ciliary body		T	0234	23.9886	$1,575.67	$511.31	$315.14
66700	Destruction, ciliary body		T	0233	16.3116	$1,071.41	$266.33	$214.29
66710	Ciliary transscleral therapy		T	0233	16.3116	$1,071.41	$266.33	$214.29
66711	Ciliary endoscopic ablation		T	0233	16.3116	$1,071.41	$266.33	$214.29
66720	Destruction, ciliary body		T	0233	16.3116	$1,071.41	$266.33	$214.29
66740	Destruction, ciliary body		T	0234	23.9886	$1,575.67	$511.31	$315.14
66761	Revision of iris		T	0247	5.3324	$350.25	$104.31	$70.05
66762	Revision of iris		T	0247	5.3324	$350.25	$104.31	$70.05
66770	Removal of inner eye lesion		T	0247	5.3324	$350.25	$104.31	$70.05
66820	Incision, secondary cataract		T	0232	4.5980	$302.02	$75.66	$60.41
66821	After cataract laser surgery		T	0247	5.3324	$350.25	$104.31	$70.05
66825	Reposition intraocular lens		T	0234	23.9886	$1,575.67	$511.31	$315.14
66830	Removal of lens lesion		T	0232	4.5980	$302.02	$75.66	$60.41
66840	Removal of lens material		T	0245	14.1643	$930.37	$212.54	$186.08
66850	Removal of lens material		T	0249	31.3050	$2,056.24	$524.67	$411.25
66852	Removal of lens material		T	0249	31.3050	$2,056.24	$524.67	$411.25
66920	Extraction of lens		T	0249	31.3050	$2,056.24	$524.67	$411.25
66930	Extraction of lens		T	0249	31.3050	$2,056.24	$524.67	$411.25
66940	Extraction of lens		T	0245	14.1643	$930.37	$212.54	$186.08
66982	Cataract surgery, complex		T	0246	24.1528	$1,586.45	$495.96	$317.29
66983	Cataract surg w/iol, 1 stage		T	0246	24.1528	$1,586.45	$495.96	$317.29

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
66984	Cataract surg w/iol, 1 stage		T	0246	24.1528	$1,586.45	$495.96	$317.29
66985	Insert lens prosthesis		T	0246	24.1528	$1,586.45	$495.96	$317.29
66986	Exchange lens prosthesis		T	0246	24.1528	$1,586.45	$495.96	$317.29
66990	Ophthalmic endoscope add-on		N					
66999	Eye surgery procedure		T	0232	4.5980	$302.02	$75.66	$60.41
67005	Partial removal of eye fluid		T	0237	22.0653	$1,449.34		$289.87
67010	Partial removal of eye fluid		T	0237	22.0653	$1,449.34		$289.87
67015	Release of eye fluid	CH	T	0672	37.8896	$2,488.74		$497.75
67025	Replace eye fluid		T	0237	22.0653	$1,449.34		$289.87
67027	Implant eye drug system		T	0672	37.8896	$2,488.74		$497.75
67028	Injection eye drug	CH	T	0238	2.9984	$196.95		$39.39
67030	Incise inner eye strands	CH	T	0237	22.0653	$1,449.34		$289.87
67031	Laser surgery, eye strands		T	0247	5.3324	$350.25	$104.31	$70.05
67036	Removal of inner eye fluid		T	0672	37.8896	$2,488.74		$497.75
67039	Laser treatment of retina		T	0672	37.8896	$2,488.74		$497.75
67040	Laser treatment of retina		T	0672	37.8896	$2,488.74		$497.75
67041	Vit for macular pucker		T	0672	37.8896	$2,488.74		$497.75
67042	Vit for macular hole		T	0672	37.8896	$2,488.74		$497.75
67043	Vit for membrane dissect		T	0672	37.8896	$2,488.74		$497.75
67101	Repair detached retina	CH	T	0235	5.8210	$382.35		$76.47
67105	Repair detached retina		T	0247	5.3324	$350.25	$104.31	$70.05
67107	Repair detached retina		T	0672	37.8896	$2,488.74		$497.75
67108	Repair detached retina		T	0672	37.8896	$2,488.74		$497.75
67110	Repair detached retina	CH	T	0237	22.0653	$1,449.34		$289.87
67112	Rerepair detached retina		T	0672	37.8896	$2,488.74		$497.75
67113	Repair retinal detach, cplx		T	0672	37.8896	$2,488.74		$497.75
67115	Release encircling material	CH	T	0237	22.0653	$1,449.34		$289.87
67120	Remove eye implant material	CH	T	0237	22.0653	$1,449.34		$289.87
67121	Remove eye implant material		T	0237	22.0653	$1,449.34		$289.87
67141	Treatment of retina		T	0235	5.8210	$382.35		$76.47
67145	Treatment of retina		T	0247	5.3324	$350.25	$104.31	$70.05

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
67208	Treatment of retinal lesion	CH	T	0235	5.8210	$382.35		$76.47
67210	Treatment of retinal lesion		T	0247	5.3324	$350.25	$104.31	$70.05
67218	Treatment of retinal lesion	CH	T	0237	22.0653	$1,449.34		$289.87
67220	Treatment of choroid lesion		T	0235	5.8210	$382.35		$76.47
67221	Ocular photodynamic ther		T	0235	5.8210	$382.35		$76.47
67225	Eye photodynamic ther add-on		T	0235	5.8210	$382.35		$76.47
67227	Treatment of retinal lesion		T	0237	22.0653	$1,449.34		$289.87
67228	Treatment of retinal lesion		T	0247	5.3324	$350.25	$104.31	$70.05
67229	Tr retinal les preterm inf		T	0247	5.3324	$350.25	$104.31	$70.05
67250	Reinforce eye wall		T	0240	19.1444	$1,257.48	$309.52	$251.50
67255	Reinforce/graft eye wall		T	0237	22.0653	$1,449.34		$289.87
67299	Eye surgery procedure		T	0235	5.8210	$382.35		$76.47
67311	Revise eye muscle		T	0243	24.5085	$1,609.82	$430.35	$321.97
67312	Revise two eye muscles		T	0243	24.5085	$1,609.82	$430.35	$321.97
67314	Revise eye muscle		T	0243	24.5085	$1,609.82	$430.35	$321.97
67316	Revise two eye muscles		T	0243	24.5085	$1,609.82	$430.35	$321.97
67318	Revise eye muscle(s)		T	0243	24.5085	$1,609.82	$430.35	$321.97
67320	Revise eye muscle(s) add-on		T	0243	24.5085	$1,609.82	$430.35	$321.97
67331	Eye surgery follow-up add-on		T	0243	24.5085	$1,609.82	$430.35	$321.97
67332	Rerevise eye muscles add-on		T	0243	24.5085	$1,609.82	$430.35	$321.97
67334	Revise eye muscle w/suture		T	0243	24.5085	$1,609.82	$430.35	$321.97
67335	Eye suture during surgery		T	0243	24.5085	$1,609.82	$430.35	$321.97
67340	Revise eye muscle add-on		T	0243	24.5085	$1,609.82	$430.35	$321.97
67343	Release eye tissue		T	0243	24.5085	$1,609.82	$430.35	$321.97
67345	Destroy nerve of eye muscle		T	0238	2.9984	$196.95		$39.39
67346	Biopsy, eye muscle		T	0699	14.3730	$944.08		$188.82
67399	Eye muscle surgery procedure		T	0243	24.5085	$1,609.82	$430.35	$321.97
67400	Explore/biopsy eye socket	CH	T	0240	19.1444	$1,257.48	$309.52	$251.50
67405	Explore/drain eye socket		T	0241	25.4908	$1,674.34	$383.45	$334.87
67412	Explore/treat eye socket	CH	T	0240	19.1444	$1,257.48	$309.52	$251.50
67413	Explore/treat eye socket		T	0241	25.4908	$1,674.34	$383.45	$334.87

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
67414	Explr/decompress eye socket		T	0242	38.2210	$2,510.51	$597.36	$502.11
67415	Aspiration, orbital contents		T	0240	19.1444	$1,257.48	$309.52	$251.50
67420	Explore/treat eye socket		T	0242	38.2210	$2,510.51	$597.36	$502.11
67430	Explore/treat eye socket		T	0242	38.2210	$2,510.51	$597.36	$502.11
67440	Explore/drain eye socket		T	0242	38.2210	$2,510.51	$597.36	$502.11
67445	Explr/decompress eye socket		T	0242	38.2210	$2,510.51	$597.36	$502.11
67450	Explore/biopsy eye socket		T	0242	38.2210	$2,510.51	$597.36	$502.11
67500	Inject/treat eye socket		S	0231	2.1019	$138.06		$27.62
67505	Inject/treat eye socket		T	0238	2.9984	$196.95		$39.39
67515	Inject/treat eye socket		T	0238	2.9984	$196.95		$39.39
67550	Insert eye socket implant		T	0242	38.2210	$2,510.51	$597.36	$502.11
67560	Revise eye socket implant		T	0241	25.4908	$1,674.34	$383.45	$334.87
67570	Decompress optic nerve		T	0242	38.2210	$2,510.51	$597.36	$502.11
67599	Orbit surgery procedure		T	0238	2.9984	$196.95		$39.39
67700	Drainage of eyelid abscess		T	0238	2.9984	$196.95		$39.39
67710	Incision of eyelid		T	0239	7.8833	$517.81		$103.57
67715	Incision of eyelid fold		T	0240	19.1444	$1,257.48	$309.52	$251.50
67800	Remove eyelid lesion		T	0238	2.9984	$196.95		$39.39
67801	Remove eyelid lesions		T	0239	7.8833	$517.81		$103.57
67805	Remove eyelid lesions		T	0238	2.9984	$196.95		$39.39
67808	Remove eyelid lesion(s)		T	0240	19.1444	$1,257.48	$309.52	$251.50
67810	Biopsy of eyelid		T	0238	2.9984	$196.95		$39.39
67820	Revise eyelashes		S	0698	0.9139	$60.03		$12.01
67825	Revise eyelashes		T	0238	2.9984	$196.95		$39.39
67830	Revise eyelashes		T	0239	7.8833	$517.81		$103.57
67835	Revise eyelashes		T	0240	19.1444	$1,257.48	$309.52	$251.50
67840	Remove eyelid lesion		T	0239	7.8833	$517.81		$103.57
67850	Treat eyelid lesion		T	0239	7.8833	$517.81		$103.57
67875	Closure of eyelid by suture		T	0239	7.8833	$517.81		$103.57
67880	Revision of eyelid		T	0233	16.3116	$1,071.41	$266.33	$214.29
67882	Revision of eyelid		T	0240	19.1444	$1,257.48	$309.52	$251.50

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
67900	Repair brow defect	CH	T	0241	25.4908	$1,674.34	$383.45	$334.87
67901	Repair eyelid defect		T	0240	19.1444	$1,257.48	$309.52	$251.50
67902	Repair eyelid defect	CH	T	0241	25.4908	$1,674.34	$383.45	$334.87
67903	Repair eyelid defect		T	0240	19.1444	$1,257.48	$309.52	$251.50
67904	Repair eyelid defect		T	0240	19.1444	$1,257.48	$309.52	$251.50
67906	Repair eyelid defect		T	0240	19.1444	$1,257.48	$309.52	$251.50
67908	Repair eyelid defect		T	0240	19.1444	$1,257.48	$309.52	$251.50
67909	Revise eyelid defect		T	0240	19.1444	$1,257.48	$309.52	$251.50
67911	Revise eyelid defect		T	0240	19.1444	$1,257.48	$309.52	$251.50
67912	Correction eyelid w/implant		T	0240	19.1444	$1,257.48	$309.52	$251.50
67914	Repair eyelid defect		T	0240	19.1444	$1,257.48	$309.52	$251.50
67915	Repair eyelid defect		T	0240	19.1444	$1,257.48	$309.52	$251.50
67916	Repair eyelid defect		T	0240	19.1444	$1,257.48	$309.52	$251.50
67917	Repair eyelid defect		T	0240	19.1444	$1,257.48	$309.52	$251.50
67921	Repair eyelid defect		T	0240	19.1444	$1,257.48	$309.52	$251.50
67922	Repair eyelid defect		T	0240	19.1444	$1,257.48	$309.52	$251.50
67923	Repair eyelid defect		T	0240	19.1444	$1,257.48	$309.52	$251.50
67924	Repair eyelid defect		T	0240	19.1444	$1,257.48	$309.52	$251.50
67930	Repair eyelid wound		T	0240	19.1444	$1,257.48	$309.52	$251.50
67935	Repair eyelid wound		T	0240	19.1444	$1,257.48	$309.52	$251.50
67938	Remove eyelid foreign body		S	0231	2.1019	$138.06		$27.62
67950	Revision of eyelid		T	0240	19.1444	$1,257.48	$309.52	$251.50
67961	Revision of eyelid		T	0240	19.1444	$1,257.48	$309.52	$251.50
67966	Revision of eyelid		T	0240	19.1444	$1,257.48	$309.52	$251.50
67971	Reconstruction of eyelid	CH	T	0240	19.1444	$1,257.48	$309.52	$251.50
67973	Reconstruction of eyelid		T	0241	25.4908	$1,674.34	$383.45	$334.87
67974	Reconstruction of eyelid	CH	T	0240	19.1444	$1,257.48	$309.52	$251.50
67975	Reconstruction of eyelid		T	0240	19.1444	$1,257.48	$309.52	$251.50
67999	Revision of eyelid		T	0238	2.9984	$196.95		$39.39
68020	Incise/drain eyelid lining	CH	T	0238	2.9984	$196.95		$39.39
68040	Treatment of eyelid lesions		S	0698	0.9139	$60.03		$12.01

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
68100	Biopsy of eyelid lining		T	0232	4.5980	$302.02	$75.66	$60.41
68110	Remove eyelid lining lesion		T	0699	14.3730	$944.08		$188.82
68115	Remove eyelid lining lesion		T	0240	19.1444	$1,257.48	$309.52	$251.50
68130	Remove eyelid lining lesion		T	0233	16.3116	$1,071.41	$266.33	$214.29
68135	Remove eyelid lining lesion		T	0239	7.8833	$517.81		$103.57
68200	Treat eyelid by injection		S	0698	0.9139	$60.03		$12.01
68320	Revise/graft eyelid lining	CH	T	0241	25.4908	$1,674.34	$383.45	$334.87
68325	Revise/graft eyelid lining		T	0241	25.4908	$1,674.34	$383.45	$334.87
68326	Revise/graft eyelid lining	CH	T	0240	19.1444	$1,257.48	$309.52	$251.50
68328	Revise/graft eyelid lining		T	0241	25.4908	$1,674.34	$383.45	$334.87
68330	Revise eyelid lining		T	0234	23.9886	$1,575.67	$511.31	$315.14
68335	Revise/graft eyelid lining		T	0241	25.4908	$1,674.34	$383.45	$334.87
68340	Separate eyelid adhesions		T	0240	19.1444	$1,257.48	$309.52	$251.50
68360	Revise eyelid lining		T	0234	23.9886	$1,575.67	$511.31	$315.14
68362	Revise eyelid lining		T	0234	23.9886	$1,575.67	$511.31	$315.14
68371	Harvest eye tissue, alograft		T	0233	16.3116	$1,071.41	$266.33	$214.29
68399	Eyelid lining surgery		T	0238	2.9984	$196.95		$39.39
68400	Incise/drain tear gland		T	0238	2.9984	$196.95		$39.39
68420	Incise/drain tear sac		T	0240	19.1444	$1,257.48	$309.52	$251.50
68440	Incise tear duct opening		T	0238	2.9984	$196.95		$39.39
68500	Removal of tear gland		T	0241	25.4908	$1,674.34	$383.45	$334.87
68505	Partial removal, tear gland		T	0241	25.4908	$1,674.34	$383.45	$334.87
68510	Biopsy of tear gland		T	0240	19.1444	$1,257.48	$309.52	$251.50
68520	Removal of tear sac		T	0241	25.4908	$1,674.34	$383.45	$334.87
68525	Biopsy of tear sac		T	0240	19.1444	$1,257.48	$309.52	$251.50
68530	Clearance of tear duct	CH	T	0238	2.9984	$196.95		$39.39
68540	Remove tear gland lesion	CH	T	0240	19.1444	$1,257.48	$309.52	$251.50
68550	Remove tear gland lesion		T	0241	25.4908	$1,674.34	$383.45	$334.87
68700	Repair tear ducts	CH	T	0240	19.1444	$1,257.48	$309.52	$251.50
68705	Revise tear duct opening		T	0238	2.9984	$196.95		$39.39
68720	Create tear sac drain		T	0241	25.4908	$1,674.34	$383.45	$334.87

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
68745	Create tear duct drain		T	0241	25.4908	$1,674.34	$383.45	$334.87
68750	Create tear duct drain		T	0241	25.4908	$1,674.34	$383.45	$334.87
68760	Close tear duct opening	CH	T	0238	2.9984	$196.95		$39.39
68761	Close tear duct opening	CH	T	0238	2.9984	$196.95		$39.39
68770	Close tear system fistula	CH	T	0241	25.4908	$1,674.34	$383.45	$334.87
68801	Dilate tear duct opening		S	0698	0.9139	$60.03		$12.01
68810	Probe nasolacrimal duct		S	0231	2.1019	$138.06		$27.62
68811	Probe nasolacrimal duct		T	0240	19.1444	$1,257.48	$309.52	$251.50
68815	Probe nasolacrimal duct		T	0240	19.1444	$1,257.48	$309.52	$251.50
68816	Probe nl duct w/balloon		T	0240	19.1444	$1,257.48	$309.52	$251.50
68840	Explore/irrigate tear ducts		S	0231	2.1019	$138.06		$27.62
68850	Injection for tear sac x-ray		N					
68899	Tear duct system surgery		T	0238	2.9984	$196.95		$39.39
69000	Drain external ear lesion		T	0006	1.4267	$93.71		$18.75
69005	Drain external ear lesion		T	0008	19.5771	$1,285.90		$257.18
69020	Drain outer ear canal lesion		T	0006	1.4267	$93.71		$18.75
69090	Pierce earlobes		E					
69100	Biopsy of external ear		T	0251	3.1568	$207.35		$41.47
69105	Biopsy of external ear canal		T	0253	17.1953	$1,129.46	$282.29	$225.90
69110	Remove external ear, partial		T	0021	15.8699	$1,042.40	$219.48	$208.48
69120	Removal of external ear		T	0254	24.6341	$1,618.07		$323.62
69140	Remove ear canal lesion(s)		T	0254	24.6341	$1,618.07		$323.62
69145	Remove ear canal lesion(s)		T	0021	15.8699	$1,042.40	$219.48	$208.48
69150	Extensive ear canal surgery		T	0252	7.7504	$509.08	$109.16	$101.82
69155	Extensive ear/neck surgery		C					
69200	Clear outer ear canal		X	0340	0.6481	$42.57		$8.52
69205	Clear outer ear canal		T	0022	21.7477	$1,428.48	$354.45	$285.70
69210	Remove impacted ear wax		X	0340	0.6481	$42.57		$8.52
69220	Clean out mastoid cavity		T	0013	0.8332	$54.73		$10.95
69222	Clean out mastoid cavity		T	0253	17.1953	$1,129.46	$282.29	$225.90
69300	Revise external ear		T	0254	24.6341	$1,618.07		$323.62

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69310	Rebuild outer ear canal		T	0256	41.6247	$2,734.08		$546.82
69320	Rebuild outer ear canal		T	0256	41.6247	$2,734.08		$546.82
69399	Outer ear surgery procedure	CH	T	0250	1.1335	$74.45	$25.10	$14.89
69400	Inflate middle ear canal		T	0251	3.1568	$207.35		$41.47
69401	Inflate middle ear canal		T	0251	3.1568	$207.35		$41.47
69405	Catheterize middle ear canal		T	0252	7.7504	$509.08	$109.16	$101.82
69420	Incision of eardrum		T	0251	3.1568	$207.35		$41.47
69421	Incision of eardrum		T	0253	17.1953	$1,129.46	$282.29	$225.90
69424	Remove ventilating tube		T	0253	17.1953	$1,129.46	$282.29	$225.90
69433	Create eardrum opening		T	0252	7.7504	$509.08	$109.16	$101.82
69436	Create eardrum opening		T	0253	17.1953	$1,129.46	$282.29	$225.90
69440	Exploration of middle ear		T	0254	24.6341	$1,618.07		$323.62
69450	Eardrum revision		T	0256	41.6247	$2,734.08		$546.82
69501	Mastoidectomy		T	0256	41.6247	$2,734.08		$546.82
69502	Mastoidectomy		T	0254	24.6341	$1,618.07		$323.62
69505	Remove mastoid structures		T	0256	41.6247	$2,734.08		$546.82
69511	Extensive mastoid surgery		T	0256	41.6247	$2,734.08		$546.82
69530	Extensive mastoid surgery		T	0256	41.6247	$2,734.08		$546.82
69535	Remove part of temporal bone		C					
69540	Remove ear lesion		T	0253	17.1953	$1,129.46	$282.29	$225.90
69550	Remove ear lesion		T	0256	41.6247	$2,734.08		$546.82
69552	Remove ear lesion		T	0256	41.6247	$2,734.08		$546.82
69554	Remove ear lesion		C					
69601	Mastoid surgery revision		T	0256	41.6247	$2,734.08		$546.82
69602	Mastoid surgery revision		T	0256	41.6247	$2,734.08		$546.82
69603	Mastoid surgery revision		T	0256	41.6247	$2,734.08		$546.82
69604	Mastoid surgery revision		T	0256	41.6247	$2,734.08		$546.82
69605	Mastoid surgery revision		T	0256	41.6247	$2,734.08		$546.82
69610	Repair of eardrum		T	0254	24.6341	$1,618.07		$323.62
69620	Repair of eardrum		T	0254	24.6341	$1,618.07		$323.62
69631	Repair eardrum structures		T	0256	41.6247	$2,734.08		$546.82

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
69632	Rebuild eardrum structures		T	0256	41.6247	$2,734.08		$546.82
69633	Rebuild eardrum structures		T	0256	41.6247	$2,734.08		$546.82
69635	Repair eardrum structures		T	0256	41.6247	$2,734.08		$546.82
69636	Rebuild eardrum structures		T	0256	41.6247	$2,734.08		$546.82
69637	Rebuild eardrum structures		T	0256	41.6247	$2,734.08		$546.82
69641	Revise middle ear & mastoid		T	0256	41.6247	$2,734.08		$546.82
69642	Revise middle ear & mastoid		T	0256	41.6247	$2,734.08		$546.82
69643	Revise middle ear & mastoid		T	0256	41.6247	$2,734.08		$546.82
69644	Revise middle ear & mastoid		T	0256	41.6247	$2,734.08		$546.82
69645	Revise middle ear & mastoid		T	0256	41.6247	$2,734.08		$546.82
69646	Revise middle ear & mastoid		T	0256	41.6247	$2,734.08		$546.82
69650	Release middle ear bone		T	0254	24.6341	$1,618.07		$323.62
69660	Revise middle ear bone		T	0256	41.6247	$2,734.08		$546.82
69661	Revise middle ear bone		T	0256	41.6247	$2,734.08		$546.82
69662	Revise middle ear bone		T	0256	41.6247	$2,734.08		$546.82
69666	Repair middle ear structures		T	0256	41.6247	$2,734.08		$546.82
69667	Repair middle ear structures		T	0256	41.6247	$2,734.08		$546.82
69670	Remove mastoid air cells		T	0256	41.6247	$2,734.08		$546.82
69676	Remove middle ear nerve		T	0256	41.6247	$2,734.08		$546.82
69700	Close mastoid fistula		T	0256	41.6247	$2,734.08		$546.82
69710	Implant/replace hearing aid		E					
69711	Remove/repair hearing aid		T	0256	41.6247	$2,734.08		$546.82
69714	Implant temple bone w/stimul	CH	T	0425	120.5685	$7,919.42		$1,583.89
69715	Temple bne implnt w/stimulat	CH	T	0425	120.5685	$7,919.42		$1,583.89
69717	Temple bone implant revision	CH	T	0425	120.5685	$7,919.42		$1,583.89
69718	Revise temple bone implant	CH	T	0425	120.5685	$7,919.42		$1,583.89
69720	Release facial nerve		T	0256	41.6247	$2,734.08		$546.82
69725	Release facial nerve		T	0256	41.6247	$2,734.08		$546.82
69740	Repair facial nerve		T	0256	41.6247	$2,734.08		$546.82
69745	Repair facial nerve		T	0256	41.6247	$2,734.08		$546.82
69799	Middle ear surgery procedure	CH	T	0250	1.1335	$74.45	$25.10	$14.89

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
69801	Incise inner ear		T	0256	41.6247	$2,734.08		$546.82
69802	Incise inner ear		T	0256	41.6247	$2,734.08		$546.82
69805	Explore inner ear		T	0256	41.6247	$2,734.08		$546.82
69806	Explore inner ear		T	0256	41.6247	$2,734.08		$546.82
69820	Establish inner ear window		T	0256	41.6247	$2,734.08		$546.82
69840	Revise inner ear window		T	0256	41.6247	$2,734.08		$546.82
69905	Remove inner ear		T	0256	41.6247	$2,734.08		$546.82
69910	Remove inner ear & mastoid		T	0256	41.6247	$2,734.08		$546.82
69915	Incise inner ear nerve		T	0256	41.6247	$2,734.08		$546.82
69930	Implant cochlear device		T	0259	383.6563	$25,200.08	$8,543.66	$5,040.02
69949	Inner ear surgery procedure	CH	T	0250	1.1335	$74.45	$25.10	$14.89
69950	Incise inner ear nerve		C					
69955	Release facial nerve		T	0256	41.6247	$2,734.08		$546.82
69960	Release inner ear canal		T	0256	41.6247	$2,734.08		$546.82
69970	Remove inner ear lesion		T	0256	41.6247	$2,734.08		$546.82
69979	Temporal bone surgery	CH	T	0250	1.1335	$74.45	$25.10	$14.89
69990	Microsurgery add-on		N					
70010	Contrast x-ray of brain		Q2	0274	5.8631	$385.11		$77.03
70015	Contrast x-ray of brain		Q2	0274	5.8631	$385.11		$77.03
70030	X-ray eye for foreign body		X	0260	0.6979	$45.84		$9.17
70100	X-ray exam of jaw		X	0260	0.6979	$45.84		$9.17
7010F	Pt info into recall system		M					
70110	X-ray exam of jaw		X	0260	0.6979	$45.84		$9.17
70120	X-ray exam of mastoids		X	0260	0.6979	$45.84		$9.17
70130	X-ray exam of mastoids		X	0260	0.6979	$45.84		$9.17
70134	X-ray exam of middle ear		X	0261	1.1555	$75.90		$15.18
70140	X-ray exam of facial bones		X	0260	0.6979	$45.84		$9.17
70150	X-ray exam of facial bones		X	0260	0.6979	$45.84		$9.17
70160	X-ray exam of nasal bones		X	0260	0.6979	$45.84		$9.17
70170	X-ray exam of tear duct	CH	Q2	0263	2.9629	$194.62		$38.93
70190	X-ray exam of eye sockets		X	0260	0.6979	$45.84		$9.17

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70200	X-ray exam of eye sockets		X	0260	0.6979	$45.84		$9.17
7020F	Mammo assess cat in dbase		M					
70210	X-ray exam of sinuses		X	0260	0.6979	$45.84		$9.17
70220	X-ray exam of sinuses		X	0260	0.6979	$45.84		$9.17
70240	X-ray exam, pituitary saddle		X	0260	0.6979	$45.84		$9.17
70250	X-ray exam of skull		X	0260	0.6979	$45.84		$9.17
7025F	Pt infosys alarm 4 nxt mammo		M					
70260	X-ray exam of skull		X	0261	1.1555	$75.90		$15.18
70300	X-ray exam of teeth		X	0262	0.5358	$35.19		$7.04
70310	X-ray exam of teeth		X	0262	0.5358	$35.19		$7.04
70320	Full mouth x-ray of teeth		X	0262	0.5358	$35.19		$7.04
70328	X-ray exam of jaw joint		X	0260	0.6979	$45.84		$9.17
70330	X-ray exam of jaw joints		X	0260	0.6979	$45.84		$9.17
70332	X-ray exam of jaw joint		Q2	0275	4.0974	$269.13	$69.09	$53.83
70336	Magnetic image, jaw joint	CH	Q3	0336	5.4285	$356.57	$137.40	$71.32
70350	X-ray head for orthodontia		X	0260	0.6979	$45.84		$9.17
70355	Panoramic x-ray of jaws		X	0260	0.6979	$45.84		$9.17
70360	X-ray exam of neck		X	0260	0.6979	$45.84		$9.17
70370	Throat x-ray & fluoroscopy		X	0272	1.2985	$85.29	$31.64	$17.06
70371	Speech evaluation, complex		X	0272	1.2985	$85.29	$31.64	$17.06
70373	Contrast x-ray of larynx		Q2	0263	2.9629	$194.62		$38.93
70380	X-ray exam of salivary gland		X	0260	0.6979	$45.84		$9.17
70390	X-ray exam of salivary duct		Q2	0263	2.9629	$194.62		$38.93
70450	Ct head/brain w/o dye	CH	Q3	0332	2.9900	$196.40	$75.24	$39.28
70460	Ct head/brain w/dye	CH	Q3	0283	4.7266	$310.46	$100.37	$62.10
70470	Ct head/brain w/o & w/dye	CH	Q3	0333	5.2620	$345.63	$119.01	$69.13
70480	Ct orbit/ear/fossa w/o dye	CH	Q3	0332	2.9900	$196.40	$75.24	$39.28
70481	Ct orbit/ear/fossa w/dye	CH	Q3	0283	4.7266	$310.46	$100.37	$62.10
70482	Ct orbit/ear/fossa w/o&w/dye	CH	Q3	0333	5.2620	$345.63	$119.01	$69.13
70486	Ct maxillofacial w/o dye	CH	Q3	0332	2.9900	$196.40	$75.24	$39.28
70487	Ct maxillofacial w/dye	CH	Q3	0283	4.7266	$310.46	$100.37	$62.10

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70488	Ct maxillofacial w/o & w/dye	CH	Q3	0333	5.2620	$345.63	$119.01	$69.13
70490	Ct soft tissue neck w/o dye	CH	Q3	0332	2.9900	$196.40	$75.24	$39.28
70491	Ct soft tissue neck w/dye	CH	Q3	0283	4.7266	$310.46	$100.37	$62.10
70492	Ct sft tsue nck w/o & w/dye	CH	Q3	0333	5.2620	$345.63	$119.01	$69.13
70496	Ct angiography, head	CH	Q3	0662	5.4448	$357.64	$118.88	$71.53
70498	Ct angiography, neck	CH	Q3	0662	5.4448	$357.64	$118.88	$71.53
70540	Mri orbit/face/neck w/o dye	CH	Q3	0336	5.4285	$356.57	$137.40	$71.32
70542	Mri orbit/face/neck w/dye	CH	Q3	0284	6.5748	$431.86	$148.40	$86.38
70543	Mri orbt/fac/nck w/o & w/dye	CH	Q3	0337	8.3173	$546.31	$199.53	$109.27
70544	Mr angiography head w/o dye	CH	Q3	0336	5.4285	$356.57	$137.40	$71.32
70545	Mr angiography head w/dye	CH	Q3	0284	6.5748	$431.86	$148.40	$86.38
70546	Mr angiograph head w/o&w/dye	CH	Q3	0337	8.3173	$546.31	$199.53	$109.27
70547	Mr angiography neck w/o dye	CH	Q3	0336	5.4285	$356.57	$137.40	$71.32
70548	Mr angiography neck w/dye	CH	Q3	0284	6.5748	$431.86	$148.40	$86.38
70549	Mr angiograph neck w/o&w/dye	CH	Q3	0337	8.3173	$546.31	$199.53	$109.27
70551	Mri brain w/o dye	CH	Q3	0336	5.4285	$356.57	$137.40	$71.32
70552	Mri brain w/dye	CH	Q3	0284	6.5748	$431.86	$148.40	$86.38
70553	Mri brain w/o & w/dye	CH	Q3	0337	8.3173	$546.31	$199.53	$109.27
70554	Fmri brain by tech	CH	Q3	0336	5.4285	$356.57	$137.40	$71.32
70555	Fmri brain by phys/psych		S	0336	5.4285	$356.57	$137.40	$71.32
70557	Mri brain w/o dye		S	0336	5.4285	$356.57	$137.40	$71.32
70558	Mri brain w/dye		S	0284	6.5748	$431.86	$148.40	$86.38
70559	Mri brain w/o & w/dye		S	0337	8.3173	$546.31	$199.53	$109.27
71010	Chest x-ray		X	0260	0.6979	$45.84		$9.17
71015	Chest x-ray		X	0260	0.6979	$45.84		$9.17
71020	Chest x-ray		X	0260	0.6979	$45.84		$9.17
71021	Chest x-ray		X	0260	0.6979	$45.84		$9.17
71022	Chest x-ray		X	0260	0.6979	$45.84		$9.17
71023	Chest x-ray and fluoroscopy		X	0272	1.2985	$85.29	$31.64	$17.06
71030	Chest x-ray		X	0260	0.6979	$45.84		$9.17
71034	Chest x-ray and fluoroscopy		X	0272	1.2985	$85.29	$31.64	$17.06

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71035	Chest x-ray		X	0260	0.6979	$45.84		$9.17
71040	Contrast x-ray of bronchi		Q2	0263	2.9629	$194.62		$38.93
71060	Contrast x-ray of bronchi	CH	Q2	0263	2.9629	$194.62		$38.93
71090	X-ray & pacemaker insertion		N					
71100	X-ray exam of ribs		X	0260	0.6979	$45.84		$9.17
71101	X-ray exam of ribs/chest		X	0260	0.6979	$45.84		$9.17
71110	X-ray exam of ribs		X	0260	0.6979	$45.84		$9.17
71111	X-ray exam of ribs/chest		X	0261	1.1555	$75.90		$15.18
71120	X-ray exam of breastbone		X	0260	0.6979	$45.84		$9.17
71130	X-ray exam of breastbone		X	0260	0.6979	$45.84		$9.17
71250	Ct thorax w/o dye	CH	Q3	0332	2.9900	$196.40	$75.24	$39.28
71260	Ct thorax w/dye	CH	Q3	0283	4.7266	$310.46	$100.37	$62.10
71270	Ct thorax w/o & w/dye	CH	Q3	0333	5.2620	$345.63	$119.01	$69.13
71275	Ct angiography, chest	CH	Q3	0662	5.4448	$357.64	$118.88	$71.53
71550	Mri chest w/o dye	CH	Q3	0336	5.4285	$356.57	$137.40	$71.32
71551	Mri chest w/dye	CH	Q3	0284	6.5748	$431.86	$148.40	$86.38
71552	Mri chest w/o & w/dye	CH	Q3	0337	8.3173	$546.31	$199.53	$109.27
71555	Mri angio chest w or w/o dye		B					
72010	X-ray exam of spine	CH	X	0261	1.1555	$75.90		$15.18
72020	X-ray exam of spine		X	0260	0.6979	$45.84		$9.17
72040	X-ray exam of neck spine		X	0260	0.6979	$45.84		$9.17
72050	X-ray exam of neck spine		X	0261	1.1555	$75.90		$15.18
72052	X-ray exam of neck spine		X	0261	1.1555	$75.90		$15.18
72069	X-ray exam of trunk spine		X	0260	0.6979	$45.84		$9.17
72070	X-ray exam of thoracic spine		X	0260	0.6979	$45.84		$9.17
72072	X-ray exam of thoracic spine		X	0260	0.6979	$45.84		$9.17
72074	X-ray exam of thoracic spine		X	0260	0.6979	$45.84		$9.17
72080	X-ray exam of trunk spine		X	0260	0.6979	$45.84		$9.17
72090	X-ray exam of trunk spine		X	0261	1.1555	$75.90		$15.18
72100	X-ray exam of lower spine		X	0260	0.6979	$45.84		$9.17
72110	X-ray exam of lower spine		X	0261	1.1555	$75.90		$15.18

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72114	X-ray exam of lower spine		X	0261	1.1555	$75.90		$15.18
72120	X-ray exam of lower spine		X	0261	1.1555	$75.90		$15.18
72125	Ct neck spine w/o dye	CH	Q3	0332	2.9900	$196.40	$75.24	$39.28
72126	Ct neck spine w/dye	CH	Q3	0283	4.7266	$310.46	$100.37	$62.10
72127	Ct neck spine w/o & w/dye	CH	Q3	0333	5.2620	$345.63	$119.01	$69.13
72128	Ct chest spine w/o dye	CH	Q3	0332	2.9900	$196.40	$75.24	$39.28
72129	Ct chest spine w/dye	CH	Q3	0283	4.7266	$310.46	$100.37	$62.10
72130	Ct chest spine w/o & w/dye	CH	Q3	0333	5.2620	$345.63	$119.01	$69.13
72131	Ct lumbar spine w/o dye	CH	Q3	0332	2.9900	$196.40	$75.24	$39.28
72132	Ct lumbar spine w/dye	CH	Q3	0283	4.7266	$310.46	$100.37	$62.10
72133	Ct lumbar spine w/o & w/dye	CH	Q3	0333	5.2620	$345.63	$119.01	$69.13
72141	Mri neck spine w/o dye	CH	Q3	0336	5.4285	$356.57	$137.40	$71.32
72142	Mri neck spine w/dye	CH	Q3	0284	6.5748	$431.86	$148.40	$86.38
72146	Mri chest spine w/o dye	CH	Q3	0336	5.4285	$356.57	$137.40	$71.32
72147	Mri chest spine w/dye	CH	Q3	0284	6.5748	$431.86	$148.40	$86.38
72148	Mri lumbar spine w/o dye	CH	Q3	0336	5.4285	$356.57	$137.40	$71.32
72149	Mri lumbar spine w/dye	CH	Q3	0284	6.5748	$431.86	$148.40	$86.38
72156	Mri neck spine w/o & w/dye	CH	Q3	0337	8.3173	$546.31	$199.53	$109.27
72157	Mri chest spine w/o & w/dye	CH	Q3	0337	8.3173	$546.31	$199.53	$109.27
72158	Mri lumbar spine w/o & w/dye	CH	Q3	0337	8.3173	$546.31	$199.53	$109.27
72159	Mr angio spine w/o&w/dye		E					
72170	X-ray exam of pelvis		X	0260	0.6979	$45.84		$9.17
72190	X-ray exam of pelvis		X	0260	0.6979	$45.84		$9.17
72191	Ct angiograph pelv w/o&w/dye	CH	Q3	0662	5.4448	$357.64	$118.88	$71.53
72192	Ct pelvis w/o dye	CH	Q3	0332	2.9900	$196.40	$75.24	$39.28
72193	Ct pelvis w/dye	CH	Q3	0283	4.7266	$310.46	$100.37	$62.10
72194	Ct pelvis w/o & w/dye	CH	Q3	0333	5.2620	$345.63	$119.01	$69.13
72195	Mri pelvis w/o dye	CH	Q3	0336	5.4285	$356.57	$137.40	$71.32
72196	Mri pelvis w/dye	CH	Q3	0284	6.5748	$431.86	$148.40	$86.38
72197	Mri pelvis w/o & w/dye	CH	Q3	0337	8.3173	$546.31	$199.53	$109.27
72198	Mr angio pelvis w/o & w/dye		B					

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72200	X-ray exam sacroiliac joints		X	0260	0.6979	$45.84		$9.17
72202	X-ray exam sacroiliac joints		X	0260	0.6979	$45.84		$9.17
72220	X-ray exam of tailbone		X	0260	0.6979	$45.84		$9.17
72240	Contrast x-ray of neck spine		Q2	0274	5.8631	$385.11		$77.03
72255	Contrast x-ray, thorax spine		Q2	0274	5.8631	$385.11		$77.03
72265	Contrast x-ray, lower spine		Q2	0274	5.8631	$385.11		$77.03
72270	Contrast x-ray, spine		Q2	0274	5.8631	$385.11		$77.03
72275	Epidurography		N					
72285	X-ray c/t spine disk		Q2	0388	20.6787	$1,358.26	$289.72	$271.66
72291	Perq vertebroplasty, fluor		N					
72292	Perq vertebroplasty, ct		N					
72295	X-ray of lower spine disk		Q2	0388	20.6787	$1,358.26	$289.72	$271.66
73000	X-ray exam of collar bone		X	0260	0.6979	$45.84		$9.17
73010	X-ray exam of shoulder blade		X	0260	0.6979	$45.84		$9.17
73020	X-ray exam of shoulder		X	0260	0.6979	$45.84		$9.17
73030	X-ray exam of shoulder		X	0260	0.6979	$45.84		$9.17
73040	Contrast x-ray of shoulder		Q2	0275	4.0974	$269.13	$69.09	$53.83
73050	X-ray exam of shoulders		X	0260	0.6979	$45.84		$9.17
73060	X-ray exam of humerus		X	0260	0.6979	$45.84		$9.17
73070	X-ray exam of elbow		X	0260	0.6979	$45.84		$9.17
73080	X-ray exam of elbow		X	0260	0.6979	$45.84		$9.17
73085	Contrast x-ray of elbow		Q2	0275	4.0974	$269.13	$69.09	$53.83
73090	X-ray exam of forearm		X	0260	0.6979	$45.84		$9.17
73092	X-ray exam of arm, infant		X	0260	0.6979	$45.84		$9.17
73100	X-ray exam of wrist		X	0260	0.6979	$45.84		$9.17
73110	X-ray exam of wrist		X	0260	0.6979	$45.84		$9.17
73115	Contrast x-ray of wrist		Q2	0275	4.0974	$269.13	$69.09	$53.83
73120	X-ray exam of hand		X	0260	0.6979	$45.84		$9.17
73130	X-ray exam of hand		X	0260	0.6979	$45.84		$9.17
73140	X-ray exam of finger(s)		X	0260	0.6979	$45.84		$9.17
73200	Ct upper extremity w/o dye	CH	Q3	0332	2.9900	$196.40	$75.24	$39.28

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73201	Ct upper extremity w/dye	CH	Q3	0283	4.7266	$310.46	$100.37	$62.10
73202	Ct uppr extremity w/o&w/dye	CH	Q3	0333	5.2620	$345.63	$119.01	$69.13
73206	Ct angio upr extrm w/o&w/dye	CH	Q3	0662	5.4448	$357.64	$118.88	$71.53
73218	Mri upper extremity w/o dye	CH	Q3	0336	5.4285	$356.57	$137.40	$71.32
73219	Mri upper extremity w/dye	CH	Q3	0284	6.5748	$431.86	$148.40	$86.38
73220	Mri uppr extremity w/o&w/dye	CH	Q3	0337	8.3173	$546.31	$199.53	$109.27
73221	Mri joint upr extrem w/o dye	CH	Q3	0336	5.4285	$356.57	$137.40	$71.32
73222	Mri joint upr extrem w/dye	CH	Q3	0284	6.5748	$431.86	$148.40	$86.38
73223	Mri joint upr extr w/o&w/dye	CH	Q3	0337	8.3173	$546.31	$199.53	$109.27
73225	Mr angio upr extr w/o&w/dye		E					
73500	X-ray exam of hip		X	0260	0.6979	$45.84		$9.17
73510	X-ray exam of hip		X	0260	0.6979	$45.84		$9.17
73520	X-ray exam of hips		X	0261	1.1555	$75.90		$15.18
73525	Contrast x-ray of hip		Q2	0275	4.0974	$269.13	$69.09	$53.83
73530	X-ray exam of hip		N					
73540	X-ray exam of pelvis & hips		X	0260	0.6979	$45.84		$9.17
73542	X-ray exam, sacroiliac joint		Q2	0275	4.0974	$269.13	$69.09	$53.83
73550	X-ray exam of thigh		X	0260	0.6979	$45.84		$9.17
73560	X-ray exam of knee, 1 or 2		X	0260	0.6979	$45.84		$9.17
73562	X-ray exam of knee, 3		X	0260	0.6979	$45.84		$9.17
73564	X-ray exam, knee, 4 or more		X	0260	0.6979	$45.84		$9.17
73565	X-ray exam of knees		X	0260	0.6979	$45.84		$9.17
73580	Contrast x-ray of knee joint		Q2	0275	4.0974	$269.13	$69.09	$53.83
73590	X-ray exam of lower leg		X	0260	0.6979	$45.84		$9.17
73592	X-ray exam of leg, infant		X	0260	0.6979	$45.84		$9.17
73600	X-ray exam of ankle		X	0260	0.6979	$45.84		$9.17
73610	X-ray exam of ankle		X	0260	0.6979	$45.84		$9.17
73615	Contrast x-ray of ankle		Q2	0275	4.0974	$269.13	$69.09	$53.83
73620	X-ray exam of foot		X	0260	0.6979	$45.84		$9.17
73630	X-ray exam of foot		X	0260	0.6979	$45.84		$9.17
73650	X-ray exam of heel		X	0260	0.6979	$45.84		$9.17

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
73660	X-ray exam of toe(s)		X	0260	0.6979	$45.84		$9.17
73700	Ct lower extremity w/o dye	CH	Q3	0332	2.9900	$196.40	$75.24	$39.28
73701	Ct lower extremity w/dye	CH	Q3	0283	4.7266	$310.46	$100.37	$62.10
73702	Ct lwr extremity w/o&w/dye	CH	Q3	0333	5.2620	$345.63	$119.01	$69.13
73706	Ct angio lwr extr w/o&w/dye	CH	Q3	0662	5.4448	$357.64	$118.88	$71.53
73718	Mri lower extremity w/o dye	CH	Q3	0336	5.4285	$356.57	$137.40	$71.32
73719	Mri lower extremity w/dye	CH	Q3	0284	6.5748	$431.86	$148.40	$86.38
73720	Mri lwr extremity w/o&w/dye	CH	Q3	0337	8.3173	$546.31	$199.53	$109.27
73721	Mri jnt of lwr extre w/o dye	CH	Q3	0336	5.4285	$356.57	$137.40	$71.32
73722	Mri joint of lwr extr w/dye	CH	Q3	0284	6.5748	$431.86	$148.40	$86.38
73723	Mri joint lwr extr w/o&w/dye	CH	Q3	0337	8.3173	$546.31	$199.53	$109.27
73725	Mr ang lwr ext w or w/o dye		B					
74000	X-ray exam of abdomen		X	0260	0.6979	$45.84		$9.17
74010	X-ray exam of abdomen		X	0260	0.6979	$45.84		$9.17
74020	X-ray exam of abdomen		X	0260	0.6979	$45.84		$9.17
74022	X-ray exam series, abdomen		X	0261	1.1555	$75.90		$15.18
74150	Ct abdomen w/o dye	CH	Q3	0332	2.9900	$196.40	$75.24	$39.28
74160	Ct abdomen w/dye	CH	Q3	0283	4.7266	$310.46	$100.37	$62.10
74170	Ct abdomen w/o & w/dye	CH	Q3	0333	5.2620	$345.63	$119.01	$69.13
74175	Ct angio abdom w/o & w/dye	CH	Q3	0662	5.4448	$357.64	$118.88	$71.53
74181	Mri abdomen w/o dye	CH	Q3	0336	5.4285	$356.57	$137.40	$71.32
74182	Mri abdomen w/dye	CH	Q3	0284	6.5748	$431.86	$148.40	$86.38
74183	Mri abdomen w/o & w/dye	CH	Q3	0337	8.3173	$546.31	$199.53	$109.27
74185	Mri angio, abdom w orw/o dye		B					
74190	X-ray exam of peritoneum	CH	Q2	0263	2.9629	$194.62		$38.93
74210	Contrst x-ray exam of throat		S	0276	1.3716	$90.09	$34.97	$18.02
74220	Contrast x-ray, esophagus		S	0276	1.3716	$90.09	$34.97	$18.02
74230	Cine/vid x-ray, throat/esoph		S	0276	1.3716	$90.09	$34.97	$18.02
74235	Remove esophagus obstruction		N					
74240	X-ray exam, upper gi tract		S	0276	1.3716	$90.09	$34.97	$18.02
74241	X-ray exam, upper gi tract		S	0276	1.3716	$90.09	$34.97	$18.02

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74245	X-ray exam, upper gi tract		S	0277	2.2278	$146.33	$54.52	$29.27
74246	Contrst x-ray uppr gi tract		S	0276	1.3716	$90.09	$34.97	$18.02
74247	Contrst x-ray uppr gi tract		S	0276	1.3716	$90.09	$34.97	$18.02
74249	Contrst x-ray uppr gi tract		S	0277	2.2278	$146.33	$54.52	$29.27
74250	X-ray exam of small bowel		S	0276	1.3716	$90.09	$34.97	$18.02
74251	X-ray exam of small bowel		S	0277	2.2278	$146.33	$54.52	$29.27
74260	X-ray exam of small bowel		S	0276	1.3716	$90.09	$34.97	$18.02
74270	Contrast x-ray exam of colon		S	0276	1.3716	$90.09	$34.97	$18.02
74280	Contrast x-ray exam of colon		S	0277	2.2278	$146.33	$54.52	$29.27
74283	Contrast x-ray exam of colon		S	0276	1.3716	$90.09	$34.97	$18.02
74290	Contrast x-ray, gallbladder		S	0276	1.3716	$90.09	$34.97	$18.02
74291	Contrast x-rays, gallbladder		S	0276	1.3716	$90.09	$34.97	$18.02
74300	X-ray bile ducts/pancreas		N					
74301	X-rays at surgery add-on		N					
74305	X-ray bile ducts/pancreas	CH	Q2	0263	2.9629	$194.62	$38.93	
74320	Contrast x-ray of bile ducts		Q2	0317	5.1751	$339.92	$67.99	
74327	X-ray bile stone removal		N					
74328	X-ray bile duct endoscopy		N					
74329	X-ray for pancreas endoscopy		N					
74330	X-ray bile/panc endoscopy		N					
74340	X-ray guide for GI tube		N					
74355	X-ray guide, intestinal tube		N					
74360	X-ray guide, GI dilation		N					
74363	X-ray, bile duct dilation		N					
74400	Contrst x-ray, urinary tract		S	0278	2.6725	$175.54	$59.40	$35.11
74410	Contrst x-ray, urinary tract		S	0278	2.6725	$175.54	$59.40	$35.11
74415	Contrst x-ray, urinary tract		S	0278	2.6725	$175.54	$59.40	$35.11
74420	Contrst x-ray, urinary tract		S	0278	2.6725	$175.54	$59.40	$35.11
74425	Contrst x-ray, urinary tract		Q2	0278	2.6725	$175.54	$59.40	$35.11
74430	Contrast x-ray, bladder		Q2	0278	2.6725	$175.54	$59.40	$35.11
74440	X-ray, male genital tract		Q2	0278	2.6725	$175.54	$59.40	$35.11

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74445	X-ray exam of penis		Q2	0278	2.6725	$175.54	$59.40	$35.11
74450	X-ray, urethra/bladder		Q2	0278	2.6725	$175.54	$59.40	$35.11
74455	X-ray, urethra/bladder		Q2	0278	2.6725	$175.54	$59.40	$35.11
74470	X-ray exam of kidney lesion		Q2	0263	2.9629	$194.62		$38.93
74475	X-ray control, cath insert		Q2	0317	5.1751	$339.92		$67.99
74480	X-ray control, cath insert		Q2	0317	5.1751	$339.92		$67.99
74485	X-ray guide, GU dilation		Q2	0317	5.1751	$339.92		$67.99
74710	X-ray measurement of pelvis		X	0261	1.1555	$75.90		$15.18
74740	X-ray, female genital tract		Q2	0263	2.9629	$194.62		$38.93
74742	X-ray, fallopian tube		N					
74775	X-ray exam of perineum		S	0278	2.6725	$175.54	$59.40	$35.11
75557	Cardiac mri for morph	CH	Q3	0336	5.4285	$356.57	$137.40	$71.32
75558	Cardiac mri flow/velocity		E					
75559	Cardiac mri w/stress img	CH	Q3	0336	5.4285	$356.57	$137.40	$71.32
75560	Cardiac mri flow/vel/stress		E					
75561	Cardiac mri for morph w/dye	CH	Q3	0337	8.3173	$546.31	$199.53	$109.27
75562	Card mri flow/vel w/dye		E					
75563	Card mri w/stress img & dye	CH	Q3	0337	8.3173	$546.31	$199.53	$109.27
75564	Ht mri w/flo/vel/strs & dye		E					
75600	Contrast x-ray exam of aorta		Q2	0279	29.6349	$1,946.54		$389.31
75605	Contrast x-ray exam of aorta		Q2	0279	29.6349	$1,946.54		$389.31
75625	Contrast x-ray exam of aorta		Q2	0279	29.6349	$1,946.54		$389.31
75630	X-ray aorta, leg arteries		Q2	0279	29.6349	$1,946.54		$389.31
75635	Ct angio abdominal arteries	CH	Q2	0662	5.4448	$357.64	$118.88	$71.53
75650	Artery x-rays, head & neck		Q2	0280	45.0529	$2,959.25		$591.85
75658	Artery x-rays, arm		Q2	0279	29.6349	$1,946.54		$389.31
75660	Artery x-rays, head & neck		Q2	0280	45.0529	$2,959.25		$591.85
75662	Artery x-rays, head & neck		Q2	0280	45.0529	$2,959.25		$591.85
75665	Artery x-rays, head & neck		Q2	0279	29.6349	$1,946.54		$389.31
75671	Artery x-rays, head & neck		Q2	0280	45.0529	$2,959.25		$591.85
75676	Artery x-rays, neck		Q2	0279	29.6349	$1,946.54		$389.31

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
75680	Artery x-rays, neck		Q2	0279	29.6349	$1,946.54		$389.31
75685	Artery x-rays, spine		Q2	0279	29.6349	$1,946.54		$389.31
75705	Artery x-rays, spine		Q2	0279	29.6349	$1,946.54		$389.31
75710	Artery x-rays, arm/leg		Q2	0279	29.6349	$1,946.54		$389.31
75716	Artery x-rays, arms/legs		Q2	0279	29.6349	$1,946.54		$389.31
75722	Artery x-rays, kidney		Q2	0279	29.6349	$1,946.54		$389.31
75724	Artery x-rays, kidneys		Q2	0279	29.6349	$1,946.54		$389.31
75726	Artery x-rays, abdomen		Q2	0279	29.6349	$1,946.54		$389.31
75731	Artery x-rays, adrenal gland		Q2	0279	29.6349	$1,946.54		$389.31
75733	Artery x-rays, adrenals		Q2	0279	29.6349	$1,946.54		$389.31
75736	Artery x-rays, pelvis		Q2	0279	29.6349	$1,946.54		$389.31
75741	Artery x-rays, lung		Q2	0279	29.6349	$1,946.54		$389.31
75743	Artery x-rays, lungs		Q2	0279	29.6349	$1,946.54		$389.31
75746	Artery x-rays, lung		Q2	0668	10.3886	$682.36		$136.48
75756	Artery x-rays, chest		Q2	0668	10.3886	$682.36		$136.48
75774	Artery x-ray, each vessel		N					
75790	Visualize A-V shunt		Q2	0668	10.3886	$682.36		$136.48
75801	Lymph vessel x-ray, arm/leg		Q2	0317	5.1751	$339.92		$67.99
75803	Lymph vessel x-ray,arms/legs		Q2	0317	5.1751	$339.92		$67.99
75805	Lymph vessel x-ray, trunk		Q2	0317	5.1751	$339.92		$67.99
75807	Lymph vessel x-ray, trunk		Q2	0317	5.1751	$339.92		$67.99
75809	Nonvascular shunt, x-ray	CH	Q2	0261	1.1555	$75.90		$15.18
75810	Vein x-ray, spleen/liver		Q2	0279	29.6349	$1,946.54		$389.31
75820	Vein x-ray, arm/leg		Q2	0668	10.3886	$682.36		$136.48
75822	Vein x-ray, arms/legs		Q2	0668	10.3886	$682.36		$136.48
75825	Vein x-ray, trunk		Q2	0279	29.6349	$1,946.54		$389.31
75827	Vein x-ray, chest		Q2	0668	10.3886	$682.36		$136.48
75831	Vein x-ray, kidney		Q2	0279	29.6349	$1,946.54		$389.31
75833	Vein x-ray, kidneys		Q2	0279	29.6349	$1,946.54		$389.31
75840	Vein x-ray, adrenal gland		Q2	0279	29.6349	$1,946.54		$389.31
75842	Vein x-ray, adrenal glands		Q2	0279	29.6349	$1,946.54		$389.31

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
75860	Vein x-ray, neck		Q2	0668	10.3886	$682.36		$136.48
75870	Vein x-ray, skull		Q2	0668	10.3886	$682.36		$136.48
75872	Vein x-ray, skull		Q2	0668	10.3886	$682.36		$136.48
75880	Vein x-ray, eye socket		Q2	0668	10.3886	$682.36		$136.48
75885	Vein x-ray, liver		Q2	0279	29.6349	$1,946.54		$389.31
75887	Vein x-ray, liver		Q2	0668	10.3886	$682.36		$136.48
75889	Vein x-ray, liver		Q2	0279	29.6349	$1,946.54		$389.31
75891	Vein x-ray, liver		Q2	0279	29.6349	$1,946.54		$389.31
75893	Venous sampling by catheter		Q2	0279	29.6349	$1,946.54		$389.31
75894	X-rays, transcath therapy		N					
75896	X-rays, transcath therapy		N					
75898	Follow-up angiography		Q1	0263	2.9629	$194.62		$38.93
75900	Intravascular cath exchange		C					
75901	Remove cva device obstruct		N					
75902	Remove cva lumen obstruct		N					
75940	X-ray placement, vein filter		N					
75945	Intravascular us		Q2	0267	2.3495	$154.32	$60.50	$30.87
75946	Intravascular us add-on		N					
75952	Endovasc repair abdom aorta		C					
75953	Abdom aneurysm endovas rpr		C					
75954	Iliac aneurysm endovas rpr		C					
75956	Xray, endovasc thor ao repr		C					
75957	Xray, endovasc thor ao repr		C					
75958	Xray, place prox ext thor ao		C					
75959	Xray, place dist ext thor ao		C					
75960	Transcath iv stent rs&i		N					
75961	Retrieval, broken catheter		N					
75962	Repair arterial blockage		Q2	0083	48.2679	$3,170.43		$634.09
75964	Repair artery blockage, each		N					
75966	Repair arterial blockage		Q2	0083	48.2679	$3,170.43		$634.09
75968	Repair artery blockage, each		N					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
75970	Vascular biopsy		N					
75978	Repair venous blockage		Q2	0083	48.2679	$3,170.43		$634.09
75980	Contrast xray exam bile duct		N					
75982	Contrast xray exam bile duct		N					
75984	Xray control catheter change		N					
75989	Abscess drainage under x-ray		N					
75992	Atherectomy, x-ray exam		N					
75993	Atherectomy, x-ray exam		N					
75994	Atherectomy, x-ray exam		N					
75995	Atherectomy, x-ray exam		N					
75996	Atherectomy, x-ray exam		N					
76000	Fluoroscope examination		Q1	0272	1.2985	$85.29	$31.64	$17.06
76001	Fluoroscope exam, extensive		N					
76010	X-ray, nose to rectum		X	0260	0.6979	$45.84		$9.17
76080	X-ray exam of fistula		Q2	0263	2.9629	$194.62		$38.93
76098	X-ray exam, breast specimen	CH	X	0317	5.1751	$339.92		$67.99
76100	X-ray exam of body section		X	0261	1.1555	$75.90		$15.18
76101	Complex body section x-ray		X	0263	2.9629	$194.62		$38.93
76102	Complex body section x-rays		X	0263	2.9629	$194.62		$38.93
76120	Cine/video x-rays		X	0272	1.2985	$85.29	$31.64	$17.06
76125	Cine/video x-rays add-on		N					
76140	X-ray consultation		E					
76150	X-ray exam, dry process		X	0260	0.6979	$45.84		$9.17
76350	Special x-ray contrast study		N					
76376	3d render w/o postprocess		N					
76377	3d rendering w/postprocess		N					
76380	CAT scan follow-up study		S	0282	1.6117	$105.86	$37.81	$21.18
76390	Mr spectroscopy		E					
76496	Fluoroscopic procedure		X	0272	1.2985	$85.29	$31.64	$17.06
76497	Ct procedure		S	0282	1.6117	$105.86	$37.81	$21.18
76498	Mri procedure	CH	S	0336	5.4285	$356.57	$137.40	$71.32

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
76499	Radiographic procedure		X	0260	0.6979	$45.84		$9.17
76506	Echo exam of head		S	0265	0.9644	$63.35	$22.35	$12.67
76510	Ophth us, b & quant a		T	0232	4.5980	$302.02	$75.66	$60.41
76511	Ophth us, quant a only		S	0266	1.5058	$98.91	$37.80	$19.79
76512	Ophth us, b w/non-quant a		S	0266	1.5058	$98.91	$37.80	$19.79
76513	Echo exam of eye, water bath		S	0266	1.5058	$98.91	$37.80	$19.79
76514	Echo exam of eye, thickness	CH	X	0035	0.2298	$15.09		$3.02
76516	Echo exam of eye		S	0265	0.9644	$63.35	$22.35	$12.67
76519	Echo exam of eye		S	0266	1.5058	$98.91	$37.80	$19.79
76529	Echo exam of eye		S	0265	0.9644	$63.35	$22.35	$12.67
76536	Us exam of head and neck		S	0266	1.5058	$98.91	$37.80	$19.79
76604	Us exam, chest	CH	Q3	0265	0.9644	$63.35	$22.35	$12.67
76645	Us exam, breast(s)		S	0265	0.9644	$63.35	$22.35	$12.67
76700	Us exam, abdom, complete	CH	Q3	0266	1.5058	$98.91	$37.80	$19.79
76705	Echo exam of abdomen	CH	Q3	0266	1.5058	$98.91	$37.80	$19.79
76770	Us exam abdo back wall, comp	CH	Q3	0266	1.5058	$98.91	$37.80	$19.79
76775	Us exam abdo back wall, lim	CH	Q3	0266	1.5058	$98.91	$37.80	$19.79
76776	Us exam k transpl w/doppler	CH	Q3	0266	1.5058	$98.91	$37.80	$19.79
76800	Us exam, spinal canal		S	0266	1.5058	$98.91	$37.80	$19.79
76801	Ob us < 14 wks, single fetus		S	0266	1.5058	$98.91	$37.80	$19.79
76802	Ob us < 14 wks, add'l fetus		S	0265	0.9644	$63.35	$22.35	$12.67
76805	Ob us >/= 14 wks, sngl fetus		S	0266	1.5058	$98.91	$37.80	$19.79
76810	Ob us >/= 14 wks, addl fetus		S	0266	1.5058	$98.91	$37.80	$19.79
76811	Ob us, detailed, sngl fetus		S	0267	2.3495	$154.32	$60.50	$30.87
76812	Ob us, detailed, addl fetus		S	0265	0.9644	$63.35	$22.35	$12.67
76813	Ob us nuchal meas, 1 gest	CH	S	0265	0.9644	$63.35	$22.35	$12.67
76814	Ob us nuchal meas, add-on		S	0265	0.9644	$63.35	$22.35	$12.67
76815	Ob us, limited, fetus(s)		S	0265	0.9644	$63.35	$22.35	$12.67
76816	Ob us, follow-up, per fetus		S	0265	0.9644	$63.35	$22.35	$12.67
76817	Transvaginal us, obstetric		S	0265	0.9644	$63.35	$22.35	$12.67
76818	Fetal biophys profile w/nst		S	0266	1.5058	$98.91	$37.80	$19.79

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
76819	Fetal biophys profil w/o nst		S	0266	1.5058	$98.91	$37.80	$19.79
76820	Umbilical artery echo		S	0096	1.4496	$95.22	$37.42	$19.05
76821	Middle cerebral artery echo		S	0096	1.4496	$95.22	$37.42	$19.05
76825	Echo exam of fetal heart		S	0266	1.5058	$98.91	$37.80	$19.79
76826	Echo exam of fetal heart		S	0265	0.9644	$63.35	$22.35	$12.67
76827	Echo exam of fetal heart		S	0265	0.9644	$63.35	$22.35	$12.67
76828	Echo exam of fetal heart		S	0265	0.9644	$63.35	$22.35	$12.67
76830	Transvaginal us, non-ob		S	0266	1.5058	$98.91	$37.80	$19.79
76831	Echo exam, uterus	CH	Q3	0267	2.3495	$154.32	$60.50	$30.87
76856	Us exam, pelvic, complete	CH	Q3	0266	1.5058	$98.91	$37.80	$19.79
76857	Us exam, pelvic, limited	CH	Q3	0265	0.9644	$63.35	$22.35	$12.67
76870	Us exam, scrotum	CH	Q3	0266	1.5058	$98.91	$37.80	$19.79
76872	Us, transrectal		S	0266	1.5058	$98.91	$37.80	$19.79
76873	Echograp trans r, pros study		S	0266	1.5058	$98.91	$37.80	$19.79
76880	Us exam, extremity		S	0266	1.5058	$98.91	$37.80	$19.79
76885	Us exam infant hips, dynamic		S	0265	0.9644	$63.35	$22.35	$12.67
76886	Us exam infant hips, static		S	0265	0.9644	$63.35	$22.35	$12.67
76930	Echo guide, cardiocentesis		N					
76932	Echo guide for heart biopsy		N					
76936	Echo guide for artery repair		N					
76937	Us guide, vascular access		N					
76940	Us guide, tissue ablation		N					
76941	Echo guide for transfusion		N					
76942	Echo guide for biopsy		N					
76945	Echo guide, villus sampling		N					
76946	Echo guide for amniocentesis		N					
76948	Echo guide, ova aspiration		N					
76950	Echo guidance radiotherapy		N					
76965	Echo guidance radiotherapy		N					
76970	Ultrasound exam follow-up		S	0265	0.9644	$63.35	$22.35	$12.67
76975	GI endoscopic ultrasound		Q2	0267	2.3495	$154.32	$60.50	$30.87

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
76977	Us bone density measure		X	0340	0.6481	$42.57		$8.52
76998	Us guide, intraop		N					
76999	Echo examination procedure		S	0265	0.9644	$63.35	$22.35	$12.67
77001	Fluoroguide for vein device		N					
77002	Needle localization by xray		N					
77003	Fluoroguide for spine inject		N					
77011	Ct scan for localization		N					
77012	Ct scan for needle biopsy		N					
77013	Ct guide for tissue ablation		N					
77014	Ct scan for therapy guide		N					
77021	Mr guidance for needle place		N					
77022	Mri for tissue ablation		N					
77031	Stereotact guide for brst bx		N					
77032	Guidance for needle, breast		N					
77051	Computer dx mammogram add-on		A					
77052	Comp screen mammogram add-on		A					
77053	X-ray of mammary duct		Q2	0263	2.9629	$194.62		$38.93
77054	X-ray of mammary ducts		Q2	0263	2.9629	$194.62		$38.93
77055	Mammogram, one breast		A					
77056	Mammogram, both breasts		A					
77057	Mammogram, screening		A					
77058	Mri, one breast		B					
77059	Mri, both breasts		B					
77071	X-ray stress view		X	0260	0.6979	$45.84		$9.17
77072	X-rays for bone age		X	0260	0.6979	$45.84		$9.17
77073	X-rays, bone length studies		X	0260	0.6979	$45.84		$9.17
77074	X-rays, bone survey, limited		X	0261	1.1555	$75.90		$15.18
77075	X-rays, bone survey complete		X	0261	1.1555	$75.90		$15.18
77076	X-rays, bone survey, infant	CH	X	0261	1.1555	$75.90		$15.18
77077	Joint survey, single view		X	0260	0.6979	$45.84		$9.17

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
77078	Ct bone density, axial		S	0288	1.1143	$73.19	$28.90	$14.64
77079	Ct bone density, peripheral		S	0282	1.6117	$105.86	$37.81	$21.18
77080	Dxa bone density, axial		S	0288	1.1143	$73.19	$28.90	$14.64
77081	Dxa bone density/peripheral		S	0665	0.5032	$33.05	$12.95	$6.61
77082	Dxa bone density, vert fx		X	0260	0.6979	$45.84		$9.17
77083	Radiographic absorptiometry		X	0261	1.1555	$75.90		$15.18
77084	Magnetic image, bone marrow	CH	S	0336	5.4285	$356.57	$137.40	$71.32
77261	Radiation therapy planning		B					
77262	Radiation therapy planning		B					
77263	Radiation therapy planning		B					
77280	Set radiation therapy field		X	0304	1.5618	$102.59	$38.68	$20.52
77285	Set radiation therapy field		X	0305	3.9871	$261.89	$91.38	$52.38
77290	Set radiation therapy field		X	0305	3.9871	$261.89	$91.38	$52.38
77295	Set radiation therapy field		X	0310	13.7096	$900.50	$325.27	$180.10
77299	Radiation therapy planning		X	0304	1.5618	$102.59	$38.68	$20.52
77300	Radiation therapy dose plan		X	0304	1.5618	$102.59	$38.68	$20.52
77301	Radiotherapy dose plan, imrt		X	0310	13.7096	$900.50	$325.27	$180.10
77305	Teletx isodose plan simple		X	0304	1.5618	$102.59	$38.68	$20.52
77310	Teletx isodose plan intermed		X	0305	3.9871	$261.89	$91.38	$52.38
77315	Teletx isodose plan complex		X	0305	3.9871	$261.89	$91.38	$52.38
77321	Special teletx port plan		X	0305	3.9871	$261.89	$91.38	$52.38
77326	Brachytx isodose calc simp		X	0304	1.5618	$102.59	$38.68	$20.52
77327	Brachytx isodose calc interm		X	0305	3.9871	$261.89	$91.38	$52.38
77328	Brachytx isodose plan compl		X	0305	3.9871	$261.89	$91.38	$52.38
77331	Special radiation dosimetry		X	0304	1.5618	$102.59	$38.68	$20.52
77332	Radiation treatment aid(s)		X	0303	2.9327	$192.63	$66.95	$38.53
77333	Radiation treatment aid(s)		X	0303	2.9327	$192.63	$66.95	$38.53
77334	Radiation treatment aid(s)		X	0303	2.9327	$192.63	$66.95	$38.53
77336	Radiation physics consult		X	0304	1.5618	$102.59	$38.68	$20.52
77370	Radiation physics consult		X	0304	1.5618	$102.59	$38.68	$20.52
77371	Srs, multisource		S	0127	115.8206	$7,607.56		$1,521.52

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
77372	Srs, linear based		B					
77373	Sbrt delivery		B					
77399	External radiation dosimetry		X	0304	1.5618	$102.59	$38.68	$20.52
77401	Radiation treatment delivery		S	0300	1.3962	$91.71		$18.35
77402	Radiation treatment delivery		S	0300	1.3962	$91.71		$18.35
77403	Radiation treatment delivery		S	0300	1.3962	$91.71		$18.35
77404	Radiation treatment delivery		S	0300	1.3962	$91.71		$18.35
77406	Radiation treatment delivery	CH	S	0301	2.2319	$146.60		$29.32
77407	Radiation treatment delivery		S	0300	1.3962	$91.71		$18.35
77408	Radiation treatment delivery		S	0300	1.3962	$91.71		$18.35
77409	Radiation treatment delivery		S	0300	1.3962	$91.71		$18.35
77411	Radiation treatment delivery		S	0301	2.2319	$146.60		$29.32
77412	Radiation treatment delivery		S	0301	2.2319	$146.60		$29.32
77413	Radiation treatment delivery		S	0301	2.2319	$146.60		$29.32
77414	Radiation treatment delivery		S	0301	2.2319	$146.60		$29.32
77416	Radiation treatment delivery		S	0301	2.2319	$146.60		$29.32
77417	Radiology port film(s)		N					
77418	Radiation tx delivery, imrt		S	0412	5.5272	$363.05		$72.61
77421	Stereoscopic x-ray guidance		N					
77422	Neutron beam tx, simple		S	0301	2.2319	$146.60		$29.32
77423	Neutron beam tx, complex		S	0301	2.2319	$146.60		$29.32
77427	Radiation tx management, x5		B					
77431	Radiation therapy management		B					
77432	Stereotactic radiation trmt		B					
77435	Sbrt management		N					
77470	Special radiation treatment		S	0299	5.8229	$382.47		$76.50
77499	Radiation therapy management		B					
77520	Proton trmt, simple w/o comp		S	0664	14.0758	$924.55		$184.91
77522	Proton trmt, simple w/comp		S	0664	14.0758	$924.55		$184.91
77523	Proton trmt, intermediate		S	0667	16.8212	$1,104.88		$220.98
77525	Proton treatment, complex		S	0667	16.8212	$1,104.88		$220.98

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
77600	Hyperthermia treatment		S	0299	5.8229	$382.47		$76.50
77605	Hyperthermia treatment		S	0299	5.8229	$382.47		$76.50
77610	Hyperthermia treatment		S	0299	5.8229	$382.47		$76.50
77615	Hyperthermia treatment		S	0299	5.8229	$382.47		$76.50
77620	Hyperthermia treatment		S	0299	5.8229	$382.47		$76.50
77750	Infuse radioactive materials		S	0301	2.2319	$146.60		$29.32
77761	Apply intrcav radiat simple		S	0312	7.9492	$522.14		$104.43
77762	Apply intrcav radiat interm		S	0312	7.9492	$522.14		$104.43
77763	Apply intrcav radiat compl		S	0312	7.9492	$522.14		$104.43
77776	Apply interstit radiat simpl		S	0312	7.9492	$522.14		$104.43
77777	Apply interstit radiat inter		S	0312	7.9492	$522.14		$104.43
77778	Apply interstit radiat compl		Q3	0651	18.1875	$1,194.63		$238.93
77781	High intensity brachytherapy		S	0313	11.4819	$754.18		$150.84
77782	High intensity brachytherapy		S	0313	11.4819	$754.18		$150.84
77783	High intensity brachytherapy		S	0313	11.4819	$754.18		$150.84
77784	High intensity brachytherapy		S	0313	11.4819	$754.18		$150.84
77789	Apply surface radiation		S	0300	1.3962	$91.71		$18.35
77790	Radiation handling		N					
77799	Radium/radioisotope therapy		S	0312	7.9492	$522.14		$104.43
78000	Thyroid, single uptake		S	0389	1.8483	$121.40	$33.81	$24.28
78001	Thyroid, multiple uptakes		S	0389	1.8483	$121.40	$33.81	$24.28
78003	Thyroid suppress/stimul		S	0392	2.8090	$184.51	$49.22	$36.91
78006	Thyroid imaging with uptake		S	0391	3.4189	$224.57	$66.18	$44.92
78007	Thyroid image, mult uptakes		S	0391	3.4189	$224.57	$66.18	$44.92
78010	Thyroid imaging		S	0390	2.0747	$136.27	$52.15	$27.26
78011	Thyroid imaging with flow		S	0390	2.0747	$136.27	$52.15	$27.26
78015	Thyroid met imaging		S	0406	4.6416	$304.88	$92.73	$60.98
78016	Thyroid met imaging/studies		S	0406	4.6416	$304.88	$92.73	$60.98
78018	Thyroid met imaging, body		S	0406	4.6416	$304.88	$92.73	$60.98
78020	Thyroid met uptake		N					
78070	Parathyroid nuclear imaging		S	0391	3.4189	$224.57	$66.18	$44.92

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78075	Adrenal nuclear imaging		S	0408	16.4653	$1,081.51		$216.31
78099	Endocrine nuclear procedure		S	0390	2.0747	$136.27	$52.15	$27.26
78102	Bone marrow imaging, ltd		S	0400	3.9437	$259.04	$93.22	$51.81
78103	Bone marrow imaging, mult		S	0400	3.9437	$259.04	$93.22	$51.81
78104	Bone marrow imaging, body		S	0400	3.9437	$259.04	$93.22	$51.81
78110	Plasma volume, single		S	0393	6.0567	$397.83	$82.04	$79.57
78111	Plasma volume, multiple		S	0393	6.0567	$397.83	$82.04	$79.57
78120	Red cell mass, single		S	0393	6.0567	$397.83	$82.04	$79.57
78121	Red cell mass, multiple		S	0393	6.0567	$397.83	$82.04	$79.57
78122	Blood volume		S	0393	6.0567	$397.83	$82.04	$79.57
78130	Red cell survival study		S	0393	6.0567	$397.83	$82.04	$79.57
78135	Red cell survival kinetics		S	0393	6.0567	$397.83	$82.04	$79.57
78140	Red cell sequestration		S	0393	6.0567	$397.83	$82.04	$79.57
78185	Spleen imaging		S	0400	3.9437	$259.04	$93.22	$51.81
78190	Platelet survival, kinetics		S	0392	2.8090	$184.51	$49.22	$36.91
78191	Platelet survival		S	0392	2.8090	$184.51	$49.22	$36.91
78195	Lymph system imaging		S	0400	3.9437	$259.04	$93.22	$51.81
78199	Blood/lymph nuclear exam		S	0400	3.9437	$259.04	$93.22	$51.81
78201	Liver imaging		S	0394	4.4916	$295.03	$102.61	$59.01
78202	Liver imaging with flow		S	0394	4.4916	$295.03	$102.61	$59.01
78205	Liver imaging (3D)		S	0394	4.4916	$295.03	$102.61	$59.01
78206	Liver image (3d) with flow		S	0394	4.4916	$295.03	$102.61	$59.01
78215	Liver and spleen imaging		S	0394	4.4916	$295.03	$102.61	$59.01
78216	Liver & spleen image/flow		S	0394	4.4916	$295.03	$102.61	$59.01
78220	Liver function study		S	0394	4.4916	$295.03	$102.61	$59.01
78223	Hepatobiliary imaging		S	0394	4.4916	$295.03	$102.61	$59.01
78230	Salivary gland imaging		S	0395	3.7913	$249.03	$89.73	$49.81
78231	Serial salivary imaging		S	0395	3.7913	$249.03	$89.73	$49.81
78232	Salivary gland function exam		S	0395	3.7913	$249.03	$89.73	$49.81
78258	Esophageal motility study		S	0395	3.7913	$249.03	$89.73	$49.81
78261	Gastric mucosa imaging		S	0395	3.7913	$249.03	$89.73	$49.81

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
78262	Gastroesophageal reflux exam		S	0395	3.7913	$249.03	$89.73	$49.81
78264	Gastric emptying study		S	0395	3.7913	$249.03	$89.73	$49.81
78267	Breath tst attain/anal c-14		A					
78268	Breath test analysis, c-14		A					
78270	Vit B-12 absorption exam		S	0392	2.8090	$184.51	$49.22	$36.91
78271	Vit b-12 absrp exam, int fac		S	0392	2.8090	$184.51	$49.22	$36.91
78272	Vit B-12 absorp, combined		S	0392	2.8090	$184.51	$49.22	$36.91
78278	Acute GI blood loss imaging		S	0395	3.7913	$249.03	$89.73	$49.81
78282	GI protein loss exam		S	0395	3.7913	$249.03	$89.73	$49.81
78290	Meckel's divert exam		S	0395	3.7913	$249.03	$89.73	$49.81
78291	Leveen/shunt patency exam		S	0395	3.7913	$249.03	$89.73	$49.81
78299	GI nuclear procedure		S	0395	3.7913	$249.03	$89.73	$49.81
78300	Bone imaging, limited area		S	0396	3.8172	$250.73	$95.02	$50.15
78305	Bone imaging, multiple areas		S	0396	3.8172	$250.73	$95.02	$50.15
78306	Bone imaging, whole body		S	0396	3.8172	$250.73	$95.02	$50.15
78315	Bone imaging, 3 phase		S	0396	3.8172	$250.73	$95.02	$50.15
78320	Bone imaging (3D)		S	0396	3.8172	$250.73	$95.02	$50.15
78350	Bone mineral, single photon		E					
78351	Bone mineral, dual photon		E					
78399	Musculoskeletal nuclear exam		S	0396	3.8172	$250.73	$95.02	$50.15
78414	Non-imaging heart function		S	0398	4.8197	$316.58	$100.06	$63.32
78428	Cardiac shunt imaging		S	0398	4.8197	$316.58	$100.06	$63.32
78445	Vascular flow imaging		S	0397	3.0344	$199.31	$49.36	$39.87
78456	Acute venous thrombus image		S	0397	3.0344	$199.31	$49.36	$39.87
78457	Venous thrombosis imaging		S	0397	3.0344	$199.31	$49.36	$39.87
78458	Ven thrombosis images, bilat		S	0397	3.0344	$199.31	$49.36	$39.87
78459	Heart muscle imaging (PET)		S	0307	17.4083	$1,143.45	$238.72	$228.69
78460	Heart muscle blood, single		S	0377	11.9216	$783.06	$158.84	$156.62
78461	Heart muscle blood, multiple		S	0377	11.9216	$783.06	$158.84	$156.62
78464	Heart image (3d), single		S	0377	11.9216	$783.06	$158.84	$156.62
78465	Heart image (3d), multiple		S	0377	11.9216	$783.06	$158.84	$156.62

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
78466	Heart infarct image		S	0398	4.8197	$316.58	$100.06	$63.32
78468	Heart infarct image (ef)		S	0398	4.8197	$316.58	$100.06	$63.32
78469	Heart infarct image (3D)		S	0398	4.8197	$316.58	$100.06	$63.32
78472	Gated heart, planar, single		S	0398	4.8197	$316.58	$100.06	$63.32
78473	Gated heart, multiple		S	0398	4.8197	$316.58	$100.06	$63.32
78478	Heart wall motion add-on		N					
78480	Heart function add-on		N					
78481	Heart first pass, single		S	0398	4.8197	$316.58	$100.06	$63.32
78483	Heart first pass, multiple		S	0398	4.8197	$316.58	$100.06	$63.32
78491	Heart image (pet), single		S	0307	17.4083	$1,143.45	$238.72	$228.69
78492	Heart image (pet), multiple		S	0307	17.4083	$1,143.45	$238.72	$228.69
78494	Heart image, spect		S	0398	4.8197	$316.58	$100.06	$63.32
78496	Heart first pass add-on		N					
78499	Cardiovascular nuclear exam		S	0398	4.8197	$316.58	$100.06	$63.32
78580	Lung perfusion imaging		S	0401	3.2732	$215.00	$77.73	$43.00
78584	Lung V/Q image single breath		S	0378	5.0294	$330.35	$125.33	$66.07
78585	Lung V/Q imaging		S	0378	5.0294	$330.35	$125.33	$66.07
78586	Aerosol lung image, single		S	0401	3.2732	$215.00	$77.73	$43.00
78587	Aerosol lung image, multiple		S	0401	3.2732	$215.00	$77.73	$43.00
78588	Perfusion lung image		S	0378	5.0294	$330.35	$125.33	$66.07
78591	Vent image, 1 breath, 1 proj		S	0401	3.2732	$215.00	$77.73	$43.00
78593	Vent image, 1 proj, gas		S	0401	3.2732	$215.00	$77.73	$43.00
78594	Vent image, mult proj, gas		S	0401	3.2732	$215.00	$77.73	$43.00
78596	Lung differential function		S	0378	5.0294	$330.35	$125.33	$66.07
78599	Respiratory nuclear exam		S	0401	3.2732	$215.00	$77.73	$43.00
78600	Brain image < 4 views		S	0403	2.8408	$186.60	$72.45	$37.32
78601	Brain image w/flow < 4 views		S	0403	2.8408	$186.60	$72.45	$37.32
78605	Brain image 4+ views		S	0403	2.8408	$186.60	$72.45	$37.32
78606	Brain image w/flow 4 + views		S	0402	8.8659	$582.35		$116.47
78607	Brain imaging (3D)		S	0402	8.8659	$582.35		$116.47
78608	Brain imaging (PET)		S	0308	16.1159	$1,058.56		$211.72

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
78609	Brain imaging (PET)		E					
78610	Brain flow imaging only		S	0402	8.8659	$582.35		$116.47
78630	Cerebrospinal fluid scan		S	0402	8.8659	$582.35		$116.47
78635	CSF ventriculography		S	0402	8.8659	$582.35		$116.47
78645	CSF shunt evaluation		S	0403	2.8408	$186.60	$72.45	$37.32
78647	Cerebrospinal fluid scan		S	0402	8.8659	$582.35		$116.47
78650	CSF leakage imaging		S	0402	8.8659	$582.35		$116.47
78660	Nuclear exam of tear flow		S	0403	2.8408	$186.60	$72.45	$37.32
78699	Nervous system nuclear exam		S	0403	2.8408	$186.60	$72.45	$37.32
78700	Kidney imaging, morphol		S	0404	5.0433	$331.26	$84.11	$66.26
78701	Kidney imaging with flow		S	0404	5.0433	$331.26	$84.11	$66.26
78707	K flow/funct image w/o drug		S	0404	5.0433	$331.26	$84.11	$66.26
78708	K flow/funct image w/drug		S	0404	5.0433	$331.26	$84.11	$66.26
78709	K flow/funct image, multiple		S	0404	5.0433	$331.26	$84.11	$66.26
78710	Kidney imaging (3D)		S	0404	5.0433	$331.26	$84.11	$66.26
78725	Kidney function study		S	0392	2.8090	$184.51	$49.22	$36.91
78730	Urinary bladder retention		S	0389	1.8483	$121.40	$33.81	$24.28
78740	Ureteral reflux study		S	0404	5.0433	$331.26	$84.11	$66.26
78761	Testicular imaging w/flow		S	0404	5.0433	$331.26	$84.11	$66.26
78799	Genitourinary nuclear exam		S	0404	5.0433	$331.26	$84.11	$66.26
78800	Tumor imaging, limited area		S	0406	4.6416	$304.88	$92.73	$60.98
78801	Tumor imaging, mult areas	CH	S	0414	8.5213	$559.71	$214.44	$111.95
78802	Tumor imaging, whole body		S	0414	8.5213	$559.71	$214.44	$111.95
78803	Tumor imaging (3D)		S	0408	16.4653	$1,081.51		$216.31
78804	Tumor imaging, whole body		S	0408	16.4653	$1,081.51		$216.31
78805	Abscess imaging, ltd area		S	0414	8.5213	$559.71	$214.44	$111.95
78806	Abscess imaging, whole body		S	0414	8.5213	$559.71	$214.44	$111.95
78807	Nuclear localization/abscess		S	0414	8.5213	$559.71	$214.44	$111.95
78811	Pet image, ltd area		S	0308	16.1159	$1,058.56		$211.72
78812	Pet image, skull-thigh		S	0308	16.1159	$1,058.56		$211.72
78813	Pet image, full body		S	0308	16.1159	$1,058.56		$211.72

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
78814	Pet image w/ct, lmtd		S	0308	16.1159	$1,058.56		$211.72
78815	Pet image w/ct, skull-thigh		S	0308	16.1159	$1,058.56		$211.72
78816	Pet image w/ct, full body		S	0308	16.1159	$1,058.56		$211.72
78890	Nuclear medicine data proc		N					
78891	Nuclear med data proc		N					
78999	Nuclear diagnostic exam		S	0389	1.8483	$121.40	$33.81	$24.28
79005	Nuclear rx, oral admin		S	0407	3.3609	$220.76	$78.13	$44.16
79101	Nuclear rx, iv admin		S	0407	3.3609	$220.76	$78.13	$44.16
79200	Nuclear rx, intracav admin		S	0413	5.6710	$372.49		$74.50
79300	Nuclr rx, interstit colloid		S	0407	3.3609	$220.76	$78.13	$44.16
79403	Hematopoietic nuclear tx		S	0413	5.6710	$372.49		$74.50
79440	Nuclear rx, intra-articular		S	0413	5.6710	$372.49		$74.50
79445	Nuclear rx, intra-arterial		S	0407	3.3609	$220.76	$78.13	$44.16
79999	Nuclear medicine therapy		S	0407	3.3609	$220.76	$78.13	$44.16
80047	Metabolic panel ionized ca		A					
80048	Metabolic panel total ca		A					
80050	General health panel		E					
80051	Electrolyte panel		A					
80053	Comprehen metabolic panel		A					
80055	Obstetric panel		E					
80061	Lipid panel		A					
80069	Renal function panel		A					
80074	Acute hepatitis panel		A					
80076	Hepatic function panel		A					
80100	Drug screen, qualitate/multi		A					
80101	Drug screen, single		A					
80102	Drug confirmation		A					
80103	Drug analysis, tissue prep		N					
80150	Assay of amikacin		A					
80152	Assay of amitriptyline		A					
80154	Assay of benzodiazepines		A					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
80156	Assay, carbamazepine, total		A					
80157	Assay, carbamazepine, free		A					
80158	Assay of cyclosporine		A					
80160	Assay of desipramine		A					
80162	Assay of digoxin		A					
80164	Assay, dipropylacetic acid		A					
80166	Assay of doxepin		A					
80168	Assay of ethosuximide		A					
80170	Assay of gentamicin		A					
80172	Assay of gold		A					
80173	Assay of haloperidol		A					
80174	Assay of imipramine		A					
80176	Assay of lidocaine		A					
80178	Assay of lithium		A					
80182	Assay of nortriptyline		A					
80184	Assay of phenobarbital		A					
80185	Assay of phenytoin, total		A					
80186	Assay of phenytoin, free		A					
80188	Assay of primidone		A					
80190	Assay of procainamide		A					
80192	Assay of procainamide		A					
80194	Assay of quinidine		A					
80195	Assay of sirolimus		A					
80196	Assay of salicylate		A					
80197	Assay of tacrolimus		A					
80198	Assay of theophylline		A					
80200	Assay of tobramycin		A					
80201	Assay of topiramate		A					
80202	Assay of vancomycin		A					
80299	Quantitative assay, drug		A					
80400	Acth stimulation panel		A					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
80402	Acth stimulation panel		A					
80406	Acth stimulation panel		A					
80408	Aldosterone suppression eval		A					
80410	Calcitonin stimul panel		A					
80412	CRH stimulation panel		A					
80414	Testosterone response		A					
80415	Estradiol response panel		A					
80416	Renin stimulation panel		A					
80417	Renin stimulation panel		A					
80418	Pituitary evaluation panel		A					
80420	Dexamethasone panel		A					
80422	Glucagon tolerance panel		A					
80424	Glucagon tolerance panel		A					
80426	Gonadotropin hormone panel		A					
80428	Growth hormone panel		A					
80430	Growth hormone panel		A					
80432	Insulin suppression panel		A					
80434	Insulin tolerance panel		A					
80435	Insulin tolerance panel		A					
80436	Metyrapone panel		A					
80438	TRH stimulation panel		A					
80439	TRH stimulation panel		A					
80440	TRH stimulation panel		A					
80500	Lab pathology consultation		X	0433	0.2499	$16.41	$5.17	$3.29
80502	Lab pathology consultation		X	0342	0.1558	$10.23		$2.05
81000	Urinalysis, nonauto w/scope		A					
81001	Urinalysis, auto w/scope		A					
81002	Urinalysis nonauto w/o scope		A					
81003	Urinalysis, auto, w/o scope		A					
81005	Urinalysis		A					
81007	Urine screen for bacteria		A					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
81015	Microscopic exam of urine		A					
81020	Urinalysis, glass test		A					
81025	Urine pregnancy test		A					
81050	Urinalysis, volume measure		A					
81099	Urinalysis test procedure		A					
82000	Assay of blood acetaldehyde		A					
82003	Assay of acetaminophen		A					
82009	Test for acetone/ketones		A					
82010	Acetone assay		A					
82013	Acetylcholinesterase assay		A					
82016	Acylcarnitines, qual		A					
82017	Acylcarnitines, quant		A					
82024	Assay of acth		A					
82030	Assay of adp & amp		A					
82040	Assay of serum albumin		A					
82042	Assay of urine albumin		A					
82043	Microalbumin, quantitative		A					
82044	Microalbumin, semiquant		A					
82045	Albumin, ischemia modified		A					
82055	Assay of ethanol		A					
82075	Assay of breath ethanol		A					
82085	Assay of aldolase		A					
82088	Assay of aldosterone		A					
82101	Assay of urine alkaloids		A					
82103	Alpha-1-antitrypsin, total		A					
82104	Alpha-1-antitrypsin, pheno		A					
82105	Alpha-fetoprotein, serum		A					
82106	Alpha-fetoprotein, amniotic		A					
82107	Alpha-fetoprotein l3		A					
82108	Assay of aluminum		A					
82120	Amines, vaginal fluid qual		A					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
82127	Amino acid, single qual		A					
82128	Amino acids, mult qual		A					
82131	Amino acids, single quant		A					
82135	Assay, aminolevulinic acid		A					
82136	Amino acids, quant, 2-5		A					
82139	Amino acids, quan, 6 or more		A					
82140	Assay of ammonia		A					
82143	Amniotic fluid scan		A					
82145	Assay of amphetamines		A					
82150	Assay of amylase		A					
82154	Androstanediol glucuronide		A					
82157	Assay of androstenedione		A					
82160	Assay of androsterone		A					
82163	Assay of angiotensin II		A					
82164	Angiotensin I enzyme test		A					
82172	Assay of apolipoprotein		A					
82175	Assay of arsenic		A					
82180	Assay of ascorbic acid		A					
82190	Atomic absorption		A					
82205	Assay of barbiturates		A					
82232	Assay of beta-2 protein		A					
82239	Bile acids, total		A					
82240	Bile acids, cholylglycine		A					
82247	Bilirubin, total		A					
82248	Bilirubin, direct		A					
82252	Fecal bilirubin test		A					
82261	Assay of biotinidase		A					
82270	Occult blood, feces		A					
82271	Occult blood, other sources		A					
82272	Occult bld feces, 1-3 tests		A					
82274	Assay test for blood, fecal		A					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
82286	Assay of bradykinin		A					
82300	Assay of cadmium		A					
82306	Assay of vitamin D		A					
82307	Assay of vitamin D		A					
82308	Assay of calcitonin		A					
82310	Assay of calcium		A					
82330	Assay of calcium		A					
82331	Calcium infusion test		A					
82340	Assay of calcium in urine		A					
82355	Calculus analysis, qual		A					
82360	Calculus assay, quant		A					
82365	Calculus spectroscopy		A					
82370	X-ray assay, calculus		A					
82373	Assay, c-d transfer measure		A					
82374	Assay, blood carbon dioxide		A					
82375	Assay, blood carbon monoxide		A					
82376	Test for carbon monoxide		A					
82378	Carcinoembryonic antigen		A					
82379	Assay of carnitine		A					
82380	Assay of carotene		A					
82382	Assay, urine catecholamines		A					
82383	Assay, blood catecholamines		A					
82384	Assay, three catecholamines		A					
82387	Assay of cathepsin-d		A					
82390	Assay of ceruloplasmin		A					
82397	Chemiluminescent assay		A					
82415	Assay of chloramphenicol		A					
82435	Assay of blood chloride		A					
82436	Assay of urine chloride		A					
82438	Assay, other fluid chlorides		A					
82441	Test for chlorohydrocarbons		A					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
82465	Assay, bld/serum cholesterol		A					
82480	Assay, serum cholinesterase		A					
82482	Assay, rbc cholinesterase		A					
82485	Assay, chondroitin sulfate		A					
82486	Gas/liquid chromatography		A					
82487	Paper chromatography		A					
82488	Paper chromatography		A					
82489	Thin layer chromatography		A					
82491	Chromotography, quant, sing		A					
82492	Chromotography, quant, mult		A					
82495	Assay of chromium		A					
82507	Assay of citrate		A					
82520	Assay of cocaine		A					
82523	Collagen crosslinks		A					
82525	Assay of copper		A					
82528	Assay of corticosterone		A					
82530	Cortisol, free		A					
82533	Total cortisol		A					
82540	Assay of creatine		A					
82541	Column chromotography, qual		A					
82542	Column chromotography, quant		A					
82543	Column chromotograph/isotope		A					
82544	Column chromotograph/isotope		A					
82550	Assay of ck (cpk)		A					
82552	Assay of cpk in blood		A					
82553	Creatine, MB fraction		A					
82554	Creatine, isoforms		A					
82565	Assay of creatinine		A					
82570	Assay of urine creatinine		A					
82575	Creatinine clearance test		A					
82585	Assay of cryofibrinogen		A					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
82595	Assay of cryoglobulin		A					
82600	Assay of cyanide		A					
82607	Vitamin B-12		A					
82608	B-12 binding capacity		A					
82610	Cystatin c		A					
82615	Test for urine cystines		A					
82626	Dehydroepiandrosterone		A					
82627	Dehydroepiandrosterone		A					
82633	Desoxycorticosterone		A					
82634	Deoxycortisol		A					
82638	Assay of dibucaine number		A					
82646	Assay of dihydrocodeinone		A					
82649	Assay of dihydromorphinone		A					
82651	Assay of dihydrotestosterone		A					
82652	Assay of dihydroxyvitamin d		A					
82654	Assay of dimethadione		A					
82656	Pancreatic elastase, fecal		A					
82657	Enzyme cell activity		A					
82658	Enzyme cell activity, ra		A					
82664	Electrophoretic test		A					
82666	Assay of epiandrosterone		A					
82668	Assay of erythropoietin		A					
82670	Assay of estradiol		A					
82671	Assay of estrogens		A					
82672	Assay of estrogen		A					
82677	Assay of estriol		A					
82679	Assay of estrone		A					
82690	Assay of ethchlorvynol		A					
82693	Assay of ethylene glycol		A					
82696	Assay of etiocholanolone		A					
82705	Fats/lipids, feces, qual		A					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
82710	Fats/lipids, feces, quant		A					
82715	Assay of fecal fat		A					
82725	Assay of blood fatty acids		A					
82726	Long chain fatty acids		A					
82728	Assay of ferritin		A					
82731	Assay of fetal fibronectin		A					
82735	Assay of fluoride		A					
82742	Assay of flurazepam		A					
82746	Blood folic acid serum		A					
82747	Assay of folic acid, rbc		A					
82757	Assay of semen fructose		A					
82759	Assay of rbc galactokinase		A					
82760	Assay of galactose		A					
82775	Assay galactose transferase		A					
82776	Galactose transferase test		A					
82784	Assay of gammaglobulin igm		A					
82785	Assay of gammaglobulin ige		A					
82787	Igg 1, 2, 3 or 4, each		A					
82800	Blood pH		A					
82803	Blood gases: pH, pO2 & pCO2		A					
82805	Blood gases w/o2 saturation		A					
82810	Blood gases, O2 sat only		A					
82820	Hemoglobin-oxygen affinity		A					
82926	Assay of gastric acid		A					
82928	Assay of gastric acid		A					
82938	Gastrin test		A					
82941	Assay of gastrin		A					
82943	Assay of glucagon		A					
82945	Glucose other fluid		A					
82946	Glucagon tolerance test		A					
82947	Assay, glucose, blood quant		A					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
82948	Reagent strip/blood glucose		A					
82950	Glucose test		A					
82951	Glucose tolerance test (GTT)		A					
82952	GTT-added samples		A					
82953	Glucose-tolbutamide test		A					
82955	Assay of g6pd enzyme		A					
82960	Test for G6PD enzyme		A					
82962	Glucose blood test		A					
82963	Assay of glucosidase		A					
82965	Assay of gdh enzyme		A					
82975	Assay of glutamine		A					
82977	Assay of GGT		A					
82978	Assay of glutathione		A					
82979	Assay, rbc glutathione		A					
82980	Assay of glutethimide		A					
82985	Glycated protein		A					
83001	Gonadotropin (FSH)		A					
83002	Gonadotropin (LH)		A					
83003	Assay, growth hormone (hgh)		A					
83008	Assay of guanosine		A					
83009	H pylori (c-13), blood		A					
83010	Assay of haptoglobin, quant		A					
83012	Assay of haptoglobins		A					
83013	H pylori (c-13), breath		A					
83014	H pylori drug admin		A					
83015	Heavy metal screen		A					
83018	Quantitative screen, metals		A					
83020	Hemoglobin electrophoresis		A					
83021	Hemoglobin chromotography		A					
83026	Hemoglobin, copper sulfate		A					
83030	Fetal hemoglobin, chemical		A					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
83033	Fetal hemoglobin assay, qual		A					
83036	Glycosylated hemoglobin test		A					
83037	Glycosylated hb, home device		A					
83045	Blood methemoglobin test		A					
83050	Blood methemoglobin assay		A					
83051	Assay of plasma hemoglobin		A					
83055	Blood sulfhemoglobin test		A					
83060	Blood sulfhemoglobin assay		A					
83065	Assay of hemoglobin heat		A					
83068	Hemoglobin stability screen		A					
83069	Assay of urine hemoglobin		A					
83070	Assay of hemosiderin, qual		A					
83071	Assay of hemosiderin, quant		A					
83080	Assay of b hexosaminidase		A					
83088	Assay of histamine		A					
83090	Assay of homocystine		A					
83150	Assay of for hva		A					
83491	Assay of corticosteroids		A					
83497	Assay of 5-hiaa		A					
83498	Assay of progesterone		A					
83499	Assay of progesterone		A					
83500	Assay, free hydroxyproline		A					
83505	Assay, total hydroxyproline		A					
83516	Immunoassay, nonantibody		A					
83518	Immunoassay, dipstick		A					
83519	Immunoassay, nonantibody		A					
83520	Immunoassay, RIA		A					
83525	Assay of insulin		A					
83527	Assay of insulin		A					
83528	Assay of intrinsic factor		A					
83540	Assay of iron		A					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
83550	Iron binding test		A					
83570	Assay of idh enzyme		A					
83582	Assay of ketogenic steroids		A					
83586	Assay 17- ketosteroids		A					
83593	Fractionation, ketosteroids		A					
83605	Assay of lactic acid		A					
83615	Lactate (LD) (LDH) enzyme		A					
83625	Assay of ldh enzymes		A					
83630	Lactoferrin, fecal (qual)		A					
83631	Lactoferrin, fecal (quant)		A					
83632	Placental lactogen		A					
83633	Test urine for lactose		A					
83634	Assay of urine for lactose		A					
83655	Assay of lead		A					
83661	L/s ratio, fetal lung		A					
83662	Foam stability, fetal lung		A					
83663	Fluoro polarize, fetal lung		A					
83664	Lamellar bdy, fetal lung		A					
83670	Assay of lap enzyme		A					
83690	Assay of lipase		A					
83695	Assay of lipoprotein(a)		A					
83698	Assay lipoprotein pla2		A					
83700	Lipopro bld, electrophoretic		A					
83701	Lipoprotein bld, hr fraction		A					
83704	Lipoprotein, bld, by nmr		A					
83718	Assay of lipoprotein		A					
83719	Assay of blood lipoprotein		A					
83721	Assay of blood lipoprotein		A					
83727	Assay of lrh hormone		A					
83735	Assay of magnesium		A					
83775	Assay of md enzyme		A					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
83785	Assay of manganese		A					
83788	Mass spectrometry qual		A					
83789	Mass spectrometry quant		A					
83805	Assay of meprobamate		A					
83825	Assay of mercury		A					
83835	Assay of metanephrines		A					
83840	Assay of methadone		A					
83857	Assay of methemalbumin		A					
83858	Assay of methsuximide		A					
83864	Mucopolysaccharides		A					
83866	Mucopolysaccharides screen		A					
83872	Assay synovial fluid mucin		A					
83873	Assay of csf protein		A					
83874	Assay of myoglobin		A					
83880	Natriuretic peptide		A					
83883	Assay, nephelometry not spec		A					
83885	Assay of nickel		A					
83887	Assay of nicotine		A					
83890	Molecule isolate		A					
83891	Molecule isolate nucleic		A					
83892	Molecular diagnostics		A					
83893	Molecule dot/slot/blot		A					
83894	Molecule gel electrophor		A					
83896	Molecular diagnostics		A					
83897	Molecule nucleic transfer		A					
83898	Molecule nucleic ampli, each		A					
83900	Molecule nucleic ampli 2 seq		A					
83901	Molecule nucleic ampli addon		A					
83902	Molecular diagnostics		A					
83903	Molecule mutation scan		A					
83904	Molecule mutation identify		A					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
83905	Molecule mutation identify		A					
83906	Molecule mutation identify		A					
83907	Lyse cells for nucleic ext		A					
83908	Nucleic acid, signal ampli		A					
83909	Nucleic acid, high resolute		A					
83912	Genetic examination		A					
83913	Molecular, rna stabilization		A					
83914	Mutation ident ola/sbce/aspe		A					
83915	Assay of nucleotidase		A					
83916	Oligoclonal bands		A					
83918	Organic acids, total, quant		A					
83919	Organic acids, qual, each		A					
83921	Organic acid, single, quant		A					
83925	Assay of opiates		A					
83930	Assay of blood osmolality		A					
83935	Assay of urine osmolality		A					
83937	Assay of osteocalcin		A					
83945	Assay of oxalate		A					
83950	Oncoprotein, her-2/neu		A					
83970	Assay of parathormone		A					
83986	Assay of body fluid acidity		A					
83992	Assay for phencyclidine		A					
83993	Assay for calprotectin fecal		A					
84022	Assay of phenothiazine		A					
84030	Assay of blood pku		A					
84035	Assay of phenylketones		A					
84060	Assay acid phosphatase		A					
84061	Phosphatase, forensic exam		A					
84066	Assay prostate phosphatase		A					
84075	Assay alkaline phosphatase		A					
84078	Assay alkaline phosphatase		A					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
84080	Assay alkaline phosphatases		A					
84081	Amniotic fluid enzyme test		A					
84085	Assay of rbc pg6d enzyme		A					
84087	Assay phosphohexose enzymes		A					
84100	Assay of phosphorus		A					
84105	Assay of urine phosphorus		A					
84106	Test for porphobilinogen		A					
84110	Assay of porphobilinogen		A					
84119	Test urine for porphyrins		A					
84120	Assay of urine porphyrins		A					
84126	Assay of feces porphyrins		A					
84127	Assay of feces porphyrins		A					
84132	Assay of serum potassium		A					
84133	Assay of urine potassium		A					
84134	Assay of prealbumin		A					
84135	Assay of pregnanediol		A					
84138	Assay of pregnanetriol		A					
84140	Assay of pregnenolone		A					
84143	Assay of 17-hydroxypregneno		A					
84144	Assay of progesterone		A					
84146	Assay of prolactin		A					
84150	Assay of prostaglandin		A					
84152	Assay of psa, complexed		A					
84153	Assay of psa, total		A					
84154	Assay of psa, free		A					
84155	Assay of protein, serum		A					
84156	Assay of protein, urine		A					
84157	Assay of protein, other		A					
84160	Assay of protein, any source		A					
84163	Pappa, serum		A					
84165	Protein e-phoresis, serum		A					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
84166	Protein e-phoresis/urine/csf		A					
84181	Western blot test		A					
84182	Protein, western blot test		A					
84202	Assay RBC protoporphyrin		A					
84203	Test RBC protoporphyrin		A					
84206	Assay of proinsulin		A					
84207	Assay of vitamin b-6		A					
84210	Assay of pyruvate		A					
84220	Assay of pyruvate kinase		A					
84228	Assay of quinine		A					
84233	Assay of estrogen		A					
84234	Assay of progesterone		A					
84235	Assay of endocrine hormone		A					
84238	Assay, nonendocrine receptor		A					
84244	Assay of renin		A					
84252	Assay of vitamin b-2		A					
84255	Assay of selenium		A					
84260	Assay of serotonin		A					
84270	Assay of sex hormone globul		A					
84275	Assay of sialic acid		A					
84285	Assay of silica		A					
84295	Assay of serum sodium		A					
84300	Assay of urine sodium		A					
84302	Assay of sweat sodium		A					
84305	Assay of somatomedin		A					
84307	Assay of somatostatin		A					
84311	Spectrophotometry		A					
84315	Body fluid specific gravity		A					
84375	Chromatogram assay, sugars		A					
84376	Sugars, single, qual		A					
84377	Sugars, multiple, qual		A					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
84378	Sugars, single, quant		A					
84379	Sugars multiple quant		A					
84392	Assay of urine sulfate		A					
84402	Assay of testosterone		A					
84403	Assay of total testosterone		A					
84425	Assay of vitamin b-1		A					
84430	Assay of thiocyanate		A					
84432	Assay of thyroglobulin		A					
84436	Assay of total thyroxine		A					
84437	Assay of neonatal thyroxine		A					
84439	Assay of free thyroxine		A					
84442	Assay of thyroid activity		A					
84443	Assay thyroid stim hormone		A					
84445	Assay of tsi		A					
84446	Assay of vitamin e		A					
84449	Assay of transcortin		A					
84450	Transferase (AST) (SGOT)		A					
84460	Alanine amino (ALT) (SGPT)		A					
84466	Assay of transferrin		A					
84478	Assay of triglycerides		A					
84479	Assay of thyroid (t3 or t4)		A					
84480	Assay, triiodothyronine (t3)		A					
84481	Free assay (FT-3)		A					
84482	T3 reverse		A					
84484	Assay of troponin, quant		A					
84485	Assay duodenal fluid trypsin		A					
84488	Test feces for trypsin		A					
84490	Assay of feces for trypsin		A					
84510	Assay of tyrosine		A					
84512	Assay of troponin, qual		A					
84520	Assay of urea nitrogen		A					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
84525	Urea nitrogen semi-quant		A					
84540	Assay of urine/urea-n		A					
84545	Urea-N clearance test		A					
84550	Assay of blood/uric acid		A					
84560	Assay of urine/uric acid		A					
84577	Assay of feces/urobilinogen		A					
84578	Test urine urobilinogen		A					
84580	Assay of urine urobilinogen		A					
84583	Assay of urine urobilinogen		A					
84585	Assay of urine vma		A					
84586	Assay of vip		A					
84588	Assay of vasopressin		A					
84590	Assay of vitamin a		A					
84591	Assay of nos vitamin		A					
84597	Assay of vitamin k		A					
84600	Assay of volatiles		A					
84620	Xylose tolerance test		A					
84630	Assay of zinc		A					
84681	Assay of c-peptide		A					
84702	Chorionic gonadotropin test		A					
84703	Chorionic gonadotropin assay		A					
84704	Hcg, free betachain test		A					
84830	Ovulation tests		A					
84999	Clinical chemistry test		A					
85002	Bleeding time test		A					
85004	Automated diff wbc count		A					
85007	Bl smear w/diff wbc count		A					
85008	Bl smear w/o diff wbc count		A					
85009	Manual diff wbc count b-coat		A					
85013	Spun microhematocrit		A					
85014	Hematocrit		A					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
85018	Hemoglobin		A					
85025	Complete cbc w/auto diff wbc		A					
85027	Complete cbc, automated		A					
85032	Manual cell count, each		A					
85041	Automated rbc count		A					
85044	Manual reticulocyte count		A					
85045	Automated reticulocyte count		A					
85046	Reticyte/hgb concentrate		A					
85048	Automated leukocyte count		A					
85049	Automated platelet count		A					
85055	Reticulated platelet assay		A					
85060	Blood smear interpretation		B					
85097	Bone marrow interpretation		X	0343	0.5322	$34.96	$10.84	$7.00
85130	Chromogenic substrate assay		A					
85170	Blood clot retraction		A					
85175	Blood clot lysis time		A					
85210	Blood clot factor II test		A					
85220	Blood clot factor V test		A					
85230	Blood clot factor VII test		A					
85240	Blood clot factor VIII test		A					
85244	Blood clot factor VIII test		A					
85245	Blood clot factor VIII test		A					
85246	Blood clot factor VIII test		A					
85247	Blood clot factor VIII test		A					
85250	Blood clot factor IX test		A					
85260	Blood clot factor X test		A					
85270	Blood clot factor XI test		A					
85280	Blood clot factor XII test		A					
85290	Blood clot factor XIII test		A					
85291	Blood clot factor XIII test		A					
85292	Blood clot factor assay		A					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
85293	Blood clot factor assay		A					
85300	Antithrombin III test		A					
85301	Antithrombin III test		A					
85302	Blood clot inhibitor antigen		A					
85303	Blood clot inhibitor test		A					
85305	Blood clot inhibitor assay		A					
85306	Blood clot inhibitor test		A					
85307	Assay activated protein c		A					
85335	Factor inhibitor test		A					
85337	Thrombomodulin		A					
85345	Coagulation time		A					
85347	Coagulation time		A					
85348	Coagulation time		A					
85360	Euglobulin lysis		A					
85362	Fibrin degradation products		A					
85366	Fibrinogen test		A					
85370	Fibrinogen test		A					
85378	Fibrin degrade, semiquant		A					
85379	Fibrin degradation, quant		A					
85380	Fibrin degradation, vte		A					
85384	Fibrinogen		A					
85385	Fibrinogen		A					
85390	Fibrinolysins screen		A					
85396	Clotting assay, whole blood		N					
85400	Fibrinolytic plasmin		A					
85410	Fibrinolytic antiplasmin		A					
85415	Fibrinolytic plasminogen		A					
85420	Fibrinolytic plasminogen		A					
85421	Fibrinolytic plasminogen		A					
85441	Heinz bodies, direct		A					
85445	Heinz bodies, induced		A					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
85460	Hemoglobin, fetal		A					
85461	Hemoglobin, fetal		A					
85475	Hemolysin		A					
85520	Heparin assay		A					
85525	Heparin neutralization		A					
85530	Heparin-protamine tolerance		A					
85536	Iron stain peripheral blood		A					
85540	Wbc alkaline phosphatase		A					
85547	RBC mechanical fragility		A					
85549	Muramidase		A					
85555	RBC osmotic fragility		A					
85557	RBC osmotic fragility		A					
85576	Blood platelet aggregation		A					
85597	Platelet neutralization		A					
85610	Prothrombin time		A					
85611	Prothrombin test		A					
85612	Viper venom prothrombin time		A					
85613	Russell viper venom, diluted		A					
85635	Reptilase test		A					
85651	Rbc sed rate, nonautomated		A					
85652	Rbc sed rate, automated		A					
85660	RBC sickle cell test		A					
85670	Thrombin time, plasma		A					
85675	Thrombin time, titer		A					
85705	Thromboplastin inhibition		A					
85730	Thromboplastin time, partial		A					
85732	Thromboplastin time, partial		A					
85810	Blood viscosity examination		A					
85999	Hematology procedure		A					
86000	Agglutinins, febrile		A					
86001	Allergen specific igg		A					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
86003	Allergen specific IgE		A					
86005	Allergen specific IgE		A					
86021	WBC antibody identification		A					
86022	Platelet antibodies		A					
86023	Immunoglobulin assay		A					
86038	Antinuclear antibodies		A					
86039	Antinuclear antibodies (ANA)		A					
86060	Antistreptolysin o, titer		A					
86063	Antistreptolysin o, screen		A					
86077	Physician blood bank service		X	0433	0.2499	$16.41	$5.17	$3.29
86078	Physician blood bank service		X	0343	0.5322	$34.96	$10.84	$7.00
86079	Physician blood bank service		X	0433	0.2499	$16.41	$5.17	$3.29
86140	C-reactive protein		A					
86141	C-reactive protein, hs		A					
86146	Glycoprotein antibody		A					
86147	Cardiolipin antibody		A					
86148	Phospholipid antibody		A					
86155	Chemotaxis assay		A					
86156	Cold agglutinin, screen		A					
86157	Cold agglutinin, titer		A					
86160	Complement, antigen		A					
86161	Complement/function activity		A					
86162	Complement, total (CH50)		A					
86171	Complement fixation, each		A					
86185	Counterimmunoelectrophoresis		A					
86200	Ccp antibody		A					
86215	Deoxyribonuclease, antibody		A					
86225	DNA antibody		A					
86226	DNA antibody, single strand		A					
86235	Nuclear antigen antibody		A					
86243	Fc receptor		A					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
86255	Fluorescent antibody, screen		A					
86256	Fluorescent antibody, titer		A					
86277	Growth hormone antibody		A					
86280	Hemagglutination inhibition		A					
86294	Immunoassay, tumor, qual		A					
86300	Immunoassay, tumor, ca 15-3		A					
86301	Immunoassay, tumor, ca 19-9		A					
86304	Immunoassay, tumor, ca 125		A					
86308	Heterophile antibodies		A					
86309	Heterophile antibodies		A					
86310	Heterophile antibodies		A					
86316	Immunoassay, tumor other		A					
86317	Immunoassay,infectious agent		A					
86318	Immunoassay,infectious agent		A					
86320	Serum immunoelectrophoresis		A					
86325	Other immunoelectrophoresis		A					
86327	Immunoelectrophoresis assay		A					
86329	Immunodiffusion		A					
86331	Immunodiffusion ouchterlony		A					
86332	Immune complex assay		A					
86334	Immunofix e-phoresis, serum		A					
86335	Immunfix e-phorsis/urine/csf		A					
86336	Inhibin A		A					
86337	Insulin antibodies		A					
86340	Intrinsic factor antibody		A					
86341	Islet cell antibody		A					
86343	Leukocyte histamine release		A					
86344	Leukocyte phagocytosis		A					
86353	Lymphocyte transformation		A					
86355	B cells, total count		A					
86356	Mononuclear cell antigen		A					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
86357	Nk cells, total count		A					
86359	T cells, total count		A					
86360	T cell, absolute count/ratio		A					
86361	T cell, absolute count		A					
86367	Stem cells, total count		A					
86376	Microsomal antibody		A					
86378	Migration inhibitory factor		A					
86382	Neutralization test, viral		A					
86384	Nitroblue tetrazolium dye		A					
86403	Particle agglutination test		A					
86406	Particle agglutination test		A					
86430	Rheumatoid factor test		A					
86431	Rheumatoid factor, quant		A					
86480	Tb test, cell immun measure		A					
86485	Skin test, candida		X	0341	0.0847	$5.56	$2.14	$1.12
86486	Skin test, nos antigen	CH	X	0341	0.0847	$5.56	$2.14	$1.12
86490	Coccidioidomycosis skin test		X	0341	0.0847	$5.56	$2.14	$1.12
86510	Histoplasmosis skin test		X	0341	0.0847	$5.56	$2.14	$1.12
86580	TB intradermal test		X	0341	0.0847	$5.56	$2.14	$1.12
86590	Streptokinase, antibody		A					
86592	Blood serology, qualitative		A					
86593	Blood serology, quantitative		A					
86602	Antinomyces antibody		A					
86603	Adenovirus antibody		A					
86606	Aspergillus antibody		A					
86609	Bacterium antibody		A					
86611	Bartonella antibody		A					
86612	Blastomyces antibody		A					
86615	Bordetella antibody		A					
86617	Lyme disease antibody		A					
86618	Lyme disease antibody		A					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
86619	Borrelia antibody		A					
86622	Brucella antibody		A					
86625	Campylobacter antibody		A					
86628	Candida antibody		A					
86631	Chlamydia antibody		A					
86632	Chlamydia igm antibody		A					
86635	Coccidioides antibody		A					
86638	Q fever antibody		A					
86641	Cryptococcus antibody		A					
86644	CMV antibody		A					
86645	CMV antibody, IgM		A					
86648	Diphtheria antibody		A					
86651	Encephalitis antibody		A					
86652	Encephalitis antibody		A					
86653	Encephalitis antibody		A					
86654	Encephalitis antibody		A					
86658	Enterovirus antibody		A					
86663	Epstein-barr antibody		A					
86664	Epstein-barr antibody		A					
86665	Epstein-barr antibody		A					
86666	Ehrlichia antibody		A					
86668	Francisella tularensis		A					
86671	Fungus antibody		A					
86674	Giardia lamblia antibody		A					
86677	Helicobacter pylori		A					
86682	Helminth antibody		A					
86684	Hemophilus influenza		A					
86687	Htlv-i antibody		A					
86688	Htlv-ii antibody		A					
86689	HTLV/HIV confirmatory test		A					
86692	Hepatitis, delta agent		A					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
86694	Herpes simplex test		A					
86695	Herpes simplex test		A					
86696	Herpes simplex type 2		A					
86698	Histoplasma		A					
86701	HIV-1		A					
86702	HIV-2		A					
86703	HIV-1/HIV-2, single assay		A					
86704	Hep b core antibody, total		A					
86705	Hep b core antibody, igm		A					
86706	Hep b surface antibody		A					
86707	Hep be antibody		A					
86708	Hep a antibody, total		A					
86709	Hep a antibody, igm		A					
86710	Influenza virus antibody		A					
86713	Legionella antibody		A					
86717	Leishmania antibody		A					
86720	Leptospira antibody		A					
86723	Listeria monocytogenes ab		A					
86727	Lymph choriomeningitis ab		A					
86729	Lympho venereum antibody		A					
86732	Mucormycosis antibody		A					
86735	Mumps antibody		A					
86738	Mycoplasma antibody		A					
86741	Neisseria meningitidis		A					
86744	Nocardia antibody		A					
86747	Parvovirus antibody		A					
86750	Malaria antibody		A					
86753	Protozoa antibody nos		A					
86756	Respiratory virus antibody		A					
86757	Rickettsia antibody		A					
86759	Rotavirus antibody		A					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
86762	Rubella antibody		A					
86765	Rubeola antibody		A					
86768	Salmonella antibody		A					
86771	Shigella antibody		A					
86774	Tetanus antibody		A					
86777	Toxoplasma antibody		A					
86778	Toxoplasma antibody, igm		A					
86781	Treponema pallidum, confirm		A					
86784	Trichinella antibody		A					
86787	Varicella-zoster antibody		A					
86788	West nile virus ab, igm		A					
86789	West nile virus antibody		A					
86790	Virus antibody nos		A					
86793	Yersinia antibody		A					
86800	Thyroglobulin antibody		A					
86803	Hepatitis c ab test		A					
86804	Hep c ab test, confirm		A					
86805	Lymphocytotoxicity assay		A					
86806	Lymphocytotoxicity assay		A					
86807	Cytotoxic antibody screening		A					
86808	Cytotoxic antibody screening		A					
86812	HLA typing, A, B, or C		A					
86813	HLA typing, A, B, or C		A					
86816	HLA typing, DR/DQ		A					
86817	HLA typing, DR/DQ		A					
86821	Lymphocyte culture, mixed		A					
86822	Lymphocyte culture, primed		A					
86849	Immunology procedure		A					
86850	RBC antibody screen		X	0345	0.2210	$14.52		$2.91
86860	RBC antibody elution		X	0346	0.3909	$25.68		$5.14
86870	RBC antibody identification		X	0346	0.3909	$25.68		$5.14

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
86880	Coombs test, direct		X	0409	0.1187	$7.80	$2.20	$1.56
86885	Coombs test, indirect, qual		X	0409	0.1187	$7.80	$2.20	$1.56
86886	Coombs test, indirect, titer		X	0409	0.1187	$7.80	$2.20	$1.56
86890	Autologous blood process		X	0347	0.8145	$53.50	$11.28	$10.70
86891	Autologous blood, op salvage	CH	X	0345	0.2210	$14.52		$2.91
86900	Blood typing, ABO		X	0409	0.1187	$7.80	$2.20	$1.56
86901	Blood typing, Rh (D)		X	0409	0.1187	$7.80	$2.20	$1.56
86903	Blood typing, antigen screen		X	0345	0.2210	$14.52		$2.91
86904	Blood typing, patient serum	CH	X	0345	0.2210	$14.52		$2.91
86905	Blood typing, RBC antigens		X	0345	0.2210	$14.52		$2.91
86906	Blood typing, Rh phenotype		X	0345	0.2210	$14.52		$2.91
86910	Blood typing, paternity test		E					
86911	Blood typing, antigen system		E					
86920	Compatibility test, spin	CH	X	0345	0.2210	$14.52		$2.91
86921	Compatibility test, incubate		X	0345	0.2210	$14.52		$2.91
86922	Compatibility test, antiglob		X	0346	0.3909	$25.68		$5.14
86923	Compatibility test, electric		X	0345	0.2210	$14.52		$2.91
86927	Plasma, fresh frozen		X	0345	0.2210	$14.52		$2.91
86930	Frozen blood prep		X	0347	0.8145	$53.50	$11.28	$10.70
86931	Frozen blood thaw		X	0347	0.8145	$53.50	$11.28	$10.70
86932	Frozen blood freeze/thaw		X	0347	0.8145	$53.50	$11.28	$10.70
86940	Hemolysins/agglutinins, auto		A					
86941	Hemolysins/agglutinins		A					
86945	Blood product/irradiation		X	0345	0.2210	$14.52		$2.91
86950	Leukacyte transfusion		X	0345	0.2210	$14.52		$2.91
86960	Vol reduction of blood/prod		X	0345	0.2210	$14.52		$2.91
86965	Pooling blood platelets		X	0346	0.3909	$25.68		$5.14
86970	RBC pretreatment		X	0345	0.2210	$14.52		$2.91
86971	RBC pretreatment		X	0345	0.2210	$14.52		$2.91
86972	RBC pretreatment	CH	X	0345	0.2210	$14.52		$2.91
86975	RBC pretreatment, serum		X	0346	0.3909	$25.68		$5.14

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
86976	RBC pretreatment, serum		X	0345	0.2210	$14.52		$2.91
86977	RBC pretreatment, serum		X	0346	0.3909	$25.68		$5.14
86978	RBC pretreatment, serum		X	0346	0.3909	$25.68		$5.14
86985	Split blood or products		X	0345	0.2210	$14.52		$2.91
86999	Transfusion procedure		X	0345	0.2210	$14.52		$2.91
87001	Small animal inoculation		A					
87003	Small animal inoculation		A					
87015	Specimen concentration		A					
87040	Blood culture for bacteria		A					
87045	Feces culture, bacteria		A					
87046	Stool cultr, bacteria, each		A					
87070	Culture, bacteria, other		A					
87071	Culture bacteri aerobic othr		A					
87073	Culture bacteria anaerobic		A					
87075	Cultr bacteria, except blood		A					
87076	Culture anaerobe ident, each		A					
87077	Culture aerobic identify		A					
87081	Culture screen only		A					
87084	Culture of specimen by kit		A					
87086	Urine culture/colony count		A					
87088	Urine bacteria culture		A					
87101	Skin fungi culture		A					
87102	Fungus isolation culture		A					
87103	Blood fungus culture		A					
87106	Fungi identification, yeast		A					
87107	Fungi identification, mold		A					
87109	Mycoplasma		A					
87110	Chlamydia culture		A					
87116	Mycobacteria culture		A					
87118	Mycobacteric identification		A					
87140	Culture type immunofluoresc		A					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
87143	Culture typing, glc/hplc		A					
87147	Culture type, immunologic		A					
87149	Culture type, nucleic acid		A					
87152	Culture type pulse field gel		A					
87158	Culture typing, added method		A					
87164	Dark field examination		A					
87166	Dark field examination		A					
87168	Macroscopic exam arthropod		A					
87169	Macroscopic exam parasite		A					
87172	Pinworm exam		A					
87176	Tissue homogenization, cultr		A					
87177	Ova and parasites smears		A					
87181	Microbe susceptible, diffuse		A					
87184	Microbe susceptible, disk		A					
87185	Microbe susceptible, enzyme		A					
87186	Microbe susceptible, mic		A					
87187	Microbe susceptible, mlc		A					
87188	Microbe suscept, macrobroth		A					
87190	Microbe suscept, mycobacteri		A					
87197	Bactericidal level, serum		A					
87205	Smear, gram stain		A					
87206	Smear, fluorescent/acid stai		A					
87207	Smear, special stain		A					
87209	Smear, complex stain		A					
87210	Smear, wet mount, saline/ink		A					
87220	Tissue exam for fungi		A					
87230	Assay, toxin or antitoxin		A					
87250	Virus inoculate, eggs/animal		A					
87252	Virus inoculation, tissue		A					
87253	Virus inoculate tissue, addl		A					
87254	Virus inoculation, shell via		A					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
87255	Genet virus isolate, hsv		A					
87260	Adenovirus ag, if		A					
87265	Pertussis ag, if		A					
87267	Enterovirus antibody, dfa		A					
87269	Giardia ag, if		A					
87270	Chlamydia trachomatis ag, if		A					
87271	Cytomegalovirus dfa		A					
87272	Cryptosporidium ag, if		A					
87273	Herpes simplex 2, ag, if		A					
87274	Herpes simplex 1, ag, if		A					
87275	Influenza b, ag, if		A					
87276	Influenza a, ag, if		A					
87277	Legionella micdadei, ag, if		A					
87278	Legion pneumophilia ag, if		A					
87279	Parainfluenza, ag, if		A					
87280	Respiratory syncytial ag, if		A					
87281	Pneumocystis carinii, ag, if		A					
87283	Rubeola, ag, if		A					
87285	Treponema pallidum, ag, if		A					
87290	Varicella zoster, ag, if		A					
87299	Antibody detection, nos, if		A					
87300	Ag detection, polyval, if		A					
87301	Adenovirus ag, eia		A					
87305	Aspergillus ag, eia		A					
87320	Chylmd trach ag, eia		A					
87324	Clostridium ag, eia		A					
87327	Cryptococcus neoform ag, eia		A					
87328	Cryptosporidium ag, eia		A					
87329	Giardia ag, eia		A					
87332	Cytomegalovirus ag, eia		A					
87335	E coli 0157 ag, eia		A					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
87336	Entamoeb hist dispr, ag, eia		A					
87337	Entamoeb hist group, ag, eia		A					
87338	Hpylori, stool, eia		A					
87339	H pylori ag, eia		A					
87340	Hepatitis b surface ag, eia		A					
87341	Hepatitis b surface, ag, eia		A					
87350	Hepatitis be ag, eia		A					
87380	Hepatitis delta ag, eia		A					
87385	Histoplasma capsul ag, eia		A					
87390	Hiv-1 ag, eia		A					
87391	Hiv-2 ag, eia		A					
87400	Influenza a/b, ag, eia		A					
87420	Resp syncytial ag, eia		A					
87425	Rotavirus ag, eia		A					
87427	Shiga-like toxin ag, eia		A					
87430	Strep a ag, eia		A					
87449	Ag detect nos, eia, mult		A					
87450	Ag detect nos, eia, single		A					
87451	Ag detect polyval, eia, mult		A					
87470	Bartonella, dna, dir probe		A					
87471	Bartonella, dna, amp probe		A					
87472	Bartonella, dna, quant		A					
87475	Lyme dis, dna, dir probe		A					
87476	Lyme dis, dna, amp probe		A					
87477	Lyme dis, dna, quant		A					
87480	Candida, dna, dir probe		A					
87481	Candida, dna, amp probe		A					
87482	Candida, dna, quant		A					
87485	Chylmd pneum, dna, dir probe		A					
87486	Chylmd pneum, dna, amp probe		A					
87487	Chylmd pneum, dna, quant		A					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
87490	Chylmd trach, dna, dir probe		A					
87491	Chylmd trach, dna, amp probe		A	-				
87492	Chylmd trach, dna, quant		A					
87495	Cytomeg, dna, dir probe		A					
87496	Cytomeg, dna, amp probe		A					
87497	Cytomeg, dna, quant		A					
87498	Enterovirus, dna, amp probe		A					
87500	Vanomycin, dna, amp probe		A					
87510	Gardner vag, dna, dir probe		A					
87511	Gardner vag, dna, amp probe		A					
87512	Gardner vag, dna, quant		A					
87515	Hepatitis b, dna, dir probe		A					
87516	Hepatitis b, dna, amp probe		A					
87517	Hepatitis b, dna, quant		A					
87520	Hepatitis c, rna, dir probe		A					
87521	Hepatitis c, rna, amp probe		A					
87522	Hepatitis c, rna, quant		A					
87525	Hepatitis g, dna, dir probe		A					
87526	Hepatitis g, dna, amp probe		A					
87527	Hepatitis g, dna, quant		A					
87528	Hsv, dna, dir probe		A					
87529	Hsv, dna, amp probe		A					
87530	Hsv, dna, quant		A					
87531	Hhv-6, dna, dir probe		A					
87532	Hhv-6, dna, amp probe		A					
87533	Hhv-6, dna, quant		A					
87534	Hiv-1, dna, dir probe		A					
87535	Hiv-1, dna, amp probe		A					
87536	Hiv-1, dna, quant		A					
87537	Hiv-2, dna, dir probe		A					
87538	Hiv-2, dna, amp probe		A					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
87539	Hiv-2, dna, quant		A					
87540	Legion pneumo, dna, dir prob		A					
87541	Legion pneumo, dna, amp prob		A					
87542	Legion pneumo, dna, quant		A					
87550	Mycobacteria, dna, dir probe		A					
87551	Mycobacteria, dna, amp probe		A					
87552	Mycobacteria, dna, quant		A					
87555	M.tuberculo, dna, dir probe		A					
87556	M.tuberculo, dna, amp probe		A					
87557	M.tuberculo, dna, quant		A					
87560	M.avium-intra, dna, dir prob		A					
87561	M.avium-intra, dna, amp prob		A					
87562	M.avium-intra, dna, quant		A					
87580	M.pneumon, dna, dir probe		A					
87581	M.pneumon, dna, amp probe		A					
87582	M.pneumon, dna, quant		A					
87590	N.gonorrhoeae, dna, dir prob		A					
87591	N.gonorrhoeae, dna, amp prob		A					
87592	N.gonorrhoeae, dna, quant		A					
87620	Hpv, dna, dir probe		A					
87621	Hpv, dna, amp probe		A					
87622	Hpv, dna, quant		A					
87640	Staph a, dna, amp probe		A					
87641	Mr-staph, dna, amp probe		A					
87650	Strep a, dna, dir probe		A					
87651	Strep a, dna, amp probe		A					
87652	Strep a, dna, quant		A					
87653	Strep b, dna, amp probe		A					
87660	Trichomonas vagin, dir probe		A					
87797	Detect agent nos, dna, dir		A					
87798	Detect agent nos, dna, amp		A					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
87799	Detect agent nos, dna, quant		A					
87800	Detect agnt mult, dna, direc		A					
87801	Detect agnt mult, dna, ampli		A					
87802	Strep b assay w/optic		A					
87803	Clostridium toxin a w/optic		A					
87804	Influenza assay w/optic		A					
87807	Rsv assay w/optic		A					
87808	Trichomonas assay w/optic		A					
87809	Adenovirus assay w/optic		A					
87810	Chylmd trach assay w/optic		A					
87850	N. gonorrhoeae assay w/optic		A					
87880	Strep a assay w/optic		A					
87899	Agent nos assay w/optic		A					
87900	Phenotype, infect agent drug		A					
87901	Genotype, dna, hiv reverse t		A					
87902	Genotype, dna, hepatitis C		A					
87903	Phenotype, dna hiv w/culture		A					
87904	Phenotype, dna hiv w/clt add		A					
87999	Microbiology procedure		A					
88000	Autopsy (necropsy), gross		E					
88005	Autopsy (necropsy), gross		E					
88007	Autopsy (necropsy), gross		E					
88012	Autopsy (necropsy), gross		E					
88014	Autopsy (necropsy), gross		E					
88016	Autopsy (necropsy), gross		E					
88020	Autopsy (necropsy), complete		E					
88025	Autopsy (necropsy), complete		E					
88027	Autopsy (necropsy), complete		E					
88028	Autopsy (necropsy), complete		E					
88029	Autopsy (necropsy), complete		E					
88036	Limited autopsy		E					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
88037	Limited autopsy		E					
88040	Forensic autopsy (necropsy)		E					
88045	Coroner's autopsy (necropsy)		E					
88099	Necropsy (autopsy) procedure		E					
88104	Cytopath fl nongyn, smears		X	0433	0.2499	$16.41	$5.17	$3.29
88106	Cytopath fl nongyn, filter		X	0433	0.2499	$16.41	$5.17	$3.29
88107	Cytopath fl nongyn, sm/fltr		X	0343	0.5322	$34.96	$10.84	$7.00
88108	Cytopath, concentrate tech	CH	X	0433	0.2499	$16.41	$5.17	$3.29
88112	Cytopath, cell enhance tech		X	0343	0.5322	$34.96	$10.84	$7.00
88125	Forensic cytopathology		X	0433	0.2499	$16.41	$5.17	$3.29
88130	Sex chromatin identification		A					
88140	Sex chromatin identification		A					
88141	Cytopath, c/v, interpret		N					
88142	Cytopath, c/v, thin layer		A					
88143	Cytopath c/v thin layer redo		A					
88147	Cytopath, c/v, automated		A					
88148	Cytopath, c/v, auto rescreen		A					
88150	Cytopath, c/v, manual		A					
88152	Cytopath, c/v, auto redo		A					
88153	Cytopath, c/v, redo		A					
88154	Cytopath, c/v, select		A					
88155	Cytopath, c/v, index add-on		A					
88160	Cytopath smear, other source		X	0433	0.2499	$16.41	$5.17	$3.29
88161	Cytopath smear, other source		X	0433	0.2499	$16.41	$5.17	$3.29
88162	Cytopath smear, other source	CH	X	0433	0.2499	$16.41	$5.17	$3.29
88164	Cytopath tbs, c/v, manual		A					
88165	Cytopath tbs, c/v, redo		A					
88166	Cytopath tbs, c/v, auto redo		A					
88167	Cytopath tbs, c/v, select		A					
88172	Cytopathology eval of fna		X	0343	0.5322	$34.96	$10.84	$7.00
88173	Cytopath eval, fna, report		X	0343	0.5322	$34.96	$10.84	$7.00

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
88174	Cytopath, c/v auto, in fluid		A					
88175	Cytopath c/v auto fluid redo		A					
88182	Cell marker study		X	0343	0.5322	$34.96	$10.84	$7.00
88184	Flowcytometry/ tc, 1 marker		X	0433	0.2499	$16.41	$5.17	$3.29
88185	Flowcytometry/tc, add-on		X	0433	0.2499	$16.41	$5.17	$3.29
88187	Flowcytometry/read, 2-8	CH	X	0342	0.1558	$10.23		$2.05
88188	Flowcytometry/read, 9-15	CH	X	0343	0.5322	$34.96	$10.84	$7.00
88189	Flowcytometry/read, 16 & >		X	0343	0.5322	$34.96	$10.84	$7.00
88199	Cytopathology procedure		X	0342	0.1558	$10.23		$2.05
88230	Tissue culture, lymphocyte		A					
88233	Tissue culture, skin/biopsy		A					
88235	Tissue culture, placenta		A					
88237	Tissue culture, bone marrow		A					
88239	Tissue culture, tumor		A					
88240	Cell cryopreserve/storage		A					
88241	Frozen cell preparation		A					
88245	Chromosome analysis, 20-25		A					
88248	Chromosome analysis, 50-100		A					
88249	Chromosome analysis, 100		A					
88261	Chromosome analysis, 5		A					
88262	Chromosome analysis, 15-20		A					
88263	Chromosome analysis, 45		A					
88264	Chromosome analysis, 20-25		A					
88267	Chromosome analys, placenta		A					
88269	Chromosome analys, amniotic		A					
88271	Cytogenetics, dna probe		A					
88272	Cytogenetics, 3-5		A					
88273	Cytogenetics, 10-30		A					
88274	Cytogenetics, 25-99		A					
88275	Cytogenetics, 100-300		A					
88280	Chromosome karyotype study		A					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
88283	Chromosome banding study		A					
88285	Chromosome count, additional		A					
88289	Chromosome study, additional		A					
88291	Cyto/molecular report		M					
88299	Cytogenetic study		X	0342	0.1558	$10.23		$2.05
88300	Surgical path, gross		X	0433	0.2499	$16.41	$5.17	$3.29
88302	Tissue exam by pathologist		X	0433	0.2499	$16.41	$5.17	$3.29
88304	Tissue exam by pathologist		X	0343	0.5322	$34.96	$10.84	$7.00
88305	Tissue exam by pathologist		X	0343	0.5322	$34.96	$10.84	$7.00
88307	Tissue exam by pathologist		X	0344	0.8373	$55.00	$15.66	$11.00
88309	Tissue exam by pathologist		X	0344	0.8373	$55.00	$15.66	$11.00
88311	Decalcify tissue	CH	X	0342	0.1558	$10.23		$2.05
88312	Special stains		X	0433	0.2499	$16.41	$5.17	$3.29
88313	Special stains		X	0433	0.2499	$16.41	$5.17	$3.29
88314	Histochemical stain		X	0433	0.2499	$16.41	$5.17	$3.29
88318	Chemical histochemistry		X	0433	0.2499	$16.41	$5.17	$3.29
88319	Enzyme histochemistry	CH	X	0343	0.5322	$34.96	$10.84	$7.00
88321	Microslide consultation		X	0433	0.2499	$16.41	$5.17	$3.29
88323	Microslide consultation		X	0343	0.5322	$34.96	$10.84	$7.00
88325	Comprehensive review of data		X	0344	0.8373	$55.00	$15.66	$11.00
88329	Path consult introp		X	0433	0.2499	$16.41	$5.17	$3.29
88331	Path consult intraop, 1 bloc		X	0343	0.5322	$34.96	$10.84	$7.00
88332	Path consult intraop, add'l		X	0433	0.2499	$16.41	$5.17	$3.29
88333	Intraop cyto path consult, 1	CH	X	0433	0.2499	$16.41	$5.17	$3.29
88334	Intraop cyto path consult, 2		X	0433	0.2499	$16.41	$5.17	$3.29
88342	Immunohistochemistry		X	0343	0.5322	$34.96	$10.84	$7.00
88346	Immunofluorescent study		X	0343	0.5322	$34.96	$10.84	$7.00
88347	Immunofluorescent study		X	0343	0.5322	$34.96	$10.84	$7.00
88348	Electron microscopy		X	0661	2.5473	$167.32	$60.52	$33.47
88349	Scanning electron microscopy		X	0661	2.5473	$167.32	$60.52	$33.47
88355	Analysis, skeletal muscle		X	0343	0.5322	$34.96	$10.84	$7.00

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
88356	Analysis, nerve		X	0344	0.8373	$55.00	$15.66	$11.00
88358	Analysis, tumor	CH	X	0343	0.5322	$34.96	$10.84	$7.00
88360	Tumor immunohistochem/manual		X	0343	0.5322	$34.96	$10.84	$7.00
88361	Tumor immunohistochem/comput	CH	X	0343	0.5322	$34.96	$10.84	$7.00
88362	Nerve teasing preparations		X	0344	0.8373	$55.00	$15.66	$11.00
88365	Insitu hybridization (fish)		X	0344	0.8373	$55.00	$15.66	$11.00
88367	Insitu hybridization, auto		X	0344	0.8373	$55.00	$15.66	$11.00
88368	Insitu hybridization, manual		X	0343	0.5322	$34.96	$10.84	$7.00
88371	Protein, western blot tissue		A					
88372	Protein analysis w/probe		A					
88380	Microdissection, laser		N					
88381	Microdissection, manual		N					
88384	Eval molecular probes, 11-50		X	0433	0.2499	$16.41	$5.17	$3.29
88385	Eval molecul probes, 51-250		X	0343	0.5322	$34.96	$10.84	$7.00
88386	Eval molecul probes, 251-500		X	0344	0.8373	$55.00	$15.66	$11.00
88399	Surgical pathology procedure		X	0342	0.1558	$10.23		$2.05
88400	Bilirubin total transcut		A					
89049	Chct for mal hyperthermia	CH	X	0342	0.1558	$10.23		$2.05
89050	Body fluid cell count		A					
89051	Body fluid cell count		A					
89055	Leukocyte assessment, fecal		A					
89060	Exam,synovial fluid crystals		A					
89100	Sample intestinal contents		X	0360	1.5404	$101.18	$33.88	$20.24
89105	Sample intestinal contents		X	0360	1.5404	$101.18	$33.88	$20.24
89125	Specimen fat stain		A					
89130	Sample stomach contents		X	0360	1.5404	$101.18	$33.88	$20.24
89132	Sample stomach contents		X	0360	1.5404	$101.18	$33.88	$20.24
89135	Sample stomach contents		X	0360	1.5404	$101.18	$33.88	$20.24
89136	Sample stomach contents		X	0360	1.5404	$101.18	$33.88	$20.24
89140	Sample stomach contents		X	0360	1.5404	$101.18	$33.88	$20.24
89141	Sample stomach contents		X	0360	1.5404	$101.18	$33.88	$20.24

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
89160	Exam feces for meat fibers		A					
89190	Nasal smear for eosinophils		A					
89220	Sputum specimen collection	CH	X	0433	0.2499	$16.41	$5.17	$3.29
89225	Starch granules, feces		A					
89230	Collect sweat for test		X	0343	0.5322	$34.96	$10.84	$7.00
89235	Water load test		A					
89240	Pathology lab procedure		X	0342	0.1558	$10.23		$2.05
89250	Cultr oocyte/embryo <4 days		X	0344	0.8373	$55.00	$15.66	$11.00
89251	Cultr oocyte/embryo <4 days		X	0344	0.8373	$55.00	$15.66	$11.00
89253	Embryo hatching		X	0344	0.8373	$55.00	$15.66	$11.00
89254	Oocyte identification		X	0344	0.8373	$55.00	$15.66	$11.00
89255	Prepare embryo for transfer		X	0344	0.8373	$55.00	$15.66	$11.00
89257	Sperm identification		X	0344	0.8373	$55.00	$15.66	$11.00
89258	Cryopreservation; embryo(s)		X	0344	0.8373	$55.00	$15.66	$11.00
89259	Cryopreservation, sperm		X	0344	0.8373	$55.00	$15.66	$11.00
89260	Sperm isolation, simple		X	0344	0.8373	$55.00	$15.66	$11.00
89261	Sperm isolation, complex		X	0344	0.8373	$55.00	$15.66	$11.00
89264	Identify sperm tissue		X	0344	0.8373	$55.00	$15.66	$11.00
89268	Insemination of oocytes		X	0344	0.8373	$55.00	$15.66	$11.00
89272	Extended culture of oocytes		X	0344	0.8373	$55.00	$15.66	$11.00
89280	Assist oocyte fertilization		X	0344	0.8373	$55.00	$15.66	$11.00
89281	Assist oocyte fertilization		X	0344	0.8373	$55.00	$15.66	$11.00
89290	Biopsy, oocyte polar body		X	0344	0.8373	$55.00	$15.66	$11.00
89291	Biopsy, oocyte polar body		X	0344	0.8373	$55.00	$15.66	$11.00
89300	Semen analysis w/huhner		A					
89310	Semen analysis w/count		A					
89320	Semen anal vol/count/mot		A					
89321	Semen anal, sperm detection		A					
89322	Semen anal, strict criteria		A					
89325	Sperm antibody test		A					
89329	Sperm evaluation test		A					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
89330	Evaluation, cervical mucus		A					
89331	Retrograde ejaculation anal		A					
89335	Cryopreserve testicular tiss		X	0344	0.8373	$55.00	$15.66	$11.00
89342	Storage/year; embryo(s)		X	0344	0.8373	$55.00	$15.66	$11.00
89343	Storage/year; sperm/semen		X	0344	0.8373	$55.00	$15.66	$11.00
89344	Storage/year; reprod tissue		X	0344	0.8373	$55.00	$15.66	$11.00
89346	Storage/year; oocyte(s)		X	0344	0.8373	$55.00	$15.66	$11.00
89352	Thawing cryopresrved; embryo		X	0344	0.8373	$55.00	$15.66	$11.00
89353	Thawing cryopresrved; sperm		X	0344	0.8373	$55.00	$15.66	$11.00
89354	Thaw cryoprsvrd; reprod tiss		X	0344	0.8373	$55.00	$15.66	$11.00
89356	Thawing cryopresrved; oocyte		X	0344	0.8373	$55.00	$15.66	$11.00
90281	Human ig, im		E					
90283	Human ig, iv		E					
90284	Human ig, sc		E					
90287	Botulinum antitoxin		E					
90288	Botulism ig, iv		E					
90291	Cmv ig, iv		E					
90296	Diphtheria antitoxin	CH	K	1212	1.5227	$100.02		$20.01
90371	Hep b ig, im		K	1630		$117.70		$23.54
90375	Rabies ig, im/sc		K	9133		$66.55		$13.31
90376	Rabies ig, heat treated		K	9134		$76.60		$15.32
90378	Rsv ig, im, 50mg		E					
90379	Rsv ig, iv		E					
90384	Rh ig, full-dose, im		E					
90385	Rh ig, minidose, im		N					
90386	Rh ig, iv		E					
90389	Tetanus ig, im		E					
90393	Vaccina ig, im		N					
90396	Varicella-zoster ig, im		K	9135		$109.89		$21.98
90399	Immune globulin		E					
90465	Immune admin 1 inj, < 8 yrs		B					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
90466	Immune admin addl inj, < 8 y		B					
90467	Immune admin o or n, < 8 yrs		B					
90468	Immune admin o/n, addl < 8 y		B					
90471	Immunization admin	CH	S	0436	0.3810	$25.03		$5.01
90472	Immunization admin, each add		S	0436	0.3810	$25.03		$5.01
90473	Immune admin oral/nasal		S	0436	0.3810	$25.03		$5.01
90474	Immune admin oral/nasal addl		S	0436	0.3810	$25.03		$5.01
90476	Adenovirus vaccine, type 4		N					
90477	Adenovirus vaccine, type 7		N					
90581	Anthrax vaccine, sc		N					
90585	Bcg vaccine, percut		K	9137		$114.69		$22.94
90586	Bcg vaccine, intravesical		B					
90632	Hep a vaccine, adult im		N					
90633	Hep a vacc, ped/adol, 2 dose		N					
90634	Hep a vacc, ped/adol, 3 dose		N					
90636	Hep a/hep b vacc, adult im		N					
90645	Hib vaccine, hboc, im		N					
90646	Hib vaccine, prp-d, im		N					
90647	Hib vaccine, prp-omp, im		N					
90648	Hib vaccine, prp-t, im		N					
90649	H papilloma vacc 3 dose im		B					
90650	Hpv typ bival 3 dose im		E					
90655	Flu vaccine no preserv 6-35m		L					
90656	Flu vaccine no preserv 3 & >		L					
90657	Flu vaccine, 3 yrs, im		L					
90658	Flu vaccine, 3 yrs & >, im		L					
90660	Flu vaccine, nasal		L					
90661	Flu vacc cell cult prsv free		E					
90662	Flu vacc prsv free inc antig		E					
90663	Flu vacc pandemic		E					
90665	Lyme disease vaccine, im	CH	K	1216	1.2166	$79.91		$15.99

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
90669	Pneumococcal vacc, ped <5		L					
90675	Rabies vaccine, im		K	9139		$149.67		$29.94
90676	Rabies vaccine, id		K	9140	1.9332	$126.98		$25.40
90680	Rotovirus vacc 3 dose, oral		N					
90681	Rotovirus vacc 2 dose oral		E					
90690	Typhoid vaccine, oral		N					
90691	Typhoid vaccine, im		N					
90692	Typhoid vaccine, h-p, sc/id		N					
90693	Typhoid vaccine, akd, sc		B					
90696	Dtap-ipv vacc 4-6 yr im		E					
90698	Dtap-hib-ip vaccine, im		N					
90700	Dtap vaccine, < 7 yrs, im		N					
90701	Dtp vaccine, im		N					
90702	Dt vaccine < 7, im		N					
90703	Tetanus vaccine, im		N					
90704	Mumps vaccine, sc		N					
90705	Measles vaccine, sc		N					
90706	Rubella vaccine, sc		N					
90707	Mmr vaccine, sc		N					
90708	Measles-rubella vaccine, sc	CH	N					
90710	Mmrv vaccine, sc		N					
90712	Oral poliovirus vaccine		N					
90713	Poliovirus, ipv, sc/im		N					
90714	Td vaccine no prsrv >/= 7 im		N					
90715	Tdap vaccine >7 im		N					
90716	Chicken pox vaccine, sc		B					
90717	Yellow fever vaccine, sc		N					
90718	Td vaccine > 7, im		N					
90719	Diphtheria vaccine, im		N					
90720	Dtp/hib vaccine, im		N					
90721	Dtap/hib vaccine, im		N					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
90723	Dtap-hep b-ipv vaccine, im		E					
90725	Cholera vaccine, injectable		N					
90727	Plague vaccine, im		N					
90732	Pneumococcal vaccine		L					
90733	Meningococcal vaccine, sc		K	9143		$92.10		$18.42
90734	Meningococcal vaccine, im		K	9145		$80.45		$16.09
90735	Encephalitis vaccine, sc		K	9144		$100.15		$20.03
90736	Zoster vacc, sc		B					
90740	Hepb vacc, ill pat 3 dose im		F					
90743	Hep b vacc, adol, 2 dose, im		F					
90744	Hepb vacc ped/adol 3 dose im		F					
90746	Hep b vaccine, adult, im		F					
90747	Hepb vacc, ill pat 4 dose im		F					
90748	Hep b/hib vaccine, im		E					
90749	Vaccine toxoid		N					
90760	Hydration iv infusion, init	CH	S	0438	1.1315	$74.32		$14.87
90761	Hydrate iv infusion, add-on	CH	S	0436	0.3810	$25.03		$5.01
90765	Ther/proph/diag iv inf, init	CH	S	0439	1.9305	$126.80		$25.36
90766	Ther/proph/dg iv inf, add-on	CH	S	0436	0.3810	$25.03		$5.01
90767	Tx/proph/dg addl seq iv inf		S	0437	0.5581	$36.66		$7.34
90768	Ther/diag concurrent inf		N					
90769	Sc ther infusion, up to 1 hr	CH	S	0438	1.1315	$74.32		$14.87
90770	Sc ther infusion, addl hr		S	0437	0.5581	$36.66		$7.34
90771	Sc ther infusion, reset pump	CH	S	0436	0.3810	$25.03		$5.01
90772	Ther/proph/diag inj, sc/im	CH	S	0436	0.3810	$25.03		$5.01
90773	Ther/proph/diag inj, ia	CH	S	0437	0.5581	$36.66		$7.34
90774	Ther/proph/diag inj, iv push	CH	S	0437	0.5581	$36.66		$7.34
90775	Tx/pro/dx inj new drug addon	CH	S	0437	0.5581	$36.66		$7.34
90776	Tx/pro/dx inj same drug adon		N					
90779	Ther/prop/diag inj/inf proc		S	0436	0.3810	$25.03		$5.01
90801	Psy dx interview		Q3	0323	1.6400	$107.72		$21.55

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
90802	Intac psy dx interview		Q3	0323	1.6400	$107.72		$21.55
90804	Psytx, office, 20-30 min		Q3	0322	1.3362	$87.77		$17.56
90805	Psytx, off, 20-30 min w/e&m		Q3	0322	1.3362	$87.77		$17.56
90806	Psytx, off, 45-50 min		Q3	0323	1.6400	$107.72		$21.55
90807	Psytx, off, 45-50 min w/e&m		Q3	0323	1.6400	$107.72		$21.55
90808	Psytx, office, 75-80 min		Q3	0323	1.6400	$107.72		$21.55
90809	Psytx, off, 75-80, w/e&m		Q3	0323	1.6400	$107.72		$21.55
90810	Intac psytx, off, 20-30 min		Q3	0322	1.3362	$87.77		$17.56
90811	Intac psytx, 20-30, w/e&m		Q3	0322	1.3362	$87.77		$17.56
90812	Intac psytx, off, 45-50 min		Q3	0323	1.6400	$107.72		$21.55
90813	Intac psytx, 45-50 min w/e&m		Q3	0323	1.6400	$107.72		$21.55
90814	Intac psytx, off, 75-80 min		Q3	0323	1.6400	$107.72		$21.55
90815	Intac psytx, 75-80 w/e&m		Q3	0323	1.6400	$107.72		$21.55
90816	Psytx, hosp, 20-30 min	CH	P					
90817	Psytx, hosp, 20-30 min w/e&m	CH	P					
90818	Psytx, hosp, 45-50 min	CH	P					
90819	Psytx, hosp, 45-50 min w/e&m	CH	P					
90821	Psytx, hosp, 75-80 min	CH	P					
90822	Psytx, hosp, 75-80 min w/e&m	CH	P					
90823	Intac psytx, hosp, 20-30 min	CH	P					
90824	Intac psytx, hsp 20-30 w/e&m	CH	P					
90826	Intac psytx, hosp, 45-50 min	CH	P					
90827	Intac psytx, hsp 45-50 w/e&m	CH	P					
90828	Intac psytx, hosp, 75-80 min	CH	P					
90829	Intac psytx, hsp 75-80 w/e&m	CH	P					
90845	Psychoanalysis		Q3	0323	1.6400	$107.72		$21.55
90846	Family psytx w/o patient		Q3	0324	2.5065	$164.64		$32.93
90847	Family psytx w/patient		Q3	0324	2.5065	$164.64		$32.93
90849	Multiple family group psytx		Q3	0325	0.9540	$62.66	$13.71	$12.54
90853	Group psychotherapy		Q3	0325	0.9540	$62.66	$13.71	$12.54
90857	Intac group psytx		Q3	0325	0.9540	$62.66	$13.71	$12.54

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
90862	Medication management		Q3	0606	1.3354	$87.71		$17.55
90865	Narcosynthesis		Q3	0323	1.6400	$107.72		$21.55
90870	Electroconvulsive therapy		S	0320	5.8540	$384.51	$80.06	$76.91
90875	Psychophysiological therapy		E					
90876	Psychophysiological therapy		E					
90880	Hypnotherapy		Q3	0323	1.6400	$107.72		$21.55
90882	Environmental manipulation		E					
90885	Psy evaluation of records		N					
90887	Consultation with family		N					
90889	Preparation of report		N					
90899	Psychiatric service/therapy		Q3	0322	1.3362	$87.77		$17.56
90901	Biofeedback train, any meth		A					
90911	Biofeedback peri/uro/rectal		T	0126	1.0401	$68.32	$16.21	$13.67
90918	ESRD related services, month		E					
90919	ESRD related services, month		E					
90920	ESRD related services, month		E					
90921	ESRD related services, month		E					
90922	ESRD related services, day		E					
90923	Esrd related services, day		E					
90924	Esrd related services, day		E					
90925	Esrd related services, day		E					
90935	Hemodialysis, one evaluation		S	0170	6.5091	$427.54		$85.51
90937	Hemodialysis, repeated eval		B					
90940	Hemodialysis access study		N					
90945	Dialysis, one evaluation		S	0170	6.5091	$427.54		$85.51
90947	Dialysis, repeated eval		B					
90989	Dialysis training, complete		B					
90993	Dialysis training, incompl		B					
90997	Hemoperfusion		B					
90999	Dialysis procedure		B					
91000	Esophageal intubation		X	0361	4.0162	$263.80	$83.23	$52.76

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
91010	Esophagus motility study		X	0361	4.0162	$263.80	$83.23	$52.76
91011	Esophagus motility study		X	0361	4.0162	$263.80	$83.23	$52.76
91012	Esophagus motility study		X	0361	4.0162	$263.80	$83.23	$52.76
91020	Gastric motility studies		X	0361	4.0162	$263.80	$83.23	$52.76
91022	Duodenal motility study		X	0361	4.0162	$263.80	$83.23	$52.76
91030	Acid perfusion of esophagus		X	0361	4.0162	$263.80	$83.23	$52.76
91034	Gastroesophageal reflux test		X	0361	4.0162	$263.80	$83.23	$52.76
91035	G-esoph reflx tst w/electrod		X	0361	4.0162	$263.80	$83.23	$52.76
91037	Esoph imped function test		X	0361	4.0162	$263.80	$83.23	$52.76
91038	Esoph imped funct test > 1h		X	0361	4.0162	$263.80	$83.23	$52.76
91040	Esoph balloon distension tst		X	0360	1.5404	$101.18	$33.88	$20.24
91052	Gastric analysis test		X	0361	4.0162	$263.80	$83.23	$52.76
91055	Gastric intubation for smear		X	0360	1.5404	$101.18	$33.88	$20.24
91065	Breath hydrogen test		X	0360	1.5404	$101.18	$33.88	$20.24
91100	Pass intestine bleeding tube		X	0360	1.5404	$101.18	$33.88	$20.24
91105	Gastric intubation treatment		X	0360	1.5404	$101.18	$33.88	$20.24
91110	Gi tract capsule endoscopy		T	0142	9.5559	$627.67	$152.78	$125.54
91111	Esophageal capsule endoscopy		T	0141	8.7109	$572.17	$143.38	$114.44
91120	Rectal sensation test		T	0126	1.0401	$68.32	$16.21	$13.67
91122	Anal pressure record		T	0164	2.2063	$144.92		$28.99
91123	Irrigate fecal impaction		N					
91132	Electrogastrography		X	0360	1.5404	$101.18	$33.88	$20.24
91133	Electrogastrography w/test		X	0360	1.5404	$101.18	$33.88	$20.24
91299	Gastroenterology procedure		X	0360	1.5404	$101.18	$33.88	$20.24
92002	Eye exam, new patient		V	0605	1.0387	$68.23		$13.65
92004	Eye exam, new patient		V	0606	1.3354	$87.71		$17.55
92012	Eye exam established pat		V	0604	0.8425	$55.34		$11.07
92014	Eye exam & treatment		V	0605	1.0387	$68.23		$13.65
92015	Refraction		E					
92018	New eye exam & treatment		T	0699	14.3730	$944.08		$188.82
92019	Eye exam & treatment		T	0699	14.3730	$944.08		$188.82

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
92020	Special eye evaluation		S	0230	0.6359	$41.77		$8.36
92025	Corneal topography		S	0698	0.9139	$60.03		$12.01
92060	Special eye evaluation		S	0698	0.9139	$60.03		$12.01
92065	Orthoptic/pleoptic training		S	0698	0.9139	$60.03		$12.01
92070	Fitting of contact lens		N					
92081	Visual field examination(s)		S	0230	0.6359	$41.77		$8.36
92082	Visual field examination(s)		S	0698	0.9139	$60.03		$12.01
92083	Visual field examination(s)		S	0698	0.9139	$60.03		$12.01
92100	Serial tonometry exam(s)		N					
92120	Tonography & eye evaluation		S	0698	0.9139	$60.03		$12.01
92130	Water provocation tonography		S	0230	0.6359	$41.77		$8.36
92135	Ophth dx imaging post seg		S	0230	0.6359	$41.77		$8.36
92136	Ophthalmic biometry		S	0698	0.9139	$60.03		$12.01
92140	Glaucoma provocative tests		S	0230	0.6359	$41.77		$8.36
92225	Special eye exam, initial		S	0230	0.6359	$41.77		$8.36
92226	Special eye exam, subsequent		S	0698	0.9139	$60.03		$12.01
92230	Eye exam with photos		S	0231	2.1019	$138.06		$27.62
92235	Eye exam with photos		S	0231	2.1019	$138.06		$27.62
92240	Icg angiography		S	0231	2.1019	$138.06		$27.62
92250	Eye exam with photos		S	0698	0.9139	$60.03		$12.01
92260	Ophthalmoscopy/dynamometry		S	0230	0.6359	$41.77		$8.36
92265	Eye muscle evaluation		S	0698	0.9139	$60.03		$12.01
92270	Electro-oculography		S	0230	0.6359	$41.77		$8.36
92275	Electroretinography		S	0231	2.1019	$138.06		$27.62
92283	Color vision examination		S	0230	0.6359	$41.77		$8.36
92284	Dark adaptation eye exam		S	0698	0.9139	$60.03		$12.01
92285	Eye photography		S	0698	0.9139	$60.03		$12.01
92286	Internal eye photography		S	0231	2.1019	$138.06		$27.62
92287	Internal eye photography		S	0231	2.1019	$138.06		$27.62
92310	Contact lens fitting		E					
92311	Contact lens fitting		S	0698	0.9139	$60.03		$12.01

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
92312	Contact lens fitting		S	0698	0.9139	$60.03		$12.01
92313	Contact lens fitting		S	0230	0.6359	$41.77		$8.36
92314	Prescription of contact lens		E					
92315	Prescription of contact lens		S	0230	0.6359	$41.77		$8.36
92316	Prescription of contact lens		S	0698	0.9139	$60.03		$12.01
92317	Prescription of contact lens		S	0230	0.6359	$41.77		$8.36
92325	Modification of contact lens		S	0230	0.6359	$41.77		$8.36
92326	Replacement of contact lens		S	0698	0.9139	$60.03		$12.01
92340	Fitting of spectacles		E					
92341	Fitting of spectacles		E					
92342	Fitting of spectacles		E					
92352	Special spectacles fitting		S	0698	0.9139	$60.03		$12.01
92353	Special spectacles fitting		S	0230	0.6359	$41.77		$8.36
92354	Special spectacles fitting		S	0230	0.6359	$41.77		$8.36
92355	Special spectacles fitting		S	0230	0.6359	$41.77		$8.36
92358	Eye prosthesis service		S	0230	0.6359	$41.77		$8.36
92370	Repair & adjust spectacles		E					
92371	Repair & adjust spectacles		S	0230	0.6359	$41.77		$8.36
92499	Eye service or procedure		S	0230	0.6359	$41.77		$8.36
92502	Ear and throat examination		T	0251	3.1568	$207.35		$41.47
92504	Ear microscopy examination		N					
92506	Speech/hearing evaluation		A					
92507	Speech/hearing therapy		A					
92508	Speech/hearing therapy		A					
92511	Nasopharyngoscopy		T	0071	0.9326	$61.26		$12.26
92512	Nasal function studies		X	0363	0.8762	$57.55	$17.10	$11.51
92516	Facial nerve function test		X	0660	1.5269	$100.29	$28.06	$20.06
92520	Laryngeal function studies		X	0660	1.5269	$100.29	$28.06	$20.06
92526	Oral function therapy		A					
92531	Spontaneous nystagmus study		N					
92532	Positional nystagmus test		N					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
92533	Caloric vestibular test		N					
92534	Optokinetic nystagmus test		N					
92541	Spontaneous nystagmus test		X	0363	0.8762	$57.55	$17.10	$11.51
92542	Positional nystagmus test		X	0363	0.8762	$57.55	$17.10	$11.51
92543	Caloric vestibular test		X	0660	1.5269	$100.29	$28.06	$20.06
92544	Optokinetic nystagmus test		X	0363	0.8762	$57.55	$17.10	$11.51
92545	Oscillating tracking test		X	0363	0.8762	$57.55	$17.10	$11.51
92546	Sinusoidal rotational test		X	0660	1.5269	$100.29	$28.06	$20.06
92547	Supplemental electrical test		N					
92548	Posturography		X	0660	1.5269	$100.29	$28.06	$20.06
92551	Pure tone hearing test, air		E					
92552	Pure tone audiometry, air		X	0364	0.4638	$30.46	$7.06	$6.10
92553	Audiometry, air & bone		X	0365	1.2904	$84.76	$18.52	$16.96
92555	Speech threshold audiometry		X	0364	0.4638	$30.46	$7.06	$6.10
92556	Speech audiometry, complete		X	0364	0.4638	$30.46	$7.06	$6.10
92557	Comprehensive hearing test		X	0365	1.2904	$84.76	$18.52	$16.96
92559	Group audiometric testing		E					
92560	Bekesy audiometry, screen		E					
92561	Bekesy audiometry, diagnosis		X	0364	0.4638	$30.46	$7.06	$6.10
92562	Loudness balance test		X	0364	0.4638	$30.46	$7.06	$6.10
92563	Tone decay hearing test		X	0364	0.4638	$30.46	$7.06	$6.10
92564	Sisi hearing test		X	0364	0.4638	$30.46	$7.06	$6.10
92565	Stenger test, pure tone		X	0364	0.4638	$30.46	$7.06	$6.10
92567	Tympanometry		X	0364	0.4638	$30.46	$7.06	$6.10
92568	Acoustic refl threshold tst		X	0364	0.4638	$30.46	$7.06	$6.10
92569	Acoustic reflex decay test		X	0364	0.4638	$30.46	$7.06	$6.10
92571	Filtered speech hearing test		X	0364	0.4638	$30.46	$7.06	$6.10
92572	Staggered spondaic word test		X	0366	1.7950	$117.90	$25.79	$23.58
92575	Sensorineural acuity test		X	0364	0.4638	$30.46	$7.06	$6.10
92576	Synthetic sentence test		X	0364	0.4638	$30.46	$7.06	$6.10
92577	Stenger test, speech		X	0366	1.7950	$117.90	$25.79	$23.58

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92579	Visual audiometry (vra)		X	0365	1.2904	$84.76	$18.52	$16.96
92582	Conditioning play audiometry		X	0365	1.2904	$84.76	$18.52	$16.96
92583	Select picture audiometry		X	0364	0.4638	$30.46	$7.06	$6.10
92584	Electrocochleography		S	0216	2.7194	$178.62		$35.73
92585	Auditor evoke potent, compre		S	0216	2.7194	$178.62		$35.73
92586	Auditor evoke potent, limit		S	0218	1.2004	$78.85		$15.77
92587	Evoked auditory test		X	0363	0.8762	$57.55	$17.10	$11.51
92588	Evoked auditory test		X	0660	1.5269	$100.29	$28.06	$20.06
92590	Hearing aid exam, one ear		E					
92591	Hearing aid exam, both ears		E					
92592	Hearing aid check, one ear		E					
92593	Hearing aid check, both ears		E					
92594	Electro hearng aid test, one		E					
92595	Electro hearng aid tst, both		E					
92596	Ear protector evaluation		X	0364	0.4638	$30.46	$7.06	$6.10
92597	Oral speech device eval		A					
92601	Cochlear implt f/up exam < 7		X	0366	1.7950	$117.90	$25.79	$23.58
92602	Reprogram cochlear implt < 7		X	0366	1.7950	$117.90	$25.79	$23.58
92603	Cochlear implt f/up exam 7 >		X	0366	1.7950	$117.90	$25.79	$23.58
92604	Reprogram cochlear implt 7 >		X	0366	1.7950	$117.90	$25.79	$23.58
92605	Eval for nonspeech device rx		A					
92606	Non-speech device service		A					
92607	Ex for speech device rx, 1hr		A					
92608	Ex for speech device rx addl		A					
92609	Use of speech device service		A					
92610	Evaluate swallowing function		A					
92611	Motion fluoroscopy/swallow		A					
92612	Endoscopy swallow tst (fees)		A					
92613	Endoscopy swallow tst (fees)		B					
92614	Laryngoscopic sensory test		A					
92615	Eval laryngoscopy sense tst		E					

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92616	Fees w/laryngeal sense test		A					
92617	Interprt fees/laryngeal test		E					
92620	Auditory function, 60 min		X	0365	1.2904	$84.76	$18.52	$16.96
92621	Auditory function, + 15 min		N					
92625	Tinnitus assessment		X	0365	1.2904	$84.76	$18.52	$16.96
92626	Eval aud rehab status	CH	X	0366	1.7950	$117.90	$25.79	$23.58
92627	Eval aud status rehab add-on		N					
92630	Aud rehab pre-ling hear loss		E					
92633	Aud rehab postling hear loss		E					
92640	Aud brainstem implt programg		X	0365	1.2904	$84.76	$18.52	$16.96
92700	Ent procedure/service		X	0364	0.4638	$30.46	$7.06	$6.10
92950	Heart/lung resuscitation cpr		S	0094	2.4550	$161.25	$46.29	$32.25
92953	Temporary external pacing		S	0094	2.4550	$161.25	$46.29	$32.25
92960	Cardioversion electric, ext		S	0679	5.4894	$360.57	$95.30	$72.12
92961	Cardioversion, electric, int		S	0679	5.4894	$360.57	$95.30	$72.12
92970	Cardioassist, internal		C					
92971	Cardioassist, external		C					
92973	Percut coronary thrombectomy		T	0088	40.2393	$2,643.08	$655.22	$528.62
92974	Cath place, cardio brachytx		T	0103	15.8354	$1,040.13		$208.03
92975	Dissolve clot, heart vessel		C					
92977	Dissolve clot, heart vessel		T	0676	2.4493	$160.88		$32.18
92978	Intravasc us, heart add-on		N					
92979	Intravasc us, heart add-on		N					
92980	Insert intracoronary stent		T	0104	83.1148	$5,459.31		$1,091.87
92981	Insert intracoronary stent		T	0104	83.1148	$5,459.31		$1,091.87
92982	Coronary artery dilation		T	0083	48.2679	$3,170.43		$634.09
92984	Coronary artery dilation		T	0083	48.2679	$3,170.43		$634.09
92986	Revision of aortic valve		T	0083	48.2679	$3,170.43		$634.09
92987	Revision of mitral valve		T	0083	48.2679	$3,170.43		$634.09
92990	Revision of pulmonary valve		T	0083	48.2679	$3,170.43		$634.09
92992	Revision of heart chamber		C					

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92993	Revision of heart chamber		C					
92995	Coronary atherectomy		T	0082	89.0122	$5,846.68		$1,169.34
92996	Coronary atherectomy add-on		T	0082	89.0122	$5,846.68		$1,169.34
92997	Pul art balloon repr, percut		T	0083	48.2679	$3,170.43		$634.09
92998	Pul art balloon repr, percut		T	0083	48.2679	$3,170.43		$634.09
93000	Electrocardiogram, complete		B					
93005	Electrocardiogram, tracing		S	0099	0.4021	$26.41		$5.29
93010	Electrocardiogram report		B					
93012	Transmission of ecg		N					
93014	Report on transmitted ecg		B					
93015	Cardiovascular stress test		B					
93016	Cardiovascular stress test		B					
93017	Cardiovascular stress test		X	0100	2.5931	$170.33	$41.44	$34.07
93018	Cardiovascular stress test		B					
93024	Cardiac drug stress test		X	0100	2.5931	$170.33	$41.44	$34.07
93025	Microvolt t-wave assess		X	0100	2.5931	$170.33	$41.44	$34.07
93040	Rhythm ECG with report		B					
93041	Rhythm ECG, tracing	CH	X	0035	0.2298	$15.09		$3.02
93042	Rhythm ECG, report		B					
93224	ECG monitor/report, 24 hrs		B					
93225	ECG monitor/record, 24 hrs		X	0097	1.0044	$65.97	$23.79	$13.20
93226	ECG monitor/report, 24 hrs		X	0097	1.0044	$65.97	$23.79	$13.20
93227	ECG monitor/review, 24 hrs		B					
93230	ECG monitor/report, 24 hrs		B					
93231	Ecg monitor/record, 24 hrs		X	0097	1.0044	$65.97	$23.79	$13.20
93232	ECG monitor/report, 24 hrs		X	0097	1.0044	$65.97	$23.79	$13.20
93233	ECG monitor/review, 24 hrs		B					
93235	ECG monitor/report, 24 hrs		B					
93236	ECG monitor/report, 24 hrs		X	0097	1.0044	$65.97	$23.79	$13.20
93237	ECG monitor/review, 24 hrs		B					
93268	ECG record/review		B					

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93270	ECG recording		X	0097	1.0044	$65.97	$23.79	$13.20
93271	Ecg/monitoring and analysis	CH	S	0692	1.7241	$113.25		$22.65
93272	Ecg/review, interpret only		B					
93278	ECG/signal-averaged		X	0340	0.6481	$42.57		$8.52
93303	Echo transthoracic		S	0269	6.4958	$426.67		$85.34
93304	Echo transthoracic		S	0697	3.4563	$227.02		$45.41
93307	Echo exam of heart		S	0269	6.4958	$426.67		$85.34
93308	Echo exam of heart		S	0697	3.4563	$227.02		$45.41
93312	Echo transesophageal		S	0270	8.3205	$546.52	$141.32	$109.31
93313	Echo transesophageal		S	0270	8.3205	$546.52	$141.32	$109.31
93314	Echo transesophageal		N					
93315	Echo transesophageal		S	0270	8.3205	$546.52	$141.32	$109.31
93316	Echo transesophageal		S	0270	8.3205	$546.52	$141.32	$109.31
93317	Echo transesophageal		N					
93318	Echo transesophageal intraop		S	0270	8.3205	$546.52	$141.32	$109.31
93320	Doppler echo exam, heart		N					
93321	Doppler echo exam, heart		N					
93325	Doppler color flow add-on		N					
93350	Echo transthoracic		S	0269	6.4958	$426.67		$85.34
93501	Right heart catheterization		T	0080	39.5675	$2,598.95	$838.92	$519.79
93503	Insert/place heart catheter		T	0103	15.8354	$1,040.13		$208.03
93505	Biopsy of heart lining		T	0103	15.8354	$1,040.13		$208.03
93508	Cath placement, angiography		T	0080	39.5675	$2,598.95	$838.92	$519.79
93510	Left heart catheterization		T	0080	39.5675	$2,598.95	$838.92	$519.79
93511	Left heart catheterization		T	0080	39.5675	$2,598.95	$838.92	$519.79
93514	Left heart catheterization		T	0080	39.5675	$2,598.95	$838.92	$519.79
93524	Left heart catheterization		T	0080	39.5675	$2,598.95	$838.92	$519.79
93526	Rt & Lt heart catheters		T	0080	39.5675	$2,598.95	$838.92	$519.79
93527	Rt & Lt heart catheters		T	0080	39.5675	$2,598.95	$838.92	$519.79
93528	Rt & Lt heart catheters		T	0080	39.5675	$2,598.95	$838.92	$519.79
93529	Rt, lt heart catheterization		T	0080	39.5675	$2,598.95	$838.92	$519.79

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
93530	Rt heart cath, congenital		T	0080	39.5675	$2,598.95	$838.92	$519.79
93531	R & l heart cath, congenital		T	0080	39.5675	$2,598.95	$838.92	$519.79
93532	R & l heart cath, congenital		T	0080	39.5675	$2,598.95	$838.92	$519.79
93533	R & l heart cath, congenital		T	0080	39.5675	$2,598.95	$838.92	$519.79
93539	Injection, cardiac cath		N					
93540	Injection, cardiac cath		N					
93541	Injection for lung angiogram		N					
93542	Injection for heart x-rays		N					
93543	Injection for heart x-rays		N					
93544	Injection for aortography		N					
93545	Inject for coronary x-rays		N					
93555	Imaging, cardiac cath		N					
93556	Imaging, cardiac cath		N					
93561	Cardiac output measurement		N					
93562	Cardiac output measurement		N					
93571	Heart flow reserve measure		N					
93572	Heart flow reserve measure		N					
93580	Transcath closure of asd		T	0434	138.5843	$9,102.77		$1,820.56
93581	Transcath closure of vsd		T	0434	138.5843	$9,102.77		$1,820.56
93600	Bundle of His recording		S	0084	10.5097	$690.32		$138.07
93602	Intra-atrial recording		S	0084	10.5097	$690.32		$138.07
93603	Right ventricular recording		S	0084	10.5097	$690.32		$138.07
93609	Map tachycardia, add-on		N					
93610	Intra-atrial pacing		S	0084	10.5097	$690.32		$138.07
93612	Intraventricular pacing		S	0084	10.5097	$690.32		$138.07
93613	Electrophys map 3d, add-on		N					
93615	Esophageal recording		S	0084	10.5097	$690.32		$138.07
93616	Esophageal recording		S	0084	10.5097	$690.32		$138.07
93618	Heart rhythm pacing		S	0084	10.5097	$690.32		$138.07
93619	Electrophysiology evaluation		Q3	0085	48.8767	$3,210.42		$642.09
93620	Electrophysiology evaluation		Q3	0085	48.8767	$3,210.42		$642.09

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
93621	Electrophysiology evaluation		N					
93622	Electrophysiology evaluation		N					
93623	Stimulation, pacing heart		N					
93624	Electrophysiologic study		T	0085	48.8767	$3,210.42		$642.09
93631	Heart pacing, mapping		N					
93640	Evaluation heart device		N					
93641	Electrophysiology evaluation		N					
93642	Electrophysiology evaluation		S	0084	10.5097	$690.32		$138.07
93650	Ablate heart dysrhythm focus		Q3	0085	48.8767	$3,210.42		$642.09
93651	Ablate heart dysrhythm focus		Q3	0086	99.5911	$6,541.54		$1,308.31
93652	Ablate heart dysrhythm focus		Q3	0086	99.5911	$6,541.54		$1,308.31
93660	Tilt table evaluation		S	0101	4.3029	$282.63	$100.24	$56.53
93662	Intracardiac ecg (ice)		N					
93668	Peripheral vascular rehab		E					
93701	Bioimpedance, thoracic		S	0099	0.4021	$26.41		$5.29
93720	Total body plethysmography		B					
93721	Plethysmography tracing		X	0368	0.8437	$55.42	$21.09	$11.09
93722	Plethysmography report		B					
93724	Analyze pacemaker system		S	0690	0.3456	$22.70	$8.67	$4.54
93727	Analyze ilr system		S	0690	0.3456	$22.70	$8.67	$4.54
93731	Analyze pacemaker system		S	0690	0.3456	$22.70	$8.67	$4.54
93732	Analyze pacemaker system		S	0690	0.3456	$22.70	$8.67	$4.54
93733	Telephone analy, pacemaker		S	0690	0.3456	$22.70	$8.67	$4.54
93734	Analyze pacemaker system		S	0690	0.3456	$22.70	$8.67	$4.54
93735	Analyze pacemaker system		S	0690	0.3456	$22.70	$8.67	$4.54
93736	Telephonic analy, pacemaker		S	0690	0.3456	$22.70	$8.67	$4.54
93740	Temperature gradient studies		X	0368	0.8437	$55.42	$21.09	$11.09
93741	Analyze ht pace device sngl		S	0689	0.5805	$38.13		$7.63
93742	Analyze ht pace device sngl		S	0689	0.5805	$38.13		$7.63
93743	Analyze ht pace device dual		S	0689	0.5805	$38.13		$7.63
93744	Analyze ht pace device dual		S	0689	0.5805	$38.13		$7.63

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93745	Set-up cardiovert-defibrill		S	0689	0.5805	$38.13		$7.63
93760	Cephalic thermogram		E					
93762	Peripheral thermogram		E					
93770	Measure venous pressure		N					
93784	Ambulatory BP monitoring		E					
93786	Ambulatory BP recording		X	0097	1.0044	$65.97	$23.79	$13.20
93788	Ambulatory BP analysis		X	0097	1.0044	$65.97	$23.79	$13.20
93790	Review/report BP recording		B					
93797	Cardiac rehab		S	0095	0.5713	$37.53	$13.86	$7.51
93798	Cardiac rehab/monitor		S	0095	0.5713	$37.53	$13.86	$7.51
93799	Cardiovascular procedure		X	0097	1.0044	$65.97	$23.79	$13.20
93875	Extracranial study		S	0096	1.4496	$95.22	$37.42	$19.05
93880	Extracranial study		S	0267	2.3495	$154.32	$60.50	$30.87
93882	Extracranial study		S	0267	2.3495	$154.32	$60.50	$30.87
93886	Intracranial study		S	0267	2.3495	$154.32	$60.50	$30.87
93888	Intracranial study		S	0265	0.9644	$63.35	$22.35	$12.67
93890	Tcd, vasoreactivity study		S	0266	1.5058	$98.91	$37.80	$19.79
93892	Tcd, emboli detect w/o inj		S	0266	1.5058	$98.91	$37.80	$19.79
93893	Tcd, emboli detect w/inj		S	0266	1.5058	$98.91	$37.80	$19.79
93922	Extremity study		S	0096	1.4496	$95.22	$37.42	$19.05
93923	Extremity study		S	0096	1.4496	$95.22	$37.42	$19.05
93924	Extremity study		S	0096	1.4496	$95.22	$37.42	$19.05
93925	Lower extremity study		S	0267	2.3495	$154.32	$60.50	$30.87
93926	Lower extremity study		S	0266	1.5058	$98.91	$37.80	$19.79
93930	Upper extremity study		S	0267	2.3495	$154.32	$60.50	$30.87
93931	Upper extremity study		S	0266	1.5058	$98.91	$37.80	$19.79
93965	Extremity study		S	0096	1.4496	$95.22	$37.42	$19.05
93970	Extremity study		S	0267	2.3495	$154.32	$60.50	$30.87
93971	Extremity study		S	0266	1.5058	$98.91	$37.80	$19.79
93975	Vascular study		S	0267	2.3495	$154.32	$60.50	$30.87
93976	Vascular study		S	0267	2.3495	$154.32	$60.50	$30.87

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93978	Vascular study		S	0267	2.3495	$154.32	$60.50	$30.87
93979	Vascular study		S	0266	1.5058	$98.91	$37.80	$19.79
93980	Penile vascular study		S	0267	2.3495	$154.32	$60.50	$30.87
93981	Penile vascular study		S	0267	2.3495	$154.32	$60.50	$30.87
93982	Aneurysm pressure sens study		X	0097	1.0044	$65.97	$23.79	$13.20
93990	Doppler flow testing		S	0266	1.5058	$98.91	$37.80	$19.79
94002	Vent mgmt inpat, init day		S	0079	2.7751	$182.28		$36.46
94003	Vent mgmt inpat, subq day		S	0079	2.7751	$182.28		$36.46
94004	Vent mgmt nf per day		B					
94005	Home vent mgmt supervision		M					
94010	Breathing capacity test		X	0368	0.8437	$55.42	$21.09	$11.09
94014	Patient recorded spirometry		X	0367	0.5744	$37.73	$13.76	$7.55
94015	Patient recorded spirometry		X	0367	0.5744	$37.73	$13.76	$7.55
94016	Review patient spirometry		A					
94060	Evaluation of wheezing	CH	S	0078	1.4146	$92.92		$18.59
94070	Evaluation of wheezing		X	0369	2.7139	$178.26	$44.18	$35.66
94150	Vital capacity test		X	0367	0.5744	$37.73	$13.76	$7.55
94200	Lung function test (MBC/MVV)		X	0367	0.5744	$37.73	$13.76	$7.55
94240	Residual lung capacity		X	0368	0.8437	$55.42	$21.09	$11.09
94250	Expired gas collection	CH	X	0368	0.8437	$55.42	$21.09	$11.09
94260	Thoracic gas volume		X	0368	0.8437	$55.42	$21.09	$11.09
94350	Lung nitrogen washout curve		X	0368	0.8437	$55.42	$21.09	$11.09
94360	Measure airflow resistance		X	0367	0.5744	$37.73	$13.76	$7.55
94370	Breath airway closing volume		X	0367	0.5744	$37.73	$13.76	$7.55
94375	Respiratory flow volume loop		X	0368	0.8437	$55.42	$21.09	$11.09
94400	CO2 breathing response curve		X	0367	0.5744	$37.73	$13.76	$7.55
94450	Hypoxia response curve		X	0368	0.8437	$55.42	$21.09	$11.09
94452	Hast w/report		X	0368	0.8437	$55.42	$21.09	$11.09
94453	Hast w/oxygen titrate	CH	X	0368	0.8437	$55.42	$21.09	$11.09
94610	Surfactant admin thru tube		S	0077	0.3971	$26.08	$7.74	$5.22
94620	Pulmonary stress test/simple		X	0368	0.8437	$55.42	$21.09	$11.09

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
94621	Pulm stress test/complex		X	0369	2.7139	$178.26	$44.18	$35.66
94640	Airway inhalation treatment		S	0077	0.3971	$26.08	$7.74	$5.22
94642	Aerosol inhalation treatment		S	0078	1.4146	$92.92		$18.59
94644	Cbt, 1st hour	CH	S	0077	0.3971	$26.08	$7.74	$5.22
94645	Cbt, each addl hour	CH	S	0077	0.3971	$26.08	$7.74	$5.22
94660	Pos airway pressure, CPAP		S	0078	1.4146	$92.92		$18.59
94662	Neg press ventilation, cnp		S	0079	2.7751	$182.28		$36.46
94664	Evaluate pt use of inhaler		S	0077	0.3971	$26.08	$7.74	$5.22
94667	Chest wall manipulation		S	0077	0.3971	$26.08	$7.74	$5.22
94668	Chest wall manipulation		S	0077	0.3971	$26.08	$7.74	$5.22
94680	Exhaled air analysis, o2		X	0368	0.8437	$55.42	$21.09	$11.09
94681	Exhaled air analysis, o2/co2		X	0368	0.8437	$55.42	$21.09	$11.09
94690	Exhaled air analysis		X	0367	0.5744	$37.73	$13.76	$7.55
94720	Monoxide diffusing capacity		X	0368	0.8437	$55.42	$21.09	$11.09
94725	Membrane diffusion capacity		X	0368	0.8437	$55.42	$21.09	$11.09
94750	Pulmonary compliance study	CH	X	0367	0.5744	$37.73	$13.76	$7.55
94760	Measure blood oxygen level		N					
94761	Measure blood oxygen level		N					
94762	Measure blood oxygen level		Q1	0097	1.0044	$65.97	$23.79	$13.20
94770	Exhaled carbon dioxide test		X	0367	0.5744	$37.73	$13.76	$7.55
94772	Breath recording, infant		X	0369	2.7139	$178.26	$44.18	$35.66
94774	Ped home apnea rec, compl		B					
94775	Ped home apnea rec, hk-up		X	0097	1.0044	$65.97	$23.79	$13.20
94776	Ped home apnea rec, downld		X	0097	1.0044	$65.97	$23.79	$13.20
94777	Ped home apnea rec, report		B					
94799	Pulmonary service/procedure		X	0367	0.5744	$37.73	$13.76	$7.55
95004	Percut allergy skin tests		X	0381	0.3866	$25.39		$5.08
95010	Percut allergy titrate test		X	0381	0.3866	$25.39		$5.08
95012	Exhaled nitric oxide meas		X	0367	0.5744	$37.73	$13.76	$7.55
95015	Id allergy titrate-drug/bug		X	0381	0.3866	$25.39		$5.08
95024	Id allergy test, drug/bug		X	0381	0.3866	$25.39		$5.08

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95027	Id allergy titrate-airborne		X	0381	0.3866	$25.39		$5.08
95028	Id allergy test-delayed type		X	0381	0.3866	$25.39		$5.08
95044	Allergy patch tests		X	0381	0.3866	$25.39		$5.08
95052	Photo patch test		X	0381	0.3866	$25.39		$5.08
95056	Photosensitivity tests		X	0370	1.3792	$90.59		$18.12
95060	Eye allergy tests		X	0370	1.3792	$90.59		$18.12
95065	Nose allergy test		X	0381	0.3866	$25.39		$5.08
95070	Bronchial allergy tests		X	0369	2.7139	$178.26	$44.18	$35.66
95071	Bronchial allergy tests		X	0369	2.7139	$178.26	$44.18	$35.66
95075	Ingestion challenge test		X	0361	4.0162	$263.80	$83.23	$52.76
95115	Immunotherapy, one injection		S	0436	0.3810	$25.03		$5.01
95117	Immunotherapy injections	CH	S	0436	0.3810	$25.03		$5.01
95120	Immunotherapy, one injection		E					
95125	Immunotherapy, many antigens		E					
95130	Immunotherapy, insect venom		E					
95131	Immunotherapy, insect venoms		E					
95132	Immunotherapy, insect venoms		E					
95133	Immunotherapy, insect venoms		E					
95134	Immunotherapy, insect venoms		E					
95144	Antigen therapy services		S	0437	0.5581	$36.66		$7.34
95145	Antigen therapy services	CH	S	0436	0.3810	$25.03		$5.01
95146	Antigen therapy services	CH	S	0438	1.1315	$74.32		$14.87
95147	Antigen therapy services	CH	S	0438	1.1315	$74.32		$14.87
95148	Antigen therapy services		S	0437	0.5581	$36.66		$7.34
95149	Antigen therapy services	CH	S	0439	1.9305	$126.80		$25.36
95165	Antigen therapy services	CH	S	0436	0.3810	$25.03		$5.01
95170	Antigen therapy services	CH	S	0436	0.3810	$25.03		$5.01
95180	Rapid desensitization		X	0370	1.3792	$90.59		$18.12
95199	Allergy immunology services		X	0381	0.3866	$25.39		$5.08
95250	Glucose monitoring, cont		V	0607	1.7777	$116.77		$23.36
95251	Gluc monitor, cont, phys i&r		B					

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95805	Multiple sleep latency test		S	0209	11.4227	$750.29	$268.73	$150.06
95806	Sleep study, unattended		S	0213	2.3220	$152.52	$53.58	$30.51
95807	Sleep study, attended		S	0209	11.4227	$750.29	$268.73	$150.06
95808	Polysomnography, 1-3		S	0209	11.4227	$750.29	$268.73	$150.06
95810	Polysomnography, 4 or more		S	0209	11.4227	$750.29	$268.73	$150.06
95811	Polysomnography w/cpap		S	0209	11.4227	$750.29	$268.73	$150.06
95812	Eeg, 41-60 minutes		S	0213	2.3220	$152.52	$53.58	$30.51
95813	Eeg, over 1 hour		S	0213	2.3220	$152.52	$53.58	$30.51
95816	Eeg, awake and drowsy		S	0213	2.3220	$152.52	$53.58	$30.51
95819	Eeg, awake and asleep		S	0213	2.3220	$152.52	$53.58	$30.51
95822	Eeg, coma or sleep only		S	0213	2.3220	$152.52	$53.58	$30.51
95824	Eeg, cerebral death only		S	0216	2.7194	$178.62		$35.73
95827	Eeg, all night recording		S	0213	2.3220	$152.52	$53.58	$30.51
95829	Surgery electrocorticogram		N					
95830	Insert electrodes for EEG		B					
95831	Limb muscle testing, manual		A					
95832	Hand muscle testing, manual		A					
95833	Body muscle testing, manual		A					
95834	Body muscle testing, manual		A					
95851	Range of motion measurements		A					
95852	Range of motion measurements		A					
95857	Tensilon test		S	0218	1.2004	$78.85		$15.77
95860	Muscle test, one limb		S	0218	1.2004	$78.85		$15.77
95861	Muscle test, 2 limbs		S	0218	1.2004	$78.85		$15.77
95863	Muscle test, 3 limbs		S	0218	1.2004	$78.85		$15.77
95864	Muscle test, 4 limbs		S	0218	1.2004	$78.85		$15.77
95865	Muscle test, larynx		S	0218	1.2004	$78.85		$15.77
95866	Muscle test, hemidiaphragm		S	0218	1.2004	$78.85		$15.77
95867	Muscle test cran nerv unilat		S	0218	1.2004	$78.85		$15.77
95868	Muscle test cran nerve bilat		S	0218	1.2004	$78.85		$15.77
95869	Muscle test, thor paraspinal	CH	S	0215	0.5969	$39.21		$7.85

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95870	Muscle test, nonparaspinal		S	0215	0.5969	$39.21		$7.85
95872	Muscle test, one fiber		S	0218	1.2004	$78.85		$15.77
95873	Guide nerv destr, elec stim		N					
95874	Guide nerv destr, needle emg		N					
95875	Limb exercise test		S	0215	0.5969	$39.21		$7.85
95900	Motor nerve conduction test		S	0215	0.5969	$39.21		$7.85
95903	Motor nerve conduction test		S	0215	0.5969	$39.21		$7.85
95904	Sense nerve conduction test		S	0215	0.5969	$39.21		$7.85
95920	Intraop nerve test add-on		N					
95921	Autonomic nerv function test	CH	S	0215	0.5969	$39.21		$7.85
95922	Autonomic nerv function test	CH	S	0215	0.5969	$39.21		$7.85
95923	Autonomic nerv function test		S	0218	1.2004	$78.85		$15.77
95925	Somatosensory testing		S	0216	2.7194	$178.62		$35.73
95926	Somatosensory testing		S	0216	2.7194	$178.62		$35.73
95927	Somatosensory testing		S	0216	2.7194	$178.62		$35.73
95928	C motor evoked, uppr limbs		S	0218	1.2004	$78.85		$15.77
95929	C motor evoked, lwr limbs		S	0218	1.2004	$78.85		$15.77
95930	Visual evoked potential test		S	0216	2.7194	$178.62		$35.73
95933	Blink reflex test		S	0215	0.5969	$39.21		$7.85
95934	H-reflex test		S	0215	0.5969	$39.21		$7.85
95936	H-reflex test		S	0215	0.5969	$39.21		$7.85
95937	Neuromuscular junction test		S	0218	1.2004	$78.85		$15.77
95950	Ambulatory eeg monitoring		S	0209	11.4227	$750.29	$268.73	$150.06
95951	EEG monitoring/videorecord		S	0209	11.4227	$750.29	$268.73	$150.06
95953	EEG monitoring/computer		S	0209	11.4227	$750.29	$268.73	$150.06
95954	EEG monitoring/giving drugs		S	0218	1.2004	$78.85		$15.77
95955	EEG during surgery		N					
95956	Eeg monitoring, cable/radio		S	0209	11.4227	$750.29	$268.73	$150.06
95957	EEG digital analysis		N					
95958	EEG monitoring/function test		S	0213	2.3220	$152.52	$53.58	$30.51
95961	Electrode stimulation, brain		S	0216	2.7194	$178.62		$35.73

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95962	Electrode stim, brain add-on		S	0216	2.7194	$178.62		$35.73
95965	Meg, spontaneous		S	0067	55.7874	$3,664.34		$732.87
95966	Meg, evoked, single		S	0065	15.1533	$995.33		$199.07
95967	Meg, evoked, each add'l		S	0065	15.1533	$995.33		$199.07
95970	Analyze neurostim, no prog		S	0218	1.2004	$78.85		$15.77
95971	Analyze neurostim, simple		S	0692	1.7241	$113.25		$22.65
95972	Analyze neurostim, complex	CH	S	0692	1.7241	$113.25		$22.65
95973	Analyze neurostim, complex	CH	S	0692	1.7241	$113.25		$22.65
95974	Cranial neurostim, complex	CH	S	0692	1.7241	$113.25		$22.65
95975	Cranial neurostim, complex		S	0692	1.7241	$113.25		$22.65
95978	Analyze neurostim brain/1h		S	0692	1.7241	$113.25		$22.65
95979	Analyz neurostim brain addon	CH	S	0692	1.7241	$113.25		$22.65
95980	Io anal gast n-stim init		N					
95981	Io anal gast n-stim subsq		S	0218	1.2004	$78.85		$15.77
95982	Io ga n-stim subsq w/reprog		S	0692	1.7241	$113.25		$22.65
95990	Spin/brain pump refil & main	CH	S	0440	2.9088	$191.06		$38.22
95991	Spin/brain pump refil & main	CH	S	0440	2.9088	$191.06		$38.22
95999	Neurological procedure		S	0215	0.5969	$39.21		$7.85
96000	Motion analysis, video/3d		S	0216	2.7194	$178.62		$35.73
96001	Motion test w/ft press meas		S	0216	2.7194	$178.62		$35.73
96002	Dynamic surface emg		S	0218	1.2004	$78.85		$15.77
96003	Dynamic fine wire emg		S	0215	0.5969	$39.21		$7.85
96004	Phys review of motion tests		B					
96020	Functional brain mapping		N					
96040	Genetic counseling, 30 min		B					
96101	Psycho testing by psych/phys		Q3	0382	2.5409	$166.90		$33.38
96102	Psycho testing by technician		Q3	0382	2.5409	$166.90		$33.38
96103	Psycho testing admin by comp		Q3	0373	1.3147	$86.35		$17.27
96105	Assessment of aphasia		A					
96110	Developmental test, lim		Q3	0373	1.3147	$86.35		$17.27
96111	Developmental test, extend		Q3	0382	2.5409	$166.90		$33.38

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96116	Neurobehavioral status exam		Q3	0382	2.5409	$166.90		$33.38
96118	Neuropsych tst by psych/phys		Q3	0382	2.5409	$166.90		$33.38
96119	Neuropsych testing by tec		Q3	0382	2.5409	$166.90		$33.38
96120	Neuropsych tst admin w/comp		Q3	0373	1.3147	$86.35		$17.27
96125	Cognitive test by hc pro		A					
96150	Assess hlth/behave, init		Q3	0432	0.4341	$28.51		$5.71
96151	Assess hlth/behave, subseq		Q3	0432	0.4341	$28.51		$5.71
96152	Intervene hlth/behave, indiv		Q3	0432	0.4341	$28.51		$5.71
96153	Intervene hlth/behave, group		Q3	0432	0.4341	$28.51		$5.71
96154	Interv hlth/behav, fam w/pt		Q3	0432	0.4341	$28.51		$5.71
96155	Interv hlth/behav fam no pt		E					
96401	Chemo, anti-neopl, sq/im	CH	S	0437	0.5581	$36.66		$7.34
96402	Chemo hormon antineopl sq/im	CH	S	0437	0.5581	$36.66		$7.34
96405	Chemo intralesional, up to 7	CH	S	0437	0.5581	$36.66		$7.34
96406	Chemo intralesional over 7		S	0438	1.1315	$74.32		$14.87
96409	Chemo, iv push, sngl drug		S	0439	1.9305	$126.80		$25.36
96411	Chemo, iv push, addl drug	CH	S	0438	1.1315	$74.32		$14.87
96413	Chemo, iv infusion, 1 hr	CH	S	0440	2.9088	$191.06		$38.22
96415	Chemo, iv infusion, addl hr	CH	S	0437	0.5581	$36.66		$7.34
96416	Chemo prolong infuse w/pump	CH	S	0440	2.9088	$191.06		$38.22
96417	Chemo iv infus each addl seq		S	0438	1.1315	$74.32		$14.87
96420	Chemo, ia, push tecnique		S	0439	1.9305	$126.80		$25.36
96422	Chemo ia infusion up to 1 hr	CH	S	0440	2.9088	$191.06		$38.22
96423	Chemo ia infuse each addl hr		S	0438	1.1315	$74.32		$14.87
96425	Chemotherapy,infusion method	CH	S	0440	2.9088	$191.06		$38.22
96440	Chemotherapy, intracavitary	CH	S	0440	2.9088	$191.06		$38.22
96445	Chemotherapy, intracavitary	CH	S	0440	2.9088	$191.06		$38.22
96450	Chemotherapy, into CNS	CH	S	0440	2.9088	$191.06		$38.22
96521	Refill/maint, portable pump		S	0440	2.9088	$191.06		$38.22
96522	Refill/maint pump/resvr syst	CH	S	0439	1.9305	$126.80		$25.36
96523	Irrig drug delivery device		Q1	0624	0.6000	$39.41	$12.65	$7.89

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96542	Chemotherapy injection	CH	S	0439	1.9305	$126.80		$25.36
96549	Chemotherapy, unspecified		S	0436	0.3810	$25.03		$5.01
96567	Photodynamic tx, skin		T	0013	0.8332	$54.73		$10.95
96570	Photodynamic tx, 30 min		T	0015	1.5126	$99.35		$19.87
96571	Photodynamic tx, addl 15 min		T	0015	1.5126	$99.35		$19.87
96900	Ultraviolet light therapy		S	0001	0.5112	$33.58	$7.00	$6.72
96902	Trichogram		N					
96904	Whole body photography		N					
96910	Photochemotherapy with UV-B		S	0001	0.5112	$33.58	$7.00	$6.72
96912	Photochemotherapy with UV-A		S	0001	0.5112	$33.58	$7.00	$6.72
96913	Photochemotherapy, UV-A or B		S	0683	2.9323	$192.61		$38.53
96920	Laser tx, skin < 250 sq cm		T	0015	1.5126	$99.35		$19.87
96921	Laser tx, skin 250-500 sq cm		T	0015	1.5126	$99.35		$19.87
96922	Laser tx, skin > 500 sq cm		T	0015	1.5126	$99.35		$19.87
96999	Dermatological procedure		T	0012	0.3156	$20.73		$4.15
97001	Pt evaluation		A					
97002	Pt re-evaluation		A					
97003	Ot evaluation		A					
97004	Ot re-evaluation		A					
97005	Athletic train eval		E					
97006	Athletic train reeval		E					
97010	Hot or cold packs therapy		A					
97012	Mechanical traction therapy		A					
97014	Electric stimulation therapy		E					
97016	Vasopneumatic device therapy		A					
97018	Paraffin bath therapy		A					
97022	Whirlpool therapy		A					
97024	Diathermy eg, microwave		A					
97026	Infrared therapy		A					
97028	Ultraviolet therapy		A					
97032	Electrical stimulation		A					

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97033	Electric current therapy		A					
97034	Contrast bath therapy		A					
97035	Ultrasound therapy		A					
97036	Hydrotherapy		A					
97039	Physical therapy treatment		A					
97110	Therapeutic exercises		A					
97112	Neuromuscular reeducation		A					
97113	Aquatic therapy/exercises		A					
97116	Gait training therapy		A					
97124	Massage therapy		A					
97139	Physical medicine procedure		A					
97140	Manual therapy		A					
97150	Group therapeutic procedures		A					
97530	Therapeutic activities		A					
97532	Cognitive skills development		A					
97533	Sensory integration		A					
97535	Self care mngment training		A					
97537	Community/work reintegration		A					
97542	Wheelchair mngment training		A					
97545	Work hardening		A					
97546	Work hardening add-on		A					
97597	Active wound care/20 cm or <		T	0015	1.5126	$99.35		$19.87
97598	Active wound care > 20 cm		T	0015	1.5126	$99.35		$19.87
97602	Wound(s) care non-selective	CH	T	0013	0.8332	$54.73		$10.95
97605	Neg press wound tx, < 50 cm		T	0013	0.8332	$54.73		$10.95
97606	Neg press wound tx, > 50 cm	CH	T	0013	0.8332	$54.73		$10.95
97750	Physical performance test		A					
97755	Assistive technology assess		A					
97760	Orthotic mgmt and training		A					
97761	Prosthetic training		A					
97762	C/o for orthotic/prosth use		A					

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97799	Physical medicine procedure		A					
97802	Medical nutrition, indiv, in		A					
97803	Med nutrition, indiv, subseq		A					
97804	Medical nutrition, group		A					
97810	Acupunct w/o stimul 15 min		E					
97811	Acupunct w/o stimul addl 15m		E					
97813	Acupunct w/stimul 15 min		E					
97814	Acupunct w/stimul addl 15m		E					
98925	Osteopathic manipulation		S	0060	0.4025	$26.44		$5.29
98926	Osteopathic manipulation		S	0060	0.4025	$26.44		$5.29
98927	Osteopathic manipulation		S	0060	0.4025	$26.44		$5.29
98928	Osteopathic manipulation		S	0060	0.4025	$26.44		$5.29
98929	Osteopathic manipulation		S	0060	0.4025	$26.44		$5.29
98940	Chiropractic manipulation		S	0060	0.4025	$26.44		$5.29
98941	Chiropractic manipulation		S	0060	0.4025	$26.44		$5.29
98942	Chiropractic manipulation		S	0060	0.4025	$26.44		$5.29
98943	Chiropractic manipulation		E					
98960	Self-mgmt educ & train, 1 pt		E					
98961	Self-mgmt educ/train, 2-4 pt		E					
98962	Self-mgmt educ/train, 5-8 pt		E					
98966	Hc pro phone call 5-10 min		E					
98967	Hc pro phone call 11-20 min		E					
98968	Hc pro phone call 21-30 min		E					
98969	Online service by hc pro		E					
99000	Specimen handling		E					
99001	Specimen handling		E					
99002	Device handling		B					
99024	Postop follow-up visit		B					
99026	In-hospital on call service		E					
99027	Out-of-hosp on call service		E					
99050	Medical services after hrs		B					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
99051	Med serv, eve/wkend/holiday		B					
99053	Med serv 10pm-8am, 24 hr fac		B					
99056	Med service out of office		B					
99058	Office emergency care		B					
99060	Out of office emerg med serv		B					
99070	Special supplies		B					
99071	Patient education materials		B					
99075	Medical testimony		E					
99078	Group health education		N					
99080	Special reports or forms		B					
99082	Unusual physician travel		B					
99090	Computer data analysis		B					
99091	Collect/review data from pt		N					
99100	Special anesthesia service		B					
99116	Anesthesia with hypothermia		B					
99135	Special anesthesia procedure		B					
99140	Emergency anesthesia		B					
99143	Mod cs by same phys, < 5 yrs		N					
99144	Mod cs by same phys, 5 yrs +		N					
99145	Mod cs by same phys add-on		N					
99148	Mod cs diff phys < 5 yrs		N					
99149	Mod cs diff phys 5 yrs +		N					
99150	Mod cs diff phys add-on		N					
99170	Anogenital exam, child		T	0191	0.1824	$11.98		$2.40
99172	Ocular function screen		E					
99173	Visual acuity screen		E					
99174	Ocular photoscreening		E					
99175	Induction of vomiting		N					
99183	Hyperbaric oxygen therapy		B					
99185	Regional hypothermia		N					
99186	Total body hypothermia		N					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
99190	Special pump services		C					
99191	Special pump services		C					
99192	Special pump services		C					
99195	Phlebotomy		X	0624	0.6000	$39.41	$12.65	$7.89
99199	Special service/proc/report		B					
99201	Office/outpatient visit, new		V	0604	0.8425	$55.34		$11.07
99202	Office/outpatient visit, new		V	0605	1.0387	$68.23		$13.65
99203	Office/outpatient visit, new		V	0606	1.3354	$87.71		$17.55
99204	Office/outpatient visit, new		V	0607	1.7777	$116.77		$23.36
99205	Office/outpatient visit, new		Q3	0608	2.3605	$155.05		$31.01
99211	Office/outpatient visit, est		V	0604	0.8425	$55.34		$11.07
99212	Office/outpatient visit, est		V	0605	1.0387	$68.23		$13.65
99213	Office/outpatient visit, est		V	0605	1.0387	$68.23		$13.65
99214	Office/outpatient visit, est		V	0606	1.3354	$87.71		$17.55
99215	Office/outpatient visit, est		Q3	0607	1.7777	$116.77		$23.36
99217	Observation care discharge		B					
99218	Observation care		B					
99219	Observation care		B					
99220	Observation care		B					
99221	Initial hospital care		B					
99222	Initial hospital care		B					
99223	Initial hospital care		B					
99231	Subsequent hospital care		B					
99232	Subsequent hospital care		B					
99233	Subsequent hospital care		B					
99234	Observ/hosp same date		B					
99235	Observ/hosp same date		B					
99236	Observ/hosp same date		B					
99238	Hospital discharge day		B					
99239	Hospital discharge day		B					
99241	Office consultation		B					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
99242	Office consultation		B					
99243	Office consultation		B					
99244	Office consultation		B					
99245	Office consultation		B					
99251	Inpatient consultation		C					
99252	Inpatient consultation		C					
99253	Inpatient consultation		C					
99254	Inpatient consultation		C					
99255	Inpatient consultation		C					
99281	Emergency dept visit		V	0609	0.8162	$53.61	$12.70	$10.73
99282	Emergency dept visit		V	0613	1.3239	$86.96	$21.06	$17.40
99283	Emergency dept visit		V	0614	2.0761	$136.37	$34.50	$27.28
99284	Emergency dept visit		Q3	0615	3.3393	$219.34	$48.49	$43.87
99285	Emergency dept visit		Q3	0616	4.9566	$325.57	$72.86	$65.12
99288	Direct advanced life support		B					
99289	Ped crit care transport		N					
99290	Ped crit care transport addl		N					
99291	Critical care, first hour		Q3	0617	7.4380	$488.56	$111.59	$97.72
99292	Critical care, add'l 30 min		N					
99293	Ped critical care, initial		C					
99294	Ped critical care, subseq		C					
99295	Neonate crit care, initial		C					
99296	Neonate critical care subseq		C					
99298	Ic for lbw infant < 1500 gm		C					
99299	Ic, lbw infant 1500-2500 gm		C					
99300	Ic, infant pbw 2501-5000 gm		N					
99304	Nursing facility care, init		B					
99305	Nursing facility care, init		B					
99306	Nursing facility care, init		B					
99307	Nursing fac care, subseq		B					
99308	Nursing fac care, subseq		B					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
99309	Nursing fac care, subseq		B					
99310	Nursing fac care, subseq		B					
99315	Nursing fac discharge day		B					
99316	Nursing fac discharge day		B					
99318	Annual nursing fac assessmnt		B					
99324	Domicil/r-home visit new pat		B					
99325	Domicil/r-home visit new pat		B					
99326	Domicil/r-home visit new pat		B					
99327	Domicil/r-home visit new pat		B					
99328	Domicil/r-home visit new pat		B					
99334	Domicil/r-home visit est pat		B					
99335	Domicil/r-home visit est pat		B					
99336	Domicil/r-home visit est pat		B					
99337	Domicil/r-home visit est pat		B					
99339	Domicil/r-home care supervis		B					
99340	Domicil/r-home care supervis		B					
99341	Home visit, new patient		B					
99342	Home visit, new patient		B					
99343	Home visit, new patient		B					
99344	Home visit, new patient		B					
99345	Home visit, new patient		B					
99347	Home visit, est patient		B					
99348	Home visit, est patient		B					
99349	Home visit, est patient		B					
99350	Home visit, est patient		B					
99354	Prolonged service, office		N					
99355	Prolonged service, office		N					
99356	Prolonged service, inpatient		C					
99357	Prolonged service, inpatient		C					
99358	Prolonged serv, w/o contact		N					
99359	Prolonged serv, w/o contact		N					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
99360	Physician standby services		B					
99363	Anticoag mgmt, init		B					
99364	Anticoag mgmt, subseq		B					
99366	Team conf w/pat by hc pro		N					
99367	Team conf w/o pat by phys		N					
99368	Team conf w/o pat by hc pro		N					
99374	Home health care supervision		B					
99375	Home health care supervision		E					
99377	Hospice care supervision		B					
99378	Hospice care supervision		E					
99379	Nursing fac care supervision		B					
99380	Nursing fac care supervision		B					
99381	Init pm e/m, new pat, inf		E					
99382	Init pm e/m, new pat 1-4 yrs		E					
99383	Prev visit, new, age 5-11		E					
99384	Prev visit, new, age 12-17		E					
99385	Prev visit, new, age 18-39		E					
99386	Prev visit, new, age 40-64		E					
99387	Init pm e/m, new pat 65+ yrs		E					
99391	Per pm reeval, est pat, inf		E					
99392	Prev visit, est, age 1-4		E					
99393	Prev visit, est, age 5-11		E					
99394	Prev visit, est, age 12-17		E					
99395	Prev visit, est, age 18-39		E					
99396	Prev visit, est, age 40-64		E					
99397	Per pm reeval est pat 65+ yr		E					
99401	Preventive counseling, indiv		E					
99402	Preventive counseling, indiv		E					
99403	Preventive counseling, indiv		E					
99404	Preventive counseling, indiv		E					
99406	Behav chng smoking 3-10 min		X	0031	0.1717	$11.28		$2.26

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
99407	Behav chng smoking < 10 min		X	0031	0.1717	$11.28		$2.26
99408	Audit/dast, 15-30 min		E					
99409	Audit/dast, over 30 min		E					
99411	Preventive counseling, group		E					
99412	Preventive counseling, group		E					
99420	Health risk assessment test		E					
99429	Unlisted preventive service		E					
99431	Initial care, normal newborn		V	0605	1.0387	$68.23		$13.65
99432	Newborn care, not in hosp		N					
99433	Normal newborn care/hospital		C					
99435	Newborn discharge day hosp		B					
99436	Attendance, birth		N					
99440	Newborn resuscitation		S	0094	2.4550	$161.25	$46.29	$32.25
99441	Phone e/m by phys 5-10 min		E					
99442	Phone e/m by phys 11-20 min		E					
99443	Phone e/m by phys 21-30 min		E					
99444	Online e/m by phys		E					
99450	Basic life disability exam		E					
99455	Work related disability exam		B					
99456	Disability examination		B					
99477	Init day hosp neonate care		C					
99499	Unlisted e&m service		B					
99500	Home visit, prenatal		E					
99501	Home visit, postnatal		E					
99502	Home visit, nb care		E					
99503	Home visit, resp therapy		E					
99504	Home visit mech ventilator		E					
99505	Home visit, stoma care		E					
99506	Home visit, im injection		E					
99507	Home visit, cath maintain		E					
99509	Home visit day life activity		E					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
99510	Home visit, sing/m/fam couns		E					
99511	Home visit, fecal/enema mgmt		E					
99512	Home visit for hemodialysis		E					
99600	Home visit nos		E					
99601	Home infusion/visit, 2 hrs		E					
99602	Home infusion, each addtl hr		E					
99605	Mtms by pharm, np, 15 min		E					
99606	Mtms by pharm, est, 15 min		E					
99607	Mtms by pharm, addl 15 min		E					
A0021	Outside state ambulance serv		E					
A0080	Noninterest escort in non er		E					
A0090	Interest escort in non er		E					
A0100	Nonemergency transport taxi		E					
A0110	Nonemergency transport bus		E					
A0120	Noner transport mini-bus		E					
A0130	Noner transport wheelch van		E					
A0140	Nonemergency transport air		E					
A0160	Noner transport case worker		E					
A0170	Transport parking fees/tolls		E					
A0180	Noner transport lodgng recip		E					
A0190	Noner transport meals recip		E					
A0200	Noner transport lodgng escrt		E					
A0210	Noner transport meals escort		E					
A0225	Neonatal emergency transport		E					
A0380	Basic life support mileage		E					
A0382	Basic support routine suppls		A					
A0384	Bls defibrillation supplies		A					
A0390	Advanced life support mileag		E					
A0392	Als defibrillation supplies		A					
A0394	Als IV drug therapy supplies		A					
A0396	Als esophageal intub suppls		A					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
A0398	Als routine disposble suppls		A					
A0420	Ambulance waiting 1/2 hr		A					
A0422	Ambulance 02 life sustaining		A					
A0424	Extra ambulance attendant		A					
A0425	Ground mileage		A					
A0426	Als 1		A					
A0427	ALS1-emergency		A					
A0428	bls		A					
A0429	BLS-emergency		A					
A0430	Fixed wing air transport		A					
A0431	Rotary wing air transport		A					
A0432	Pl volunteer ambulance co		A					
A0433	als 2		A					
A0434	Specialty care transport		A					
A0435	Fixed wing air mileage		A					
A0436	Rotary wing air mileage		A					
A0888	Noncovered ambulance mileage		E					
A0998	Ambulance response/treatment		E					
A0999	Unlisted ambulance service		A					
A4206	1 CC sterile syringe&needle		E					
A4207	2 CC sterile syringe&needle		E					
A4208	3 CC sterile syringe&needle		E					
A4209	5+ CC sterile syringe&needle		E					
A4210	Nonneedle injection device		E					
A4211	Supp for self-adm injections		E					
A4212	Non coring needle or stylet		B					
A4213	20+ CC syringe only		E					
A4215	Sterile needle		E					
A4216	Sterile water/saline, 10 ml		A					
A4217	Sterile water/saline, 500 ml		A					
A4218	Sterile saline or water		N					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
A4220	Infusion pump refill kit		N					
A4221	Maint drug infus cath per wk		Y					
A4222	Infusion supplies with pump		Y					
A4223	Infusion supplies w/o pump		E					
A4230	Infus insulin pump non needl		Y					
A4231	Infusion insulin pump needle		Y					
A4232	Syringe w/needle insulin 3cc		E					
A4233	Alkalin batt for glucose mon		Y					
A4234	J-cell batt for glucose mon		Y					
A4235	Lithium batt for glucose mon		Y					
A4236	Silvr oxide batt glucose mon		Y					
A4244	Alcohol or peroxide per pint		E					
A4245	Alcohol wipes per box		E					
A4246	Betadine/phisohex solution		E					
A4247	Betadine/iodine swabs/wipes		E					
A4248	Chlorhexidine antisept		N					
A4250	Urine reagent strips/tablets		E					
A4252	Blood ketone test or strip		E					
A4253	Blood glucose/reagent strips		Y					
A4255	Glucose monitor platforms		Y					
A4256	Calibrator solution/chips		Y					
A4257	Replace Lensshield Cartridge		Y					
A4258	Lancet device each		Y					
A4259	Lancets per box		Y					
A4261	Cervical cap contraceptive		E					
A4262	Temporary tear duct plug		N					
A4263	Permanent tear duct plug		N					
A4265	Paraffin		Y					
A4266	Diaphragm		E					
A4267	Male condom		E					
A4268	Female condom		E					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
A4269	Spermicide		E					
A4270	Disposable endoscope sheath		N					
A4280	Brst prsths adhsv attchmnt		A					
A4281	Replacement breastpump tube		E					
A4282	Replacement breastpump adpt		E					
A4283	Replacement breastpump cap		E					
A4284	Replcmnt breast pump shield		E					
A4285	Replcmnt breast pump bottle		E					
A4286	Replcmnt breastpump lok ring		E					
A4290	Sacral nerve stim test lead		B					
A4300	Cath impl vasc access portal		N					
A4301	Implantable access syst perc		N					
A4305	Drug delivery system >=50 ML		N					
A4306	Drug delivery system <=50 ml		N					
A4310	Insert tray w/o bag/cath		A					
A4311	Catheter w/o bag 2-way latex		A					
A4312	Cath w/o bag 2-way silicone		A					
A4313	Catheter w/bag 3-way		A					
A4314	Cath w/drainage 2-way latex		A					
A4315	Cath w/drainage 2-way silcne		A					
A4316	Cath w/drainage 3-way		A					
A4320	Irrigation tray		A					
A4321	Cath therapeutic irrig agent		A					
A4322	Irrigation syringe		A					
A4326	Male external catheter		A					
A4327	Fem urinary collect dev cup		A					
A4328	Fem urinary collect pouch		A					
A4330	Stool collection pouch		A					
A4331	Extension drainage tubing		A					
A4332	Lube sterile packet		A					
A4333	Urinary cath anchor device		A					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
A4334	Urinary cath leg strap		A					
A4335	Incontinence supply		A					
A4338	Indwelling catheter latex		A					
A4340	Indwelling catheter special		A					
A4344	Cath indw foley 2 way silicn		A					
A4346	Cath indw foley 3 way		A					
A4349	Disposable male external cat		A					
A4351	Straight tip urine catheter		A					
A4352	Coude tip urinary catheter		A					
A4353	Intermittent urinary cath		A					
A4354	Cath insertion tray w/bag		A					
A4355	Bladder irrigation tubing		A					
A4356	Ext ureth clmp or compr dvc		A					
A4357	Bedside drainage bag		A					
A4358	Urinary leg or abdomen bag		A					
A4361	Ostomy face plate		A					
A4362	Solid skin barrier		A					
A4363	Ostomy clamp, replacement		A					
A4364	Adhesive, liquid or equal		A					
A4365	Adhesive remover wipes		A					
A4366	Ostomy vent		A					
A4367	Ostomy belt		A					
A4368	Ostomy filter		A					
A4369	Skin barrier liquid per oz		A					
A4371	Skin barrier powder per oz		A					
A4372	Skin barrier solid 4x4 equiv		A					
A4373	Skin barrier with flange		A					
A4375	Drainable plastic pch w fcpl		A					
A4376	Drainable rubber pch w fcplt		A					
A4377	Drainable plstic pch w/o fp		A					
A4378	Drainable rubber pch w/o fp		A					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
A4379	Urinary plastic pouch w fcpl		A					
A4380	Urinary rubber pouch w fcplt		A					
A4381	Urinary plastic pouch w/o fp		A					
A4382	Urinary hvy plstc pch w/o fp		A					
A4383	Urinary rubber pouch w/o fp		A					
A4384	Ostomy faceplt/silicone ring		A					
A4385	Ost skn barrier sld ext wear		A					
A4387	Ost clsd pouch w att st barr		A					
A4388	Drainable pch w ex wear barr		A					
A4389	Drainable pch w st wear barr		A					
A4390	Drainable pch ex wear convex		A					
A4391	Urinary pouch w ex wear barr		A					
A4392	Urinary pouch w st wear barr		A					
A4393	Urine pch w ex wear bar conv		A					
A4394	Ostomy pouch liq deodorant		A					
A4395	Ostomy pouch solid deodorant		A					
A4396	Peristomal hernia supprt blt		A					
A4397	Irrigation supply sleeve		A					
A4398	Ostomy irrigation bag		A					
A4399	Ostomy irrig cone/cath w brs		A					
A4400	Ostomy irrigation set		A					
A4402	Lubricant per ounce		A					
A4404	Ostomy ring each		A					
A4405	Nonpectin based ostomy paste		A					
A4406	Pectin based ostomy paste		A					
A4407	Ext wear ost skn barr <=4sqö		A					
A4408	Ext wear ost skn barr >4sqö		A					
A4409	Ost skn barr convex <=4 sq i		A					
A4410	Ost skn barr extnd >4 sq		A					
A4411	Ost skn barr extnd =4sq		A					
A4412	Ost pouch drain high output		A					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
A4413	2 pc drainable ost pouch		A					
A4414	Ost sknbar w/o conv<=4 sq in		A					
A4415	Ost skn barr w/o conv >4 sqi		A					
A4416	Ost pch clsd w barrier/filtr		A					
A4417	Ost pch w bar/bltinconv/fltr		A					
A4418	Ost pch clsd w/o bar w filtr		A					
A4419	Ost pch for bar w flange/flt		A					
A4420	Ost pch clsd for bar w lk fl		A					
A4421	Ostomy supply misc		E					
A4422	Ost pouch absorbent material		A					
A4423	Ost pch for bar w lk fl/fltr		A					
A4424	Ost pch drain w bar & filter		A					
A4425	Ost pch drain for barrier fl		A					
A4426	Ost pch drain 2 piece system		A					
A4427	Ost pch drain/barr lk flng/f		A					
A4428	Urine ost pouch w faucet/tap		A					
A4429	Urine ost pouch w bltinconv		A					
A4430	Ost urine pch w b/bltin conv		A					
A4431	Ost pch urine w barrier/tapv		A					
A4432	Os pch urine w bar/tange/tap		A					
A4433	Urine ost pch bar w lock fln		A					
A4434	Ost pch urine w lock flng/ft		A					
A4450	Non-waterproof tape		A					
A4452	Waterproof tape		A					
A4455	Adhesive remover per ounce		A					
A4458	Reusable enema bag		E					
A4461	Surgicl dress hold non-reuse		A					
A4463	Surgical dress holder reuse		A					
A4465	Non-elastic extremity binder		A					
A4470	Gravlee jet washer		A					
A4480	Vabra aspirator		A					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
A4481	Tracheostoma filter		A					
A4483	Moisture exchanger		A					
A4490	Above knee surgical stocking		E					
A4495	Thigh length surg stocking		E					
A4500	Below knee surgical stocking		E					
A4510	Full length surg stocking		E					
A4520	Incontinence garment anytype		E					
A4550	Surgical trays		B					
A4554	Disposable underpads		E					
A4556	Electrodes, pair		Y					
A4557	Lead wires, pair		Y					
A4558	Conductive gel or paste		Y					
A4559	Coupling gel or paste		Y					
A4561	Pessary rubber, any type		N					
A4562	Pessary, non rubber,any type		N					
A4565	Slings		A					
A4570	Splint		E					
A4575	Hyperbaric o2 chamber disps		E					
A4580	Cast supplies (plaster)		E					
A4590	Special casting material		E					
A4595	TENS suppl 2 lead per month		Y					
A4600	Sleeve, inter limb comp dev		Y					
A4601	Lith ion batt, non-pros use		Y					
A4604	Tubing with heating element		Y					
A4605	Trach suction cath close sys		Y					
A4606	Oxygen probe used w oximeter		A					
A4608	Transtracheal oxygen cath		Y					
A4611	Heavy duty battery		Y					
A4612	Battery cables		Y					
A4613	Battery charger		Y					
A4614	Hand-held PEFR meter		N					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
A4615	Cannula nasal		Y					
A4616	Tubing (oxygen) per foot		Y					
A4617	Mouth piece		Y					
A4618	Breathing circuits		Y					
A4619	Face tent		Y					
A4620	Variable concentration mask		Y					
A4623	Tracheostomy inner cannula		A					
A4624	Tracheal suction tube		Y					
A4625	Trach care kit for new trach		A					
A4626	Tracheostomy cleaning brush		A					
A4627	Spacer bag/reservoir		E					
A4628	Oropharyngeal suction cath		Y					
A4629	Tracheostomy care kit		A					
A4630	Repl bat t.e.n.s. own by pt		Y					
A4633	Uvl replacement bulb		Y					
A4634	Replacement bulb th lightbox		A					
A4635	Underarm crutch pad		Y					
A4636	Handgrip for cane etc		Y					
A4637	Repl tip cane/crutch/walker		Y					
A4638	Repl batt pulse gen sys		Y					
A4639	Infrared ht sys replcmnt pad		Y					
A4640	Alternating pressure pad		Y					
A4641	Radiopharm dx agent noc		N					
A4642	In111 satumomab		N					
A4648	Implantable tissue marker		N					
A4649	Surgical supplies		A					
A4650	Implant radiation dosimeter		N					
A4651	Calibrated microcap tube		A					
A4652	Microcapillary tube sealant		A					
A4653	PD catheter anchor belt		A					
A4657	Syringe w/wo needle		A					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
A4660	Sphyg/bp app w cuff and stet		A					
A4663	Dialysis blood pressure cuff		A					
A4670	Automatic bp monitor, dial		E					
A4671	Disposable cycler set		B					
A4672	Drainage ext line, dialysis		B					
A4673	Ext line w easy lock connect		B					
A4674	Chem/antisept solution, 8oz		B					
A4680	Activated carbon filter, ea		A					
A4690	Dialyzer, each		A					
A4706	Bicarbonate conc sol per gal		A					
A4707	Bicarbonate conc pow per pac		A					
A4708	Acetate conc sol per gallon		A					
A4709	Acid conc sol per gallon		A					
A4714	Treated water per gallon		A					
A4719	"Y set" tubing		A					
A4720	Dialysat sol fld vol > 249cc		A					
A4721	Dialysat sol fld vol > 999cc		A					
A4722	Dialys sol fld vol > 1999cc		A					
A4723	Dialys sol fld vol > 2999cc		A					
A4724	Dialys sol fld vol > 3999cc		A					
A4725	Dialys sol fld vol > 4999cc		A					
A4726	Dialys sol fld vol > 5999cc		A					
A4728	Dialysate solution, non-dex		B					
A4730	Fistula cannulation set, ea		A					
A4736	Topical anesthetic, per gram		A					
A4737	Inj anesthetic per 10 ml		A					
A4740	Shunt accessory		A					
A4750	Art or venous blood tubing		A					
A4755	Comb art/venous blood tubing		A					
A4760	Dialysate sol test kit, each		A					
A4765	Dialysate conc pow per pack		A					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
A4766	Dialysate conc sol add 10 ml		A					
A4770	Blood collection tube/vacuum		A					
A4771	Serum clotting time tube		A					
A4772	Blood glucose test strips		A					
A4773	Occult blood test strips		A					
A4774	Ammonia test strips		A					
A4802	Protamine sulfate per 50 mg		A					
A4860	Disposable catheter tips		A					
A4870	Plumb/elec wk hm hemo equip		A					
A4890	Repair/maint cont hemo equip		A					
A4911	Drain bag/bottle		A					
A4913	Misc dialysis supplies noc		A					
A4918	Venous pressure clamp		A					
A4927	Non-sterile gloves		A					
A4928	Surgical mask		A					
A4929	Tourniquet for dialysis, ea		A					
A4930	Sterile, gloves per pair		A					
A4931	Reusable oral thermometer		A					
A4932	Reusable rectal thermometer		E					
A5051	Pouch clsd w barr attached		A					
A5052	Clsd ostomy pouch w/o barr		A					
A5053	Clsd ostomy pouch faceplate		A					
A5054	Clsd ostomy pouch w/flange		A					
A5055	Stoma cap		A					
A5061	Pouch drainable w barrier at		A					
A5062	Drnble ostomy pouch w/o barr		A					
A5063	Drain ostomy pouch w/flange		A					
A5071	Urinary pouch w/barrier		A					
A5072	Urinary pouch w/o barrier		A					
A5073	Urinary pouch on barr w/flng		A					
A5081	Continent stoma plug		A					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
A5082	Continent stoma catheter		A					
A5083	Stoma absorptive cover		A					
A5093	Ostomy accessory convex inse		A					
A5102	Bedside drain btl w/wo tube		A					
A5105	Urinary suspensory		A					
A5112	Urinary leg bag		A					
A5113	Latex leg strap		A					
A5114	Foam/fabric leg strap		A					
A5120	Skin barrier, wipe or swab		A					
A5121	Solid skin barrier 6x6		A					
A5122	Solid skin barrier 8x8		A					
A5126	Disk/foam pad +or- adhesive		A					
A5131	Appliance cleaner		A					
A5200	Percutaneous catheter anchor		A					
A5500	Diab shoe for density insert		Y					
A5501	Diabetic custom molded shoe		Y					
A5503	Diabetic shoe w/roller/rockr		Y					
A5504	Diabetic shoe with wedge		Y					
A5505	Diab shoe w/metatarsal bar		Y					
A5506	Diabetic shoe w/off set heel		Y					
A5507	Modification diabetic shoe		Y					
A5508	Diabetic deluxe shoe		Y					
A5510	Compression form shoe insert		E					
A5512	Multi den insert direct form		Y					
A5513	Multi den insert custom mold		Y					
A6000	Wound warming wound cover		E					
A6010	Collagen based wound filler		A					
A6011	Collagen gel/paste wound fil		A					
A6021	Collagen dressing <=16 sq in		A					
A6022	Collagen drsg>6<=48 sq in		A					
A6023	Collagen dressing >48 sq in		A					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
A6024	Collagen dsg wound filler		A					
A6025	Silicone gel sheet, each		E					
A6154	Wound pouch each		A					
A6196	Alginate dressing <=16 sq in		A					
A6197	Alginate drsg >16 <=48 sq in		A					
A6198	alginate dressing > 48 sq in		A					
A6199	Alginate drsg wound filler		A					
A6200	Compos drsg <=16 no border		E					
A6201	Compos drsg >16<=48 no bdr		E					
A6202	Compos drsg >48 no border		E					
A6203	Composite drsg <= 16 sq in		A					
A6204	Composite drsg >16<=48 sq in		A					
A6205	Composite drsg > 48 sq in		A					
A6206	Contact layer <= 16 sq in		A					
A6207	Contact layer >16<= 48 sq in		A					
A6208	Contact layer > 48 sq in		A					
A6209	Foam drsg <=16 sq in w/o bdr		A					
A6210	Foam drg >16<=48 sq in w/o b		A					
A6211	Foam drg > 48 sq in w/o brdr		A					
A6212	Foam drg <=16 sq in w/border		A					
A6213	Foam drg >16<=48 sq in w/bdr		A					
A6214	Foam drg > 48 sq in w/border		A					
A6215	Foam dressing wound filler		A					
A6216	Non-sterile gauze<=16 sq in		A					
A6217	Non-sterile gauze>16<=48 sq		A					
A6218	Non-sterile gauze > 48 sq in		A					
A6219	Gauze <= 16 sq in w/border		A					
A6220	Gauze >16 <=48 sq in w/bordr		A					
A6221	Gauze > 48 sq in w/border		A					
A6222	Gauze <=16 in no w/sal w/o b		A					
A6223	Gauze >16<=48 no w/sal w/o b		A					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
A6224	Gauze > 48 in no w/sal w/o b		A					
A6228	Gauze <= 16 sq in water/sal		A					
A6229	Gauze >16<=48 sq in watr/sal		A					
A6230	Gauze > 48 sq in water/salne		A					
A6231	Hydrogel dsg<=16 sq in		A					
A6232	Hydrogel dsg>16<=48 sq in		A					
A6233	Hydrogel dressing >48 sq in		A					
A6234	Hydrocolld drg <=16 w/o bdr		A					
A6235	Hydrocolld drg >16<=48 w/o b		A					
A6236	Hydrocolld drg > 48 in w/o b		A					
A6237	Hydrocolld drg <=16 in w/bdr		A					
A6238	Hydrocolld drg >16<=48 w/bdr		A					
A6239	Hydrocolld drg > 48 in w/bdr		A					
A6240	Hydrocolld drg filler paste		A					
A6241	Hydrocolloid drg filler dry		A					
A6242	Hydrogel drg <=16 in w/o bdr		A					
A6243	Hydrogel drg >16<=48 w/o bdr		A					
A6244	Hydrogel drg >48 in w/o bdr		A					
A6245	Hydrogel drg <= 16 in w/bdr		A					
A6246	Hydrogel drg >16<=48 in w/b		A					
A6247	Hydrogel drg > 48 sq in w/b		A					
A6248	Hydrogel drsg gel filler		A					
A6250	Skin seal protect moisturizr		A					
A6251	Absorpt drg <=16 sq in w/o b		A					
A6252	Absorpt drg >16 <=48 w/o bdr		A					
A6253	Absorpt drg > 48 sq in w/o b		A					
A6254	Absorpt drg <=16 sq in w/bdr		A					
A6255	Absorpt drg >16<=48 in w/bdr		A					
A6256	Absorpt drg > 48 sq in w/bdr		A					
A6257	Transparent film <= 16 sq in		A					
A6258	Transparent film >16<=48 in		A					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
A6259	Transparent film > 48 sq in		A					
A6260	Wound cleanser any type/size		A					
A6261	Wound filler gel/paste /oz		A					
A6262	Wound filler dry form / gram		A					
A6266	Impreg gauze no h20/sal/yard		A					
A6402	Sterile gauze <= 16 sq in		A					
A6403	Sterile gauze>16 <= 48 sq in		A					
A6404	Sterile gauze > 48 sq in		A					
A6407	Packing strips, non-impreg		A					
A6410	Sterile eye pad		A					
A6411	Non-sterile eye pad		A					
A6412	Occlusive eye patch		E					
A6413	Adhesive bandage, first-aid		E					
A6441	Pad band w>=3ö <5ö/yd		A					
A6442	Conform band n/s w<3ö/yd		A					
A6443	Conform band n/s w>=3ö<5ö/yd		A					
A6444	Conform band n/s w>=5ö/yd		A					
A6445	Conform band s w <3ö/yd		A					
A6446	Conform band s w>=3ö <5ö/yd		A					
A6447	Conform band s w >=5ö/yd		A					
A6448	Lt compres band <3ö/yd		A					
A6449	Lt compres band >=3ö <5ö/yd		A					
A6450	Lt compres band >=5ö/yd		A					
A6451	Mod compres band w>=3ö<5ö/yd		A					
A6452	High compres band w>=3ö<5öyd		A					
A6453	Self-adher band w <3ö/yd		A					
A6454	Self-adher band w>=3ö <5ö/yd		A					
A6455	Self-adher band >=5ö/yd		A					
A6456	Zinc paste band w >=3ö<5ö/yd		A					
A6457	Tubular dressing		A					
A6501	Compres burngarment bodysuit		A					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
A6502	Compres burngarment chinstrp		A					
A6503	Compres burngarment facehood		A	-				
A6504	Cmprsburngarment glove-wrist		A					
A6505	Cmprsburngarment glove-elbow		A					
A6506	Cmprsburngrmnt glove-axilla		A					
A6507	Cmprs burngarment foot-knee		A					
A6508	Cmprs burngarment foot-thigh		A					
A6509	Compres burn garment jacket		A					
A6510	Compres burn garment leotard		A					
A6511	Compres burn garment panty		A					
A6512	Compres burn garment, noc		A					
A6513	Compress burn mask face/neck		B					
A6530	Compression stocking BK18-30		E					
A6531	Compression stocking BK30-40		A					
A6532	Compression stocking BK40-50		A					
A6533	Gc stocking thighlngth 18-30		E					
A6534	Gc stocking thighlngth 30-40		E					
A6535	Gc stocking thighlngth 40-50		E					
A6536	Gc stocking full lngth 18-30		E					
A6537	Gc stocking full lngth 30-40		E					
A6538	Gc stocking full lngth 40-50		E					
A6539	Gc stocking waistlngth 18-30		E					
A6540	Gc stocking waistlngth 30-40		E					
A6541	Gc stocking waistlngth 40-50		E					
A6542	Gc stocking custom made		E					
A6543	Gc stocking lymphedema		E					
A6544	Gc stocking garter belt		E					
A6549	G compression stocking		E					
A6550	Neg pres wound ther drsg set		Y					
A7000	Disposable canister for pump		Y					
A7001	Nondisposable pump canister		Y					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
A7002	Tubing used w suction pump		Y					
A7003	Nebulizer administration set		Y					
A7004	Disposable nebulizer sml vol		Y					
A7005	Nondisposable nebulizer set		Y					
A7006	Filtered nebulizer admin set		Y					
A7007	Lg vol nebulizer disposable		Y					
A7008	Disposable nebulizer prefill		Y					
A7009	Nebulizer reservoir bottle		Y					
A7010	Disposable corrugated tubing		Y					
A7011	Nondispos corrugated tubing		Y					
A7012	Nebulizer water collec devic		Y					
A7013	Disposable compressor filter		Y					
A7014	Compressor nondispos filter		Y					
A7015	Aerosol mask used w nebulize		Y					
A7016	Nebulizer dome & mouthpiece		Y					
A7017	Nebulizer not used w oxygen		Y					
A7018	Water distilled w/nebulizer		Y					
A7025	Replace chest compress vest		Y					
A7026	Replace chst cmprss sys hose		Y					
A7027	Combination oral/nasal mask		Y					
A7028	Repl oral cushion combo mask		Y					
A7029	Repl nasal pillow comb mask		Y					
A7030	CPAP full face mask		Y					
A7031	Replacement facemask interfa		Y					
A7032	Replacement nasal cushion		Y					
A7033	Replacement nasal pillows		Y					
A7034	Nasal application device		Y					
A7035	Pos airway press headgear		Y					
A7036	Pos airway press chinstrap		Y					
A7037	Pos airway pressure tubing		Y					
A7038	Pos airway pressure filter		Y					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
A7039	Filter, non disposable w pap		Y					
A7040	One way chest drain valve		A					
A7041	Water seal drain container		A					
A7042	Implanted pleural catheter		A					
A7043	Vacuum drainagebottle/tubing		A					
A7044	PAP oral interface		Y					
A7045	Repl exhalation port for PAP		Y					
A7046	Repl water chamber, PAP dev		Y					
A7501	Tracheostoma valve w diaphra		A					
A7502	Replacement diaphragm/fplate		A					
A7503	HMES filter holder or cap		A					
A7504	Tracheostoma HMES filter		A					
A7505	HMES or trach valve housing		A					
A7506	HMES/trachvalve adhesivedisk		A					
A7507	Integrated filter & holder		A					
A7508	Housing & Integrated Adhesiv		A					
A7509	Heat & moisture exchange sys		A					
A7520	Trach/laryn tube non-cuffed		A					
A7521	Trach/laryn tube cuffed		A					
A7522	Trach/laryn tube stainless		A					
A7523	Tracheostomy shower protect		A					
A7524	Tracheostoma stent/stud/bttn		A					
A7525	Tracheostomy mask		A					
A7526	Tracheostomy tube collar		A					
A7527	Trach/laryn tube plug/stop		A					
A8000	Soft protect helmet prefab		Y					
A8001	Hard protect helmet prefab		Y					
A8002	Soft protect helmet custom		Y					
A8003	Hard protect helmet custom		Y					
A8004	Repl soft interface, helmet		Y					
A9150	Misc/exper non-prescript dru		B					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
A9152	Single vitamin nos		E					
A9153	Multi-vitamin nos		E					
A9155	Artificial saliva		B					
A9180	Lice treatment, topical		E					
A9270	Non-covered item or service		E					
A9274	Ext amb insulin delivery sys		E					
A9275	Disp home glucose monitor		E					
A9276	Disposable sensor, CGM sys		E					
A9277	External transmitter, CGM		E					
A9278	External receiver, CGM sys		E					
A9279	Monitoring feature/deviceNOC		E					
A9280	Alert device, noc		E					
A9281	Reaching/grabbing device		E					
A9282	Wig any type		E					
A9283	Foot press off load supp dev		E					
A9300	Exercise equipment		E					
A9500	Tc99m sestamibi		N					
A9501	Technetium TC-99m teboroxime		N					
A9502	Tc99m tetrofosmin		N					
A9503	Tc99m medronate		N					
A9504	Tc99m apcitide		N					
A9505	TL201 thallium		N					
A9507	In111 capromab		N					
A9508	I131 iodobenguate, dx		N					
A9509	Iodine I-123 sod iodide mil		N					
A9510	Tc99m disofenin		N					
A9512	Tc99m pertechnetate		N					
A9516	Iodine I-123 sod iodide mic		N					
A9517	I131 iodide cap, rx	CH	K	1064	0.2447	$16.07		$3.22
A9521	Tc99m exametazime		N					
A9524	I131 serum albumin, dx		N					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
A9526	Nitrogen N-13 ammonia		N					
A9527	Iodine I-125 sodium iodide		U	2632	0.5488	$36.05		$7.21
A9528	Iodine I-131 iodide cap, dx		N					
A9529	I131 iodide sol, dx		N					
A9530	I131 iodide sol, rx	CH	K	1150	0.1603	$10.53		$2.11
A9531	I131 max 100uCi		N					
A9532	I125 serum albumin, dx		N					
A9535	Injection, methylene blue		N					
A9536	Tc99m depreotide		N					
A9537	Tc99m mebrofenin		N					
A9538	Tc99m pyrophosphate		N					
A9539	Tc99m pentetate		N					
A9540	Tc99m MAA		N					
A9541	Tc99m sulfur colloid		N					
A9542	In111 ibritumomab, dx		N					
A9543	Y90 ibritumomab, rx	CH	K	1643	230.7968	$15,159.66		$3,031.94
A9544	I131 tositumomab, dx		N					
A9545	I131 tositumomab, rx	CH	K	1645	160.6856	$10,554.47		$2,110.90
A9546	Co57/58		N					
A9547	In111 oxyquinoline		N					
A9548	In111 pentetate		N					
A9550	Tc99m gluceptate		N					
A9551	Tc99m succimer		N					
A9552	F18 fdg		N					
A9553	Cr51 chromate		N					
A9554	I125 iothalamate, dx		N					
A9555	Rb82 rubidium		N					
A9556	Ga67 gallium		N					
A9557	Tc99m bicisate		N					
A9558	Xe133 xenon 10mci		N					
A9559	Co57 cyano		N					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
A9560	Tc99m labeled rbc		N					
A9561	Tc99m oxidronate		N					
A9562	Tc99m mertiatide		N					
A9563	P32 Na phosphate	CH	K	1675	1.5948	$104.75		$20.95
A9564	P32 chromic phosphate	CH	K	1676	2.4062	$158.05		$31.61
A9566	Tc99m fanolesomab		N					
A9567	Technetium TC-99m aerosol		N					
A9568	Technetium tc99m arcitumomab		N					
A9569	Technetium TC-99m auto WBC		N					
A9570	Indium In-111 auto WBC		N					
A9571	Indium IN-111 auto platelet		N					
A9572	Indium In-111 pentetreotide		N					
A9576	Inj prohance multipack		N					
A9577	Inj multihance		N					
A9578	Inj multihance multipack		N					
A9579	Gad-base MR contrast NOS,1ml		N					
A9600	Sr89 strontium	CH	K	0701	9.6387	$633.11		$126.63
A9605	Sm 153 lexidronm	CH	K	0702	22.6536	$1,487.98		$297.60
A9698	Non-rad contrast materialNOC		N					
A9699	Radiopharm rx agent noc		N					
A9700	Echocardiography Contrast		B					
A9900	Supply/accessory/service		Y					
A9901	Delivery/set up/dispensing		A					
A9999	DME supply or accessory, nos		Y					
B4034	Enter feed supkit syr by day		Y					
B4035	Enteral feed supp pump per d		Y					
B4036	Enteral feed sup kit grav by		Y					
B4081	Enteral ng tubing w/ stylet		Y					
B4082	Enteral ng tubing w/o stylet		Y					
B4083	Enteral stomach tube levine		Y					
B4087	Gastro/jejuno tube, std		A					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
B4088	Gastro/jejuno tube, low-pro		A					
B4100	Food thickener oral		E					
B4102	EF adult fluids and electro		Y					
B4103	EF ped fluid and electrolyte		Y					
B4104	Additive for enteral formula		E					
B4149	EF blenderized foods		Y					
B4150	EF complet w/intact nutrient		Y					
B4152	EF calorie dense>/=1.5Kcal		Y					
B4153	EF hydrolyzed/amino acids		Y					
B4154	EF spec metabolic noninherit		Y					
B4155	EF incomplete/modular		Y					
B4157	EF special metabolic inherit		Y					
B4158	EF ped complete intact nut		Y					
B4159	EF ped complete soy based		Y					
B4160	EF ped caloric dense>/=0.7kc		Y					
B4161	EF ped hydrolyzed/amino acid		Y					
B4162	EF ped specmetabolic inherit		Y					
B4164	Parenteral 50% dextrose solu		Y					
B4168	Parenteral sol amino acid 3.		Y					
B4172	Parenteral sol amino acid 5.		Y					
B4176	Parenteral sol amino acid 7-		Y					
B4178	Parenteral sol amino acid >		Y					
B4180	Parenteral sol carb > 50%		Y					
B4185	Parenteral sol 10 gm lipids		B					
B4189	Parenteral sol amino acid &		Y					
B4193	Parenteral sol 52-73 gm prot		Y					
B4197	Parenteral sol 74-100 gm pro		Y					
B4199	Parenteral sol > 100gm prote		Y					
B4216	Parenteral nutrition additiv		Y					
B4220	Parenteral supply kit premix		Y					
B4222	Parenteral supply kit homemi		Y					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
B4224	Parenteral administration ki		Y					
B5000	Parenteral sol renal-amirosy		Y					
B5100	Parenteral sol hepatic-fream		Y					
B5200	Parenteral sol stres-brnch c		Y					
B9000	Enter infusion pump w/o alrm		Y					
B9002	Enteral infusion pump w/ ala		Y					
B9004	Parenteral infus pump portab		Y					
B9006	Parenteral infus pump statio		Y					
B9998	Enteral supp not otherwise c		Y					
B9999	Parenteral supp not othrws c		Y					
C1300	HYPERBARIC Oxygen		S	0659	1.5663	$102.88		$20.58
C1713	Anchor/screw bn/bn,tis/bn		N					
C1714	Cath, trans atherectomy, dir		N					
C1715	Brachytherapy needle		N					
C1716	Brachytx, non-str, Gold-198		U	1716	0.5161	$33.90		$6.78
C1717	Brachytx, non-str,HDR Ir-192		U	1717	3.2258	$211.88		$42.38
C1719	Brachytx, NS, Non-HDRIr-192		U	1719	0.9851	$64.71		$12.95
C1721	AICD, dual chamber		N					
C1722	AICD, single chamber		N					
C1724	Cath, trans atherec,rotation		N					
C1725	Cath, translumin non-laser		N					
C1726	Cath, bal dil, non-vascular		N					
C1727	Cath, bal tis dis, non-vas		N					
C1728	Cath, brachytx seed adm		N					
C1729	Cath, drainage		N					
C1730	Cath, EP, 19 or few elect		N					
C1731	Cath, EP, 20 or more elec		N					
C1732	Cath, EP, diag/abl, 3D/vect		N					
C1733	Cath, EP, othr than cool-tip		N					
C1750	Cath, hemodialysis,long-term		N					
C1751	Cath, inf, per/cent/midline		N					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
C1752	Cath,hemodialysis,short-term		N					
C1753	Cath, intravas ultrasound		N					
C1754	Catheter, intradiscal		N					
C1755	Catheter, intraspinal		N					
C1756	Cath, pacing, transesoph		N					
C1757	Cath, thrombectomy/embolect		N					
C1758	Catheter, ureteral		N					
C1759	Cath, intra echocardiography		N					
C1760	Closure dev, vasc		N					
C1762	Conn tiss, human(inc fascia)		N					
C1763	Conn tiss, non-human		N					
C1764	Event recorder, cardiac		N					
C1765	Adhesion barrier		N					
C1766	Intro/sheath,strble,non-peel		N					
C1767	Generator, neuro non-recharg		N					
C1768	Graft, vascular		N					
C1769	Guide wire		N					
C1770	Imaging coil, MR, insertable		N					
C1771	Rep dev, urinary, w/sling		N					
C1772	Infusion pump, programmable		N					
C1773	Ret dev, insertable		N					
C1776	Joint device (implantable)		N					
C1777	Lead, AICD, endo single coil		N					
C1778	Lead, neurostimulator		N					
C1779	Lead, pmkr, transvenous VDD		N					
C1780	Lens, intraocular (new tech)		N					
C1781	Mesh (implantable)		N					
C1782	Morcellator		N					
C1783	Ocular imp, aqueous drain de		N					
C1784	Ocular dev, intraop, det ret		N					
C1785	Pmkr, dual, rate-resp		N					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
C1786	Pmkr, single, rate-resp		N					
C1787	Patient progr, neurostim		N					
C1788	Port, indwelling, imp		N					
C1789	Prosthesis, breast, imp		N					
C1813	Prosthesis, penile, inflatab		N					
C1814	Retinal tamp, silicone oil		N					
C1815	Pros, urinary sph, imp		N					
C1816	Receiver/transmitter, neuro		N					
C1817	Septal defect imp sys		N					
C1818	Integrated keratoprosthesis		N					
C1819	Tissue localization-excision		N					
C1820	Generator neuro rechg bat sy		N					
C1821	Interspinous implant	CH	N					
C1874	Stent, coated/cov w/del sys		N					
C1875	Stent, coated/cov w/o del sy		N					
C1876	Stent, non-coa/non-cov w/del		N					
C1877	Stent, non-coat/cov w/o del		N					
C1878	Matrl for vocal cord		N					
C1879	Tissue marker, implantable		N					
C1880	Vena cava filter		N					
C1881	Dialysis access system		N					
C1882	AICD, other than sing/dual		N					
C1883	Adapt/ext, pacing/neuro lead		N					
C1884	Embolization Protect syst		N					
C1885	Cath, translumin angio laser		N					
C1887	Catheter, guiding		N					
C1888	Endovas non-cardiac abl cath		N					
C1891	Infusion pump,non-prog, perm		N					
C1892	Intro/sheath,fixed,peel-away		N					
C1893	Intro/sheath, fixed,non-peel		N					
C1894	Intro/sheath, non-laser		N					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
C1895	Lead, AICD, endo dual coil		N					
C1896	Lead, AICD, non sing/dual		N					
C1897	Lead, neurostim test kit		N					
C1898	Lead, pmkr, other than trans		N					
C1899	Lead, pmkr/AICD combination		N					
C1900	Lead, coronary venous		N					
C2614	Probe, perc lumb disc		N					
C2615	Sealant, pulmonary, liquid		N					
C2616	Brachytx, non-str,Yttrium-90		U	2616	204.7634	$13,449.68		$2,689.94
C2617	Stent, non-cor, tem w/o del		N					
C2618	Probe, cryoablation		N					
C2619	Pmkr, dual, non rate-resp		N					
C2620	Pmkr, single, non rate-resp		N					
C2621	Pmkr, other than sing/dual		N					
C2622	Prosthesis, penile, non-inf		N					
C2625	Stent, non-cor, tem w/del sy		N					
C2626	Infusion pump, non-prog,temp		N					
C2627	Cath, suprapubic/cystoscopic		N					
C2628	Catheter, occlusion		N					
C2629	Intro/sheath, laser		N					
C2630	Cath, EP, cool-tip		N					
C2631	Rep dev, urinary, w/o sling		N					
C2634	Brachytx, non-str, HA, I-125		U	2634	0.6518	$42.81		$8.57
C2635	Brachytx, non-str, HA, P-103		U	2635	0.4101	$26.94		$5.39
C2636	Brachy linear, non-str,P-103		U	2636	0.9201	$60.44		$12.09
C2637	Brachy,non-str,Ytterbium-169		B					
C2638	Brachytx, stranded, I-125		U	2638	0.6144	$40.36		$8.08
C2639	Brachytx, non-stranded,I-125		U	2639	0.5553	$36.47		$7.30
C2640	Brachytx, stranded, P-103		U	2640	1.0130	$66.54		$13.31
C2641	Brachytx, non-stranded,P-103		U	2641	0.9658	$63.44		$12.69
C2642	Brachytx, stranded, C-131		U	2642	1.5178	$99.70		$19.94

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
C2643	Brachytx, non-stranded,C-131		U	2643	0.9051	$59.45		$11.89
C2698	Brachytx, stranded, NOS		U	2698	0.6144	$40.36		$8.08
C2699	Brachytx, non-stranded, NOS		U	2699	0.4101	$26.94		$5.39
C8900	MRA w/cont, abd	CH	Q3	0284	6.5748	$431.86	$148.40	$86.38
C8901	MRA w/o cont, abd	CH	Q3	0336	5.4285	$356.57	$137.40	$71.32
C8902	MRA w/o fol w/cont, abd	CH	Q3	0337	8.3173	$546.31	$199.53	$109.27
C8903	MRI w/cont, breast, uni	CH	Q3	0284	6.5748	$431.86	$148.40	$86.38
C8904	MRI w/o cont, breast, uni	CH	Q3	0336	5.4285	$356.57	$137.40	$71.32
C8905	MRI w/o fol w/cont, brst, un	CH	Q3	0337	8.3173	$546.31	$199.53	$109.27
C8906	MRI w/cont, breast, bi	CH	Q3	0284	6.5748	$431.86	$148.40	$86.38
C8907	MRI w/o cont, breast, bi	CH	Q3	0336	5.4285	$356.57	$137.40	$71.32
C8908	MRI w/o fol w/cont, breast,	CH	Q3	0337	8.3173	$546.31	$199.53	$109.27
C8909	MRA w/cont, chest	CH	Q3	0284	6.5748	$431.86	$148.40	$86.38
C8910	MRA w/o cont, chest	CH	Q3	0336	5.4285	$356.57	$137.40	$71.32
C8911	MRA w/o fol w/cont, chest	CH	Q3	0337	8.3173	$546.31	$199.53	$109.27
C8912	MRA w/cont, lwr ext	CH	Q3	0284	6.5748	$431.86	$148.40	$86.38
C8913	MRA w/o cont, lwr ext	CH	Q3	0336	5.4285	$356.57	$137.40	$71.32
C8914	MRA w/o fol w/cont, lwr ext	CH	Q3	0337	8.3173	$546.31	$199.53	$109.27
C8918	MRA w/cont, pelvis	CH	Q3	0284	6.5748	$431.86	$148.40	$86.38
C8919	MRA w/o cont, pelvis	CH	Q3	0336	5.4285	$356.57	$137.40	$71.32
C8920	MRA w/o fol w/cont, pelvis	CH	Q3	0337	8.3173	$546.31	$199.53	$109.27
C8921	TTE w or w/o fol w/cont, com		S	0128	8.5914	$564.32	$216.29	$112.87
C8922	TTE w or w/o fol w/cont, f/u		S	0128	8.5914	$564.32	$216.29	$112.87
C8923	2D TTE w or w/o fol w/con,co		S	0128	8.5914	$564.32	$216.29	$112.87
C8924	2D TTE w or w/o fol w/con,fu		S	0128	8.5914	$564.32	$216.29	$112.87
C8925	2D TEE w or w/o fol w/con,in		S	0128	8.5914	$564.32	$216.29	$112.87
C8926	TEE w or w/o fol w/cont,cong		S	0128	8.5914	$564.32	$216.29	$112.87
C8927	TEE w or w/o fol w/cont, mon		S	0128	8.5914	$564.32	$216.29	$112.87
C8928	TEE w or w/o fol w/con,stres		S	0128	8.5914	$564.32	$216.29	$112.87
C8957	Prolonged IV inf, req pump	CH	S	0440	2.9088	$191.06		$38.22
C9003	Palivizumab, per 50 mg		K	9003		$802.95		$160.59

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C9113	Inj pantoprazole sodium, via		N					
C9121	Injection, argatroban		K	9121		$19.82		$3.97
C9237	Inj, lanreotide acetate		K	9237		$23.90		$4.78
C9238	Inj, levetiracetam		G	9238		$0.43		$0.09
C9239	Inj, temsirolimus		G	1168		$47.78		$9.38
C9240	Injection, ixabepilone		G	9240		$65.15		$12.79
C9241	Injection, doripenem		G	9241		$0.81		$0.16
C9352	Neuragen nerve guide, per cm	CH	N					
C9353	Neurawrap nerve protector,cm	CH	N					
C9354	Veritas collagen matrix, cm2		G	9354		$11.77		$2.31
C9355	Neuromatrix nerve cuff, cm		G	9355		$208.67		$40.95
C9399	Unclassified drugs or biolog		A					
C9716	Radiofrequency energy to anu		T	0150	31.2003	$2,049.36	$437.12	$409.88
C9723	Dyn IR Perf Img	CH	B					
C9724	EPS gast cardia plic		T	0422	26.4591	$1,737.94	$448.81	$347.59
C9725	Place endorectal app	CH	T	0164	2.2063	$144.92		$28.99
C9726	Rxt breast appl place/remov	CH	T	0028	21.5003	$1,412.23	$303.74	$282.45
C9727	Insert palate implants	CH	T	0252	7.7504	$509.08	$109.16	$101.82
C9728	Place device/marker, non pro	CH	X	0310	13.7096	$900.50	$325.27	$180.10
D0120	Periodic oral evaluation		E					
D0140	Limit oral eval problm focus		E					
D0145	Oral evaluation, pt < 3yrs		E					
D0150	Comprehensve oral evaluation		S	0330	7.9447	$521.84		$104.37
D0160	Extensv oral eval prob focus		E					
D0170	Re-eval,est pt,problem focus		E					
D0180	Comp periodontal evaluation		E					
D0210	Intraor complete film series		E					
D0220	Intraoral periapical first f		E					
D0230	Intraoral periapical ea add		E					
D0240	Intraoral occlusal film		S	0330	7.9447	$521.84		$104.37
D0250	Extraoral first film		S	0330	7.9447	$521.84		$104.37

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
D0260	Extraoral ea additional film		S	0330	7.9447	$521.84		$104.37
D0270	Dental bitewing single film		S	0330	7.9447	$521.84		$104.37
D0272	Dental bitewings two films		S	0330	7.9447	$521.84		$104.37
D0273	Bitewings - three films		E					
D0274	Dental bitewings four films		S	0330	7.9447	$521.84		$104.37
D0277	Vert bitewings-sev to eight		S	0330	7.9447	$521.84		$104.37
D0290	Dental film skull/facial bon		E					
D0310	Dental saliography		E					
D0320	Dental tmj arthrogram incl i		E					
D0321	Dental other tmj films		E					
D0322	Dental tomographic survey		E					
D0330	Dental panoramic film		E					
D0340	Dental cephalometric film		E					
D0350	Oral/facial photo images		E					
D0360	Cone beam ct		E					
D0362	Cone beam, two dimensional		E					
D0363	Cone beam, three dimensional		E					
D0415	Collection of microorganisms		E					
D0416	Viral culture		B					
D0421	Gen tst suscept oral disease		B					
D0425	Caries susceptibility test		E					
D0431	Diag tst detect mucos abnorm		B					
D0460	Pulp vitality test		S	0330	7.9447	$521.84		$104.37
D0470	Diagnostic casts		E					
D0472	Gross exam, prep & report		B					
D0473	Micro exam, prep & report		B					
D0474	Micro w exam of surg margins		B					
D0475	Decalcification procedure		B					
D0476	Spec stains for microorganis		B					
D0477	Spec stains not for microorg		B					
D0478	Immunohistochemical stains		B					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
D0479	Tissue in-situ hybridization		B					
D0480	Cytopath smear prep & report		B					
D0481	Electron microscopy diagnost		B					
D0482	Direct immunofluorescence		B					
D0483	Indirect immunofluorescence		B					
D0484	Consult slides prep elsewher		B					
D0485	Consult inc prep of slides		B					
D0486	Accession of brush biopsy		E					
D0502	Other oral pathology procedu		B					
D0999	Unspecified diagnostic proce		B					
D1110	Dental prophylaxis adult		E					
D1120	Dental prophylaxis child		E					
D1203	Topical fluor w/o prophy chi		E					
D1204	Topical fluor w/o prophy adu		E					
D1206	Topical fluoride varnish		E					
D1310	Nutri counsel-control caries		E					
D1320	Tobacco counseling		E					
D1330	Oral hygiene instruction		E					
D1351	Dental sealant per tooth		E					
D1510	Space maintainer fxd unilat		S	0330	7.9447	$521.84		$104.37
D1515	Fixed bilat space maintainer		S	0330	7.9447	$521.84		$104.37
D1520	Remove unilat space maintain		S	0330	7.9447	$521.84		$104.37
D1525	Remove bilat space maintain		S	0330	7.9447	$521.84		$104.37
D1550	Recement space maintainer		S	0330	7.9447	$521.84		$104.37
D1555	Remove fix space maintainer		E					
D2140	Amalgam one surface permanen		E					
D2150	Amalgam two surfaces permane		E					
D2160	Amalgam three surfaces perma		E					
D2161	Amalgam 4 or > surfaces perm		E					
D2330	Resin one surface-anterior		E					
D2331	Resin two surfaces-anterior		E					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
D2332	Resin three surfaces-anterio		E					
D2335	Resin 4/> surf or w incis an		E					
D2390	Ant resin-based cmpst crown		E					
D2391	Post 1 srfc resinbased cmpst		E					
D2392	Post 2 srfc resinbased cmpst		E					
D2393	Post 3 srfc resinbased cmpst		E					
D2394	Post >=4srfc resinbase cmpst		E					
D2410	Dental gold foil one surface		E					
D2420	Dental gold foil two surface		E					
D2430	Dental gold foil three surfa		E					
D2510	Dental inlay metalic 1 surf		E					
D2520	Dental inlay metallic 2 surf		E					
D2530	Dental inlay metl 3/more sur		E					
D2542	Dental onlay metallic 2 surf		E					
D2543	Dental onlay metallic 3 surf		E					
D2544	Dental onlay metl 4/more sur		E					
D2610	Inlay porcelain/ceramic 1 su		E					
D2620	Inlay porcelain/ceramic 2 su		E					
D2630	Dental onlay porc 3/more sur		E					
D2642	Dental onlay porcelin 2 surf		E					
D2643	Dental onlay porcelin 3 surf		E					
D2644	Dental onlay porc 4/more sur		E					
D2650	Inlay composite/resin one su		E					
D2651	Inlay composite/resin two su		E					
D2652	Dental inlay resin 3/mre sur		E					
D2662	Dental onlay resin 2 surface		E					
D2663	Dental onlay resin 3 surface		E					
D2664	Dental onlay resin 4/mre sur		E					
D2710	Crown resin-based indirect		E					
D2712	Crown 3/4 resin-based compos		E					
D2720	Crown resin w/ high noble me		E					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
D2721	Crown resin w/ base metal		E					
D2722	Crown resin w/ noble metal		E					
D2740	Crown porcelain/ceramic subs		E					
D2750	Crown porcelain w/ h noble m		E					
D2751	Crown porcelain fused base m		E					
D2752	Crown porcelain w/ noble met		E					
D2780	Crown 3/4 cast hi noble met		E					
D2781	Crown 3/4 cast base metal		E					
D2782	Crown 3/4 cast noble metal		E					
D2783	Crown 3/4 porcelain/ceramic		E					
D2790	Crown full cast high noble m		E					
D2791	Crown full cast base metal		E					
D2792	Crown full cast noble metal		E					
D2794	Crown-titanium		E					
D2799	Provisional crown		E					
D2910	Recement inlay onlay or part		E					
D2915	Recement cast or prefab post		E					
D2920	Dental recement crown		E					
D2930	Prefab stnlss steel crwn pri		E					
D2931	Prefab stnlss steel crown pe		E					
D2932	Prefabricated resin crown		E					
D2933	Prefab stainless steel crown		E					
D2934	Prefab steel crown primary		E					
D2940	Dental sedative filling		E					
D2950	Core build-up incl any pins		E					
D2951	Tooth pin retention		E					
D2952	Post and core cast + crown		E					
D2953	Each addtnl cast post		E					
D2954	Prefab post/core + crown		E					
D2955	Post removal		E					
D2957	Each addtnl prefab post		E					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
D2960	Laminate labial veneer		E					
D2961	Lab labial veneer resin		E					
D2962	Lab labial veneer porcelain		E					
D2970	Temp crown (fractured tooth)		E					
D2971	Add proc construct new crown		E					
D2975	Coping		E					
D2980	Crown repair		E					
D2999	Dental unspec restorative pr		S	0330	7.9447	$521.84		$104.37
D3110	Pulp cap direct		E					
D3120	Pulp cap indirect		E					
D3220	Therapeutic pulpotomy		E					
D3221	Gross pulpal debridement		E					
D3230	Pulpal therapy anterior prim		E					
D3240	Pulpal therapy posterior pri		E					
D3310	Anterior		E					
D3320	Root canal therapy 2 canals		E					
D3330	Root canal therapy 3 canals		E					
D3331	Non-surg tx root canal obs		E					
D3332	Incomplete endodontic tx		E					
D3333	Internal root repair		E					
D3346	Retreat root canal anterior		E					
D3347	Retreat root canal bicuspid		E					
D3348	Retreat root canal molar		E					
D3351	Apexification/recalc initial		E					
D3352	Apexification/recalc interim		E					
D3353	Apexification/recalc final		E					
D3410	Apicoect/perirad surg anter		E					
D3421	Root surgery bicuspid		E					
D3425	Root surgery molar		E					
D3426	Root surgery ea add root		E					
D3430	Retrograde filling		E					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
D3450	Root amputation		E					
D3460	Endodontic endosseous implan		S	0330	7.9447	$521.84		$104.37
D3470	Intentional replantation		E					
D3910	Isolation- tooth w rubb dam		E					
D3920	Tooth splitting		E					
D3950	Canal prep/fitting of dowel		E					
D3999	Endodontic procedure		S	0330	7.9447	$521.84		$104.37
D4210	Gingivectomy/plasty per quad		E					
D4211	Gingivectomy/plasty per toot		E					
D4230	Ana crown exp 4 or> per quad		E					
D4231	Ana crown exp 1-3 per quad		E					
D4240	Gingival flap proc w/ planin		E					
D4241	Gngvl flap w rootplan 1-3 th		E					
D4245	Apically positioned flap		E					
D4249	Crown lengthen hard tissue		E					
D4260	Osseous surgery per quadrant		S	0330	7.9447	$521.84		$104.37
D4261	Osseous surgl-3teethperquad		E					
D4263	Bone replce graft first site		S	0330	7.9447	$521.84		$104.37
D4264	Bone replce graft each add		S	0330	7.9447	$521.84		$104.37
D4265	Bio mtrls to aid soft/os reg		E					
D4266	Guided tiss regen resorble		E					
D4267	Guided tiss regen nonresorb		E					
D4268	Surgical revision procedure		S	0330	7.9447	$521.84		$104.37
D4270	Pedicle soft tissue graft pr		S	0330	7.9447	$521.84		$104.37
D4271	Free soft tissue graft proc		S	0330	7.9447	$521.84		$104.37
D4273	Subepithelial tissue graft		S	0330	7.9447	$521.84		$104.37
D4274	Distal/proximal wedge proc		E					
D4275	Soft tissue allograft		E					
D4276	Con tissue w dble ped graft		E					
D4320	Provision splnt intracoronal		E					
D4321	Provisional splint extracoro		E					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
D4341	Periodontal scaling & root		E					
D4342	Periodontal scaling 1-3teeth		E					
D4355	Full mouth debridement		S	0330	7.9447	$521.84		$104.37
D4381	Localized delivery antimicro		S	0330	7.9447	$521.84		$104.37
D4910	Periodontal maint procedures		E					
D4920	Unscheduled dressing change		E					
D4999	Unspecified periodontal proc		E					
D5110	Dentures complete maxillary		E					
D5120	Dentures complete mandible		E					
D5130	Dentures immediat maxillary		E					
D5140	Dentures immediat mandible		E					
D5211	Dentures maxill part resin		E					
D5212	Dentures mand part resin		E					
D5213	Dentures maxill part metal		E					
D5214	Dentures mandibl part metal		E					
D5225	Maxillary part denture flex		E					
D5226	Mandibular part denture flex		E					
D5281	Removable partial denture		E					
D5410	Dentures adjust cmplt maxil		E					
D5411	Dentures adjust cmplt mand		E					
D5421	Dentures adjust part maxill		E					
D5422	Dentures adjust part mandbl		E					
D5510	Dentur repr broken compl bas		E					
D5520	Replace denture teeth complt		E					
D5610	Dentures repair resin base		E					
D5620	Rep part denture cast frame		E					
D5630	Rep partial denture clasp		E					
D5640	Replace part denture teeth		E					
D5650	Add tooth to partial denture		E					
D5660	Add clasp to partial denture		E					
D5670	Replc tth&acrlc on mtl frmwk		E					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
D5671	Replc tth&acrlc mandibular		E					
D5710	Dentures rebase cmplt maxil		E					
D5711	Dentures rebase cmplt mand		E					
D5720	Dentures rebase part maxill		E					
D5721	Dentures rebase part mandbl		E					
D5730	Denture reln cmplt maxil ch		E					
D5731	Denture reln cmplt mand chr		E					
D5740	Denture reln part maxil chr		E					
D5741	Denture reln part mand chr		E					
D5750	Denture reln cmplt max lab		E					
D5751	Denture reln cmplt mand lab		E					
D5760	Denture reln part maxil lab		E					
D5761	Denture reln part mand lab		E					
D5810	Denture interm cmplt maxill		E					
D5811	Denture interm cmplt mandbl		E					
D5820	Denture interm part maxill		E					
D5821	Denture interm part mandbl		E					
D5850	Denture tiss conditn maxill		E					
D5851	Denture tiss condtin mandbl		E					
D5860	Overdenture complete		E					
D5861	Overdenture partial		E					
D5862	Precision attachment		E					
D5867	Replacement of precision att		E					
D5875	Prosthesis modification		E					
D5899	Removable prosthodontic proc		E					
D5911	Facial moulage sectional		S	0330	7.9447	$521.84		$104.37
D5912	Facial moulage complete		S	0330	7.9447	$521.84		$104.37
D5913	Nasal prosthesis		E					
D5914	Auricular prosthesis		E					
D5915	Orbital prosthesis		E					
D5916	Ocular prosthesis		E					

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D5919	Facial prosthesis		E					
D5922	Nasal septal prosthesis		E					
D5923	Ocular prosthesis interim		E					
D5924	Cranial prosthesis		E					
D5925	Facial augmentation implant		E					
D5926	Replacement nasal prosthesis		E					
D5927	Auricular replacement		E					
D5928	Orbital replacement		E					
D5929	Facial replacement		E					
D5931	Surgical obturator		E					
D5932	Postsurgical obturator		E					
D5933	Refitting of obturator		E					
D5934	Mandibular flange prosthesis		E					
D5935	Mandibular denture prosth		E					
D5936	Temp obturator prosthesis		E					
D5937	Trismus appliance		E					
D5951	Feeding aid		E					
D5952	Pediatric speech aid		E					
D5953	Adult speech aid		E					
D5954	Superimposed prosthesis		E					
D5955	Palatal lift prosthesis		E					
D5958	Intraoral con def inter plt		E					
D5959	Intraoral con def mod palat		E					
D5960	Modify speech aid prosthesis		E					
D5982	Surgical stent		E					
D5983	Radiation applicator		S	0330	7.9447	$521.84		$104.37
D5984	Radiation shield		S	0330	7.9447	$521.84		$104.37
D5985	Radiation cone locator		S	0330	7.9447	$521.84		$104.37
D5986	Fluoride applicator		E					
D5987	Commissure splint		S	0330	7.9447	$521.84		$104.37
D5988	Surgical splint		E					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
D5999	Maxillofacial prosthesis		E					
D6010	Odontics endosteal implant		E					
D6012	Endosteal implant		E					
D6040	Odontics eposteal implant		E					
D6050	Odontics transosteal implnt		E					
D6053	Implnt/abtmnt spprt remv dnt		E					
D6054	Implnt/abtmnt spprt remvprtl		E					
D6055	Implant connecting bar		E					
D6056	Prefabricated abutment		E					
D6057	Custom abutment		E					
D6058	Abutment supported crown		E					
D6059	Abutment supported mtl crown		E					
D6060	Abutment supported mtl crown		E					
D6061	Abutment supported mtl crown		E					
D6062	Abutment supported mtl crown		E					
D6063	Abutment supported mtl crown		E					
D6064	Abutment supported mtl crown		E					
D6065	Implant supported crown		E					
D6066	Implant supported mtl crown		E					
D6067	Implant supported mtl crown		E					
D6068	Abutment supported retainer		E					
D6069	Abutment supported retainer		E					
D6070	Abutment supported retainer		E					
D6071	Abutment supported retainer		E					
D6072	Abutment supported retainer		E					
D6073	Abutment supported retainer		E					
D6074	Abutment supported retainer		E					
D6075	Implant supported retainer		E					
D6076	Implant supported retainer		E					
D6077	Implant supported retainer		E					
D6078	Implnt/abut suprtd fixd dent		E					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
D6079	Implnt/abut suprtd fixd dent		E					
D6080	Implant maintenance		E					
D6090	Repair implant		E					
D6091	Repl semi/precision attach		E					
D6092	Recement supp crown		E					
D6093	Recement supp part denture		E					
D6094	Abut support crown titanium		E					
D6095	Odontics repr abutment		E					
D6100	Removal of implant		E					
D6190	Radio/surgical implant index		E					
D6194	Abut support retainer titani		E					
D6199	Implant procedure		E					
D6205	Pontic-indirect resin based		E					
D6210	Prosthodont high noble metal		E					
D6211	Bridge base metal cast		E					
D6212	Bridge noble metal cast		E					
D6214	Pontic titanium		E					
D6240	Bridge porcelain high noble		E					
D6241	Bridge porcelain base metal		E					
D6242	Bridge porcelain nobel metal		E					
D6245	Bridge porcelain/ceramic		E					
D6250	Bridge resin w/high noble		E					
D6251	Bridge resin base metal		E					
D6252	Bridge resin w/noble metal		E					
D6253	Provisional pontic		E					
D6545	Dental retainr cast metl		E					
D6548	Porcelain/ceramic retainer		E					
D6600	Porcelain/ceramic inlay 2srf		E					
D6601	Porc/ceram inlay >= 3 surfac		E					
D6602	Cst hgh nble mtl inlay 2 srf		E					
D6603	Cst hgh nble mtl inlay >=3sr		E					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
D6604	Cst bse mtl inlay 2 surfaces		E					
D6605	Cst bse mtl inlay >= 3 surfa		E					
D6606	Cast noble metal inlay 2 sur		E					
D6607	Cst noble mtl inlay >=3 surf		E					
D6608	Onlay porc/crmc 2 surfaces		E					
D6609	Onlay porc/crmc >=3 surfaces		E					
D6610	Onlay cst hgh nbl mtl 2 srfc		E					
D6611	Onlay cst hgh nbl mtl >=3srf		E					
D6612	Onlay cst base mtl 2 surface		E					
D6613	Onlay cst base mtl >=3 surfa		E					
D6614	Onlay cst nbl mtl 2 surfaces		E					
D6615	Onlay cst nbl mtl >=3 surfac		E					
D6624	Inlay titanium		E					
D6634	Onlay titanium		E					
D6710	Crown-indirect resin based		E					
D6720	Retain crown resin w hi nble		E					
D6721	Crown resin w/base metal		E					
D6722	Crown resin w/noble metal		E					
D6740	Crown porcelain/ceramic		E					
D6750	Crown porcelain high noble		E					
D6751	Crown porcelain base metal		E					
D6752	Crown porcelain noble metal		E					
D6780	Crown 3/4 high noble metal		E					
D6781	Crown 3/4 cast based metal		E					
D6782	Crown 3/4 cast noble metal		E					
D6783	Crown 3/4 porcelain/ceramic		E					
D6790	Crown full high noble metal		E					
D6791	Crown full base metal cast		E					
D6792	Crown full noble metal cast		E					
D6793	Provisional retainer crown		E					
D6794	Crown titanium		E					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
D6920	Dental connector bar		S	0330	7.9447	$521.84		$104.37
D6930	Dental recement bridge		E					
D6940	Stress breaker		E					
D6950	Precision attachment		E					
D6970	Post & core plus retainer		E					
D6972	Prefab post & core plus reta		E					
D6973	Core build up for retainer		E					
D6975	Coping metal		E					
D6976	Each addtnl cast post		E					
D6977	Each addtl prefab post		E					
D6980	Bridge repair		E					
D6985	Pediatric partial denture fx		E					
D6999	Fixed prosthodontic proc		E					
D7111	Extraction coronal remnants		S	0330	7.9447	$521.84		$104.37
D7140	Extraction erupted tooth/exr		S	0330	7.9447	$521.84		$104.37
D7210	Rem imp tooth w mucoper flp		S	0330	7.9447	$521.84		$104.37
D7220	Impact tooth remov soft tiss		S	0330	7.9447	$521.84		$104.37
D7230	Impact tooth remov part bony		S	0330	7.9447	$521.84		$104.37
D7240	Impact tooth remov comp bony		S	0330	7.9447	$521.84		$104.37
D7241	Impact tooth rem bony w/comp		S	0330	7.9447	$521.84		$104.37
D7250	Tooth root removal		S	0330	7.9447	$521.84		$104.37
D7260	Oral antral fistula closure		S	0330	7.9447	$521.84		$104.37
D7261	Primary closure sinus perf		S	0330	7.9447	$521.84		$104.37
D7270	Tooth reimplantation		E					
D7272	Tooth transplantation		E					
D7280	Exposure impact tooth orthod		E					
D7282	Mobilize erupted/malpos toot		E					
D7283	Place device impacted tooth		B					
D7285	Biopsy of oral tissue hard		E					
D7286	Biopsy of oral tissue soft		E					
D7287	Exfoliative cytolog collect		E					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
D7288	Brush biopsy		B					
D7290	Repositioning of teeth		E					
D7291	Transseptal fiberotomy		S	0330	7.9447	$521.84		$104.37
D7292	Screw retained plate		E					
D7293	Temp anchorage dev w flap		E					
D7294	Temp anchorage dev w/o flap		E					
D7310	Alveoplasty w/ extraction		E					
D7311	Alveoloplasty w/extract 1-3		E					
D7320	Alveoplasty w/o extraction		E					
D7321	Alveoloplasty not w/extracts		B					
D7340	Vestibuloplasty ridge extens		E					
D7350	Vestibuloplasty exten graft		E					
D7410	Rad exc lesion up to 1.25 cm		E					
D7411	Excision benign lesion>1.25c		E					
D7412	Excision benign lesion compl		E					
D7413	Excision malig lesion<=1.25c		E					
D7414	Excision malig lesion>1.25cm		E					
D7415	Excision malig les complicat		E					
D7440	Malig tumor exc to 1.25 cm		E					
D7441	Malig tumor > 1.25 cm		E					
D7450	Rem odontogen cyst to 1.25cm		E					
D7451	Rem odontogen cyst > 1.25 cm		E					
D7460	Rem nonodonto cyst to 1.25cm		E					
D7461	Rem nonodonto cyst > 1.25 cm		E					
D7465	Lesion destruction		E					
D7471	Rem exostosis any site		E					
D7472	Removal of torus palatinus		E					
D7473	Remove torus mandibularis		E					
D7485	Surg reduct osseoustuberosit		E					
D7490	Maxilla or mandible resectio		E					
D7510	I&d absc intraoral soft tiss		E					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
D7511	Incision/drain abscess intra		B					
D7520	I&d abscess extraoral		E					
D7521	Incision/drain abscess extra		B					
D7530	Removal fb skin/areolar tiss		E					
D7540	Removal of fb reaction		E					
D7550	Removal of sloughed off bone		E					
D7560	Maxillary sinusotomy		E					
D7610	Maxilla open reduct simple		E					
D7620	Clsd reduct simpl maxilla fx		E					
D7630	Open red simpl mandible fx		E					
D7640	Clsd red simpl mandible fx		E					
D7650	Open red simp malar/zygom fx		E					
D7660	Clsd red simp malar/zygom fx		E					
D7670	Closd rductn splint alveolus		E					
D7671	Alveolus open reduction		E					
D7680	Reduct simple facial bone fx		E					
D7710	Maxilla open reduct compound		E					
D7720	Clsd reduct compd maxilla fx		E					
D7730	Open reduct compd mandble fx		E					
D7740	Clsd reduct compd mandble fx		E					
D7750	Open red comp malar/zygma fx		E					
D7760	Clsd red comp malar/zygma fx		E					
D7770	Open reduc compd alveolus fx		E					
D7771	Alveolus clsd reduc stblz te		E					
D7780	Reduct compnd facial bone fx		E					
D7810	Tmj open reduct-dislocation		E					
D7820	Closed tmp manipulation		E					
D7830	Tmj manipulation under anest		E					
D7840	Removal of tmj condyle		E					
D7850	Tmj meniscectomy		E					
D7852	Tmj repair of joint disc		E					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
D7854	Tmj excisn of joint membrane		E					
D7856	Tmj cutting of a muscle		E					
D7858	Tmj reconstruction		E					
D7860	Tmj cutting into joint		E					
D7865	Tmj reshaping components		E					
D7870	Tmj aspiration joint fluid		E					
D7871	Lysis + lavage w catheters		E					
D7872	Tmj diagnostic arthroscopy		E					
D7873	Tmj arthroscopy lysis adhesn		E					
D7874	Tmj arthroscopy disc reposit		E					
D7875	Tmj arthroscopy synovectomy		E					
D7876	Tmj arthroscopy discectomy		E					
D7877	Tmj arthroscopy debridement		E					
D7880	Occlusal orthotic appliance		E					
D7899	Tmj unspecified therapy		E					
D7910	Dent sutur recent wnd to 5cm		E					
D7911	Dental suture wound to 5 cm		E					
D7912	Suture complicate wnd > 5 cm		E					
D7920	Dental skin graft		E					
D7940	Reshaping bone orthognathic		S	0330	7.9447	$521.84		$104.37
D7941	Bone cutting ramus closed		E					
D7943	Cutting ramus open w/graft		E					
D7944	Bone cutting segmented		E					
D7945	Bone cutting body mandible		E					
D7946	Reconstruction maxilla total		E					
D7947	Reconstruct maxilla segment		E					
D7948	Reconstruct midface no graft		E					
D7949	Reconstruct midface w/graft		E					
D7950	Mandible graft		E					
D7951	Sinus aug w bone/bone sup		E					
D7953	Bone replacement graft		E					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
D7955	Repair maxillofacial defects		E					
D7960	Frenulectomy/frenulotomy		E					
D7963	Frenuloplasty		E					
D7970	Excision hyperplastic tissue		E					
D7971	Excision pericoronal gingiva		E					
D7972	Surg redct fibrous tuberosit		E					
D7980	Sialolithotomy		E					
D7981	Excision of salivary gland		E					
D7982	Sialodochoplasty		E					
D7983	Closure of salivary fistula		E					
D7990	Emergency tracheotomy		E					
D7991	Dental coronoidectomy		E					
D7995	Synthetic graft facial bones		E					
D7996	Implant mandible for augment		E					
D7997	Appliance removal		E					
D7998	Intraoral place of fix dev		E					
D7999	Oral surgery procedure		E					
D8010	Limited dental tx primary		E					
D8020	Limited dental tx transition		E					
D8030	Limited dental tx adolescent		E					
D8040	Limited dental tx adult		E					
D8050	Intercep dental tx primary		E					
D8060	Intercep dental tx transitn		E					
D8070	Compre dental tx transition		E					
D8080	Compre dental tx adolescent		E					
D8090	Compre dental tx adult		E					
D8210	Orthodontic rem appliance tx		E					
D8220	Fixed appliance therapy habt		E					
D8660	Preorthodontic tx visit		E					
D8670	Periodic orthodontc tx visit		E					
D8680	Orthodontic retention		E					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
D8690	Orthodontic treatment		E					
D8691	Repair ortho appliance		E					
D8692	Replacement retainer		E					
D8693	Rebond/cement/repair retain		E					
D8999	Orthodontic procedure		E					
D9110	Tx dental pain minor proc		N					
D9120	Fix partial denture section		E					
D9210	Dent anesthesia w/o surgery		E					
D9211	Regional block anesthesia		E					
D9212	Trigeminal block anesthesia		E					
D9215	Local anesthesia		E					
D9220	General anesthesia		E					
D9221	General anesthesia ea ad 15m		E					
D9230	Analgesia		N					
D9241	Intravenous sedation		E					
D9242	IV sedation ea ad 30 m		E					
D9248	Sedation (non-iv)		N					
D9310	Dental consultation		E					
D9410	Dental house call		E					
D9420	Hospital call		E					
D9430	Office visit during hours		E					
D9440	Office visit after hours		E					
D9450	Case presentation tx plan		E					
D9610	Dent therapeutic drug inject		E					
D9612	Thera par drugs 2 or > admin		E					
D9630	Other drugs/medicaments		S	0330	7.9447	$521.84		$104.37
D9910	Dent appl desensitizing med		E					
D9911	Appl desensitizing resin		E					
D9920	Behavior management		E					
D9930	Treatment of complications		S	0330	7.9447	$521.84		$104.37
D9940	Dental occlusal guard		S	0330	7.9447	$521.84		$104.37

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
D9941	Fabrication athletic guard		E					
D9942	Repair/reline occlusal guard		E					
D9950	Occlusion analysis		S	0330	7.9447	$521.84		$104.37
D9951	Limited occlusal adjustment		S	0330	7.9447	$521.84		$104.37
D9952	Complete occlusal adjustment		S	0330	7.9447	$521.84		$104.37
D9970	Enamel microabrasion		E					
D9971	Odontoplasty 1-2 teeth		E					
D9972	Extrnl bleaching per arch		E					
D9973	Extrnl bleaching per tooth		E					
D9974	Intrnl bleaching per tooth		E					
D9999	Adjunctive procedure		E					
E0100	Cane adjust/fixed with tip		Y					
E0105	Cane adjust/fixed quad/3 pro		Y					
E0110	Crutch forearm pair		Y					
E0111	Crutch forearm each		Y					
E0112	Crutch underarm pair wood		Y					
E0113	Crutch underarm each wood		Y					
E0114	Crutch underarm pair no wood		Y					
E0116	Crutch underarm each no wood		Y					
E0117	Underarm springassist crutch		Y					
E0118	Crutch substitute		E					
E0130	Walker rigid adjust/fixed ht		Y					
E0135	Walker folding adjust/fixed		Y					
E0140	Walker w trunk support		Y					
E0141	Rigid wheeled walker adj/fix		Y					
E0143	Walker folding wheeled w/o s		Y					
E0144	Enclosed walker w rear seat		Y					
E0147	Walker variable wheel resist		Y					
E0148	Heavyduty walker no wheels		Y					
E0149	Heavy duty wheeled walker		Y					
E0153	Forearm crutch platform atta		Y					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
E0154	Walker platform attachment		Y					
E0155	Walker wheel attachment,pair		Y					
E0156	Walker seat attachment		Y					
E0157	Walker crutch attachment		Y					
E0158	Walker leg extenders set of4		Y					
E0159	Brake for wheeled walker		Y					
E0160	Sitz type bath or equipment		Y					
E0161	Sitz bath/equipment w/faucet		Y					
E0162	Sitz bath chair		Y					
E0163	Commode chair with fixed arm		Y					
E0165	Commode chair with detacharm		Y					
E0167	Commode chair pail or pan		Y					
E0168	Heavyduty/wide commode chair		Y					
E0170	Commode chair electric		Y					
E0171	Commode chair non-electric		Y					
E0172	Seat lift mechanism toilet		E					
E0175	Commode chair foot rest		Y					
E0181	Press pad alternating w/ pum		Y					
E0182	Replace pump, alt press pad		Y					
E0184	Dry pressure mattress		Y					
E0185	Gel pressure mattress pad		Y					
E0186	Air pressure mattress		Y					
E0187	Water pressure mattress		Y					
E0188	Synthetic sheepskin pad		Y					
E0189	Lambswool sheepskin pad		Y					
E0190	Positioning cushion		E					
E0191	Protector heel or elbow		Y					
E0193	Powered air flotation bed		Y					
E0194	Air fluidized bed		Y					
E0196	Gel pressure mattress		Y					
E0197	Air pressure pad for mattres		Y					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
E0198	Water pressure pad for mattr		Y					
E0199	Dry pressure pad for mattres		Y					
E0200	Heat lamp without stand		Y					
E0202	Phototherapy light w/ photom		Y					
E0203	Therapeutic lightbox tabletp		E					
E0205	Heat lamp with stand		Y					
E0210	Electric heat pad standard		Y					
E0215	Electric heat pad moist		Y					
E0217	Water circ heat pad w pump		Y					
E0218	Water circ cold pad w pump		Y					
E0220	Hot water bottle		Y					
E0221	Infrared heating pad system		Y					
E0225	Hydrocollator unit		Y					
E0230	Ice cap or collar		Y					
E0231	Wound warming device		E					
E0232	Warming card for NWT		E					
E0235	Paraffin bath unit portable		Y					
E0236	Pump for water circulating p		Y					
E0238	Heat pad non-electric moist		Y					
E0239	Hydrocollator unit portable		Y					
E0240	Bath/shower chair		E					
E0241	Bath tub wall rail		E					
E0242	Bath tub rail floor		E					
E0243	Toilet rail		E					
E0244	Toilet seat raised		E					
E0245	Tub stool or bench		E					
E0246	Transfer tub rail attachment		E					
E0247	Trans bench w/wo comm open		E					
E0248	HDtrans bench w/wo comm open		E					
E0249	Pad water circulating heat u		Y					
E0250	Hosp bed fixed ht w/ mattres		E					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
E0251	Hosp bed fixd ht w/o mattres		E					
E0255	Hospital bed var ht w/ mattr		E					
E0256	Hospital bed var ht w/o matt		E					
E0260	Hosp bed semi-electr w/ matt		E					
E0261	Hosp bed semi-electr w/o mat		E					
E0265	Hosp bed total electr w/ mat		E					
E0266	Hosp bed total elec w/o matt		E					
E0270	Hospital bed institutional t		E					
E0271	Mattress innerspring		E					
E0272	Mattress foam rubber		E					
E0273	Bed board		E					
E0274	Over-bed table		E					
E0275	Bed pan standard		Y					
E0276	Bed pan fracture		Y					
E0277	Powered pres-redu air mattrs		Y					
E0280	Bed cradle		Y					
E0290	Hosp bed fx ht w/o rails w/m		E					
E0291	Hosp bed fx ht w/o rail w/o		Y					
E0292	Hosp bed var ht w/o rail w/o		E					
E0293	Hosp bed var ht w/o rail w/		Y					
E0294	Hosp bed semi-elect w/ mattr		E					
E0295	Hosp bed semi-elect w/o matt		Y					
E0296	Hosp bed total elect w/ matt		E					
E0297	Hosp bed total elect w/o mat		Y					
E0300	Enclosed ped crib hosp grade		Y					
E0301	HD hosp bed, 350-600 lbs		Y					
E0302	Ex hd hosp bed > 600 lbs		Y					
E0303	Hosp bed hvy dty xtra wide		E					
E0304	Hosp bed xtra hvy dty x wide		E					
E0305	Rails bed side half length		E					
E0310	Rails bed side full length		E					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
E0315	Bed accessory brd/tbl/supprt		E					
E0316	Bed safety enclosure		Y					
E0325	Urinal male jug-type		Y					
E0326	Urinal female jug-type		Y					
E0328	Ped hospital bed, manual		Y					
E0329	Ped hospital bed semi/elect		Y					
E0350	Control unit bowel system		E					
E0352	Disposable pack w/bowel syst		E					
E0370	Air elevator for heel		E					
E0371	Nonpower mattress overlay		Y					
E0372	Powered air mattress overlay		Y					
E0373	Nonpowered pressure mattress		Y					
E0424	Stationary compressed gas 02		Y					
E0425	Gas system stationary compre		E					
E0430	Oxygen system gas portable		E					
E0431	Portable gaseous 02		Y					
E0434	Portable liquid 02		Y					
E0435	Oxygen system liquid portabl		E					
E0439	Stationary liquid 02		Y					
E0440	Oxygen system liquid station		E					
E0441	Oxygen contents, gaseous		Y					
E0442	Oxygen contents, liquid		Y					
E0443	Portable 02 contents, gas		Y					
E0444	Portable 02 contents, liquid		Y					
E0445	Oximeter non-invasive		A					
E0450	Vol control vent invasiv int		Y					
E0455	Oxygen tent excl croup/ped t		Y					
E0457	Chest shell		Y					
E0459	Chest wrap		Y					
E0460	Neg press vent portabl/statn		Y					
E0461	Vol control vent noninv int		Y					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
E0462	Rocking bed w/ or w/o side r		Y					
E0463	Press supp vent invasive int		Y					
E0464	Press supp vent noninv int		Y					
E0470	RAD w/o backup non-inv intfc		Y					
E0471	RAD w/backup non inv intrfc		Y					
E0472	RAD w backup invasive intrfc		Y					
E0480	Percussor elect/pneum home m		Y					
E0481	Intrpulmnry percuss vent sys		E					
E0482	Cough stimulating device		Y					
E0483	Chest compression gen system		Y					
E0484	Non-elec oscillatory pep dvc		Y					
E0485	Oral device/appliance prefab		Y					
E0486	Oral device/appliance cusfab		Y					
E0500	Ippb all types		Y					
E0550	Humidif extens supple w ippb		Y					
E0555	Humidifier for use w/ regula		Y					
E0560	Humidifier supplemental w/ i		Y					
E0561	Humidifier nonheated w PAP		Y					
E0562	Humidifier heated used w PAP		Y					
E0565	Compressor air power source		Y					
E0570	Nebulizer with compression		Y					
E0571	Aerosol compressor for svneb		Y					
E0572	Aerosol compressor adjust pr		Y					
E0574	Ultrasonic generator w svneb		Y					
E0575	Nebulizer ultrasonic		Y					
E0580	Nebulizer for use w/ regulat		Y					
E0585	Nebulizer w/ compressor & he		Y					
E0600	Suction pump portab hom modl		Y					
E0601	Cont airway pressure device		Y					
E0602	Manual breast pump		Y					
E0603	Electric breast pump		A					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
E0604	Hosp grade elec breast pump		A					
E0605	Vaporizer room type		Y					
E0606	Drainage board postural		Y					
E0607	Blood glucose monitor home		Y					
E0610	Pacemaker monitr audible/vis		Y					
E0615	Pacemaker monitr digital/vis		Y					
E0616	Cardiac event recorder		N					
E0617	Automatic ext defibrillator		Y					
E0618	Apnea monitor		A					
E0619	Apnea monitor w recorder		A					
E0620	Cap bld skin piercing laser		Y					
E0621	Patient lift sling or seat		Y					
E0625	Patient lift bathroom or toi		E					
E0627	Seat lift incorp lift-chair		Y					
E0628	Seat lift for pt furn-electr		Y					
E0629	Seat lift for pt furn-non-el		Y					
E0630	Patient lift hydraulic		Y					
E0635	Patient lift electric		Y					
E0636	PT support & positioning sys		Y					
E0637	Combination sit to stand sys		E					
E0638	Standing frame sys		E					
E0639	Moveable patient lift system		E					
E0640	Fixed patient lift system		E					
E0641	Multi-position stnd fram sys		E					
E0642	Dynamic standing frame		E					
E0650	Pneuma compresor non-segment		Y					
E0651	Pneum compressor segmental		Y					
E0652	Pneum compres w/cal pressure		Y					
E0655	Pneumatic appliance half arm		Y					
E0660	Pneumatic appliance full leg		Y					
E0665	Pneumatic appliance full arm		Y					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
E0666	Pneumatic appliance half leg		Y					
E0667	Seg pneumatic appl full leg		Y					
E0668	Seg pneumatic appl full arm		Y					
E0669	Seg pneumatic appli half leg		Y					
E0671	Pressure pneum appl full leg		Y					
E0672	Pressure pneum appl full arm		Y					
E0673	Pressure pneum appl half leg		Y					
E0675	Pneumatic compression device		Y					
E0676	Inter limb compress dev NOS		Y					
E0691	Uvl pnl 2 sq ft or less		Y					
E0692	Uvl sys panel 4 ft		Y					
E0693	Uvl sys panel 6 ft		Y					
E0694	Uvl md cabinet sys 6 ft		Y					
E0700	Safety equipment		E					
E0705	Transfer device		B					
E0710	Restraints any type		E					
E0720	Tens two lead		Y					
E0730	Tens four lead		Y					
E0731	Conductive garment for tens/		Y					
E0740	Incontinence treatment systm		Y					
E0744	Neuromuscular stim for scoli		Y					
E0745	Neuromuscular stim for shock		Y					
E0746	Electromyograph biofeedback		A					
E0747	Elec osteogen stim not spine		Y					
E0748	Elec osteogen stim spinal		Y					
E0749	Elec osteogen stim implanted		N					
E0755	Electronic salivary reflex s		E					
E0760	Osteogen ultrasound stimltor		Y					
E0761	Nontherm electromgntc device		E					
E0762	Trans elec jt stim dev sys		B					
E0764	Functional neuromuscularstim		Y					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
E0765	Nerve stimulator for tx n&v		Y					
E0769	Electric wound treatment dev		B					
E0776	Iv pole		Y					
E0779	Amb infusion pump mechanical		Y					
E0780	Mech amb infusion pump <8hrs		Y					
E0781	External ambulatory infus pu		Y					
E0782	Non-programble infusion pump		N					
E0783	Programmable infusion pump		N					
E0784	Ext amb infusn pump insulin		Y					
E0785	Replacement impl pump cathet		N					
E0786	Implantable pump replacement		N					
E0791	Parenteral infusion pump sta		Y					
E0830	Ambulatory traction device		N					
E0840	Tract frame attach headboard		Y					
E0849	Cervical pneum trac equip		Y					
E0850	Traction stand free standing		Y					
E0855	Cervical traction equipment		Y					
E0856	Cervic collar w air bladder		Y					
E0860	Tract equip cervical tract		Y					
E0870	Tract frame attach footboard		Y					
E0880	Trac stand free stand extrem		Y					
E0890	Traction frame attach pelvic		Y					
E0900	Trac stand free stand pelvic		Y					
E0910	Trapeze bar attached to bed		Y					
E0911	HD trapeze bar attach to bed		Y					
E0912	HD trapeze bar free standing		Y					
E0920	Fracture frame attached to b		Y					
E0930	Fracture frame free standing		Y					
E0935	Cont pas motion exercise dev		Y					
E0936	CPM device, other than knee		E					
E0940	Trapeze bar free standing		Y					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
E0941	Gravity assisted traction de		Y					
E0942	Cervical head harness/halter		Y					
E0944	Pelvic belt/harness/boot		Y					
E0945	Belt/harness extremity		Y					
E0946	Fracture frame dual w cross		Y					
E0947	Fracture frame attachmnts pe		Y					
E0948	Fracture frame attachmnts ce		Y					
E0950	Tray		A					
E0951	Loop heel		A					
E0952	Toe loop/holder, each		A					
E0955	Cushioned headrest		Y					
E0956	W/c lateral trunk/hip suppor		Y					
E0957	W/c medial thigh support		Y					
E0958	Whlchr att- conv 1 arm drive		A					
E0959	Amputee adapter		B					
E0960	W/c shoulder harness/straps		Y					
E0961	Wheelchair brake extension		B					
E0966	Wheelchair head rest extensi		B					
E0967	Manual wc hand rim w project		Y					
E0968	Wheelchair commode seat		Y					
E0969	Wheelchair narrowing device		Y					
E0970	Wheelchair no. 2 footplates		E					
E0971	Wheelchair anti-tipping devi		B					
E0973	W/Ch access det adj armrest		B					
E0974	W/Ch access anti-rollback		B					
E0978	W/C acc,saf belt pelv strap		B					
E0980	Wheelchair safety vest		Y					
E0981	Seat uphclstery, replacement		Y					
E0982	Back upholstery, replacement		Y					
E0983	Add pwr joystick		Y					
E0984	Add pwr tiller		Y					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
E0985	W/c seat lift mechanism		Y					
E0986	Man w/c push-rim pow assist		Y					
E0990	Wheelchair elevating leg res		B					
E0992	Wheelchair solid seat insert		B					
E0994	Wheelchair arm rest		Y					
E0995	Wheelchair calf rest		B					
E1002	Pwr seat tilt		Y					
E1003	Pwr seat recline		Y					
E1004	Pwr seat recline mech		Y					
E1005	Pwr seat recline pwr		Y					
E1006	Pwr seat combo w/o shear		Y					
E1007	Pwr seat combo w/shear		Y					
E1008	Pwr seat combo pwr shear		Y					
E1009	Add mech leg elevation		Y					
E1010	Add pwr leg elevation		Y					
E1011	Ped wc modify width adjustm		Y					
E1014	Reclining back add ped w/c		Y					
E1015	Shock absorber for man w/c		Y					
E1016	Shock absorber for power w/c		Y					
E1017	HD shck absrbr for hd man wc		Y					
E1018	HD shck absrber for hd powwc		Y					
E1020	Residual limb support system		Y					
E1028	W/c manual swingaway		Y					
E1029	W/c vent tray fixed		Y					
E1030	W/c vent tray gimbaled		Y					
E1031	Rollabout chair with casters		Y					
E1035	Patient transfer system		Y					
E1037	Transport chair, ped size		Y					
E1038	Transport chair pt wt<=300lb		Y					
E1039	Transport chair pt wt >300lb		Y					
E1050	Whelchr fxd full length arms		A					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
E1060	Wheelchair detachable arms		A					
E1070	Wheelchair detachable foot r		A					
E1083	Hemi-wheelchair fixed arms		A					
E1084	Hemi-wheelchair detachable a		A					
E1085	Hemi-wheelchair fixed arms		E					
E1086	Hemi-wheelchair detachable a		E					
E1087	Wheelchair lightwt fixed arm		A					
E1088	Wheelchair lightweight det a		A					
E1089	Wheelchair lightwt fixed arm		E					
E1090	Wheelchair lightweight det a		E					
E1092	Wheelchair wide w/ leg rests		A					
E1093	Wheelchair wide w/ foot rest		A					
E1100	Whchr s-recl fxd arm leg res		A					
E1110	Wheelchair semi-recl detach		A					
E1130	Whlchr stand fxd arm ft rest		E					
E1140	Wheelchair standard detach a		E					
E1150	Wheelchair standard w/ leg r		Y					
E1160	Wheelchair fixed arms		A					
E1161	Manual adult wc w tiltinspac		A					
E1170	Whlchr ampu fxd arm leg rest		A					
E1171	Wheelchair amputee w/o leg r		A					
E1172	Wheelchair amputee detach ar		A					
E1180	Wheelchair amputee w/ foot r		A					
E1190	Wheelchair amputee w/ leg re		A					
E1195	Wheelchair amputee heavy dut		A					
E1200	Wheelchair amputee fixed arm		A					
E1220	Whlchr special size/constrc		A					
E1221	Wheelchair spec size w foot		A					
E1222	Wheelchair spec size w/ leg		A					
E1223	Wheelchair spec size w foot		A					
E1224	Wheelchair spec size w/ leg		A					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
E1225	Manual semi-reclining back		Y					
E1226	Manual fully reclining back		B					
E1227	Wheelchair spec sz spec ht a		Y					
E1228	Wheelchair spec sz spec ht b		Y					
E1229	Pediatric wheelchair NOS		Y					
E1230	Power operated vehicle		Y					
E1231	Rigid ped w/c tilt-in-space		Y					
E1232	Folding ped wc tilt-in-space		Y					
E1233	Rig ped wc tltnspc w/o seat		Y					
E1234	Fld ped wc tltnspc w/o seat		Y					
E1235	Rigid ped wc adjustable		Y					
E1236	Folding ped wc adjustable		Y					
E1237	Rgd ped wc adjstabl w/o seat		Y					
E1238	Fld ped wc adjstabl w/o seat		Y					
E1239	Ped power wheelchair NOS		Y					
E1240	Whchr litwt det arm leg rest		A					
E1250	Wheelchair lightwt fixed arm		E					
E1260	Wheelchair lightwt foot rest		E					
E1270	Wheelchair lightweight leg r		A					
E1280	Whchr h-duty det arm leg res		A					
E1285	Wheelchair heavy duty fixed		E					
E1290	Wheelchair hvy duty detach a		E					
E1295	Wheelchair heavy duty fixed		A					
E1296	Wheelchair special seat heig		Y					
E1297	Wheelchair special seat dept		Y					
E1298	Wheelchair spec seat depth/w		Y					
E1300	Whirlpool portable		E					
E1310	Whirlpool non-portable		Y					
E1340	Repair for DME, per 15 min		Y					
E1353	Oxygen supplies regulator		Y					
E1355	Oxygen supplies stand/rack		Y					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
E1372	Oxy suppl heater for nebuliz		Y					
E1390	Oxygen concentrator		Y					
E1391	Oxygen concentrator, dual		Y					
E1392	Portable oxygen concentrator		Y					
E1399	Durable medical equipment mi		Y					
E1405	O2/water vapor enrich w/heat		Y					
E1406	O2/water vapor enrich w/o he		Y					
E1500	Centrifuge		A					
E1510	Kidney dialysate delivry sys		A					
E1520	Heparin infusion pump		A					
E1530	Replacement air bubble detec		A					
E1540	Replacement pressure alarm		A					
E1550	Bath conductivity meter		A					
E1560	Replace blood leak detector		A					
E1570	Adjustable chair for esrd pt		A					
E1575	Transducer protect/fld bar		A					
E1580	Unipuncture control system		A					
E1590	Hemodialysis machine		A					
E1592	Auto interm peritoneal dialy		A					
E1594	Cycler dialysis machine		A					
E1600	Deli/install chrg hemo equip		A					
E1610	Reverse osmosis h2o puri sys		A					
E1615	Deionizer H2O puri system		A					
E1620	Replacement blood pump		A					
E1625	Water softening system		A					
E1630	Reciprocating peritoneal dia		A					
E1632	Wearable artificial kidney		A					
E1634	Peritoneal dialysis clamp		B					
E1635	Compact travel hemodialyzer		A					
E1636	Sorbent cartridges per 10		A					
E1637	Hemostats for dialysis, each		A					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
E1639	Dialysis scale		A					
E1699	Dialysis equipment noc		A					
E1700	Jaw motion rehab system		Y					
E1701	Repl cushions for jaw motion		Y					
E1702	Repl measr scales jaw motion		Y					
E1800	Adjust elbow ext/flex device		Y					
E1801	SPS elbow device		Y					
E1802	Adjst forearm pro/sup device		Y					
E1805	Adjust wrist ext/flex device		Y					
E1806	SPS wrist device		Y					
E1810	Adjust knee ext/flex device		Y					
E1811	SPS knee device		Y					
E1812	Knee ext/flex w act res ctrl		Y					
E1815	Adjust ankle ext/flex device		Y					
E1816	SPS ankle device		Y					
E1818	SPS forearm device		Y					
E1820	Soft interface material		Y					
E1821	Replacement interface SPSD		Y					
E1825	Adjust finger ext/flex devc		Y					
E1830	Adjust toe ext/flex device		Y					
E1840	Adj shoulder ext/flex device		Y					
E1841	Static str shldr dev rom adj		Y					
E1902	AAC non-electronic board		A					
E2000	Gastric suction pump hme mdl		Y					
E2100	Bld glucose monitor w voice		Y					
E2101	Bld glucose monitor w lance		Y					
E2120	Pulse gen sys tx endolymp fl		Y					
E2201	Man w/ch acc seat w>=20ö<24ö		Y					
E2202	Seat width 24-27 in		Y					
E2203	Frame depth less than 22 in		Y					
E2204	Frame depth 22 to 25 in		Y					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
E2205	Manual wc accessory, handrim		Y					
E2206	Complete wheel lock assembly		Y					
E2207	Crutch and cane holder		Y					
E2208	Cylinder tank carrier		Y					
E2209	Arm trough each		Y					
E2210	Wheelchair bearings		Y					
E2211	Pneumatic propulsion tire		Y					
E2212	Pneumatic prop tire tube		Y					
E2213	Pneumatic prop tire insert		Y					
E2214	Pneumatic caster tire each		Y					
E2215	Pneumatic caster tire tube		Y					
E2216	Foam filled propulsion tire		Y					
E2217	Foam filled caster tire each		Y					
E2218	Foam propulsion tire each		Y					
E2219	Foam caster tire any size ea		Y					
E2220	Solid propulsion tire each		Y					
E2221	Solid caster tire each		Y					
E2222	Solid caster integrated whl		Y					
E2223	Valve replacement only each		Y					
E2224	Propulsion whl excludes tire		Y					
E2225	Caster wheel excludes tire		Y					
E2226	Caster fork replacement only		Y					
E2227	Gear reduction drive wheel		Y					
E2228	Mwc acc, wheelchair brake		Y					
E2291	Planar back for ped size wc		Y					
E2292	Planar seat for ped size wc		Y					
E2293	Contour back for ped size wc		Y					
E2294	Contour seat for ped size wc		Y					
E2300	Pwr seat elevation sys		Y					
E2301	Pwr standing		Y					
E2310	Electro connect btw control		Y					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
E2311	Electro connect btw 2 sys		Y					
E2312	Mini-prop remote joystick		Y					
E2313	PWC harness, expand control		Y					
E2321	Hand interface joystick		Y					
E2322	Mult mech switches		Y					
E2323	Special joystick handle		Y					
E2324	Chin cup interface		Y					
E2325	Sip and puff interface		Y					
E2326	Breath tube kit		Y					
E2327	Head control interface mech		Y					
E2328	Head/extremity control inter		Y					
E2329	Head control nonproportional		Y					
E2330	Head control proximity switc		Y					
E2331	Attendant control		Y					
E2340	W/c wdth 20-23 in seat frame		Y					
E2341	W/c wdth 24-27 in seat frame		Y					
E2342	W/c dpth 20-21 in seat frame		Y					
E2343	W/c dpth 22-25 in seat frame		Y					
E2351	Electronic SGD interface		Y					
E2360	22nf nonsealed leadacid		Y					
E2361	22nf sealed leadacid battery		Y					
E2362	Gr24 nonsealed leadacid		Y					
E2363	Gr24 sealed leadacid battery		Y					
E2364	U1nonsealed leadacid battery		Y					
E2365	U1 sealed leadacid battery		Y					
E2366	Battery charger, single mode		Y					
E2367	Battery charger, dual mode		Y					
E2368	Power wc motor replacement		Y					
E2369	Pwr wc gear box replacement		Y					
E2370	Pwr wc motor/gear box combo		Y					
E2371	Gr27 sealed leadacid battery		Y					

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E2372	Gr27 non-sealed leadacid		Y					
E2373	Hand/chin ctrl spec joystick		Y					
E2374	Hand/chin ctrl std joystick		Y					
E2375	Non-expandable controller		Y					
E2376	Expandable controller, repl		Y					
E2377	Expandable controller, initl		Y					
E2381	Pneum drive wheel tire		Y					
E2382	Tube, pneum wheel drive tire		Y					
E2383	Insert, pneum wheel drive		Y					
E2384	Pneumatic caster tire		Y					
E2385	Tube, pneumatic caster tire		Y					
E2386	Foam filled drive wheel tire		Y					
E2387	Foam filled caster tire		Y					
E2388	Foam drive wheel tire		Y					
E2389	Foam caster tire		Y					
E2390	Solid drive wheel tire		Y					
E2391	Solid caster tire		Y					
E2392	Solid caster tire, integrate		Y					
E2393	Valve, pneumatic tire tube		Y					
E2394	Drive wheel excludes tire		Y					
E2395	Caster wheel excludes tire		Y					
E2396	Caster fork		Y					
E2397	Pwc acc, lith-based battery		Y					
E2399	Noc interface		Y					
E2402	Neg press wound therapy pump		Y					
E2500	SGD digitized pre-rec <=8min		Y					
E2502	SGD prerec msg >8min <=20min		Y					
E2504	SGD prerec msg>20min <=40min		Y					
E2506	SGD prerec msg > 40 min		Y					
E2508	SGD spelling phys contact		Y					
E2510	SGD w multi methods msg/accs		Y					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
E2511	SGD sftwre prgrm for PC/PDA		Y					
E2512	SGD accessory, mounting sys		Y					
E2599	SGD accessory noc		Y					
E2601	Gen w/c cushion wdth < 22 in		Y					
E2602	Gen w/c cushion wdth >=22 in		Y					
E2603	Skin protect wc cus wd <22in		Y					
E2604	Skin protect wc cus wd>=22in		Y					
E2605	Position wc cush wdth <22 in		Y					
E2606	Position wc cush wdth>=22 in		Y					
E2607	Skin pro/pos wc cus wd <22in		Y					
E2608	Skin pro/pos wc cus wd>=22in		Y					
E2609	Custom fabricate w/c cushion		Y					
E2610	Powered w/c cushion		B					
E2611	Gen use back cush wdth <22in		Y					
E2612	Gen use back cush wdth>=22in		Y					
E2613	Position back cush wd <22in		Y					
E2614	Position back cush wd>=22in		Y					
E2615	Pos back post/lat wdth <22in		Y					
E2616	Pos back post/lat wdth>=22in		Y					
E2617	Custom fab w/c back cushion		Y					
E2619	Replace cover w/c seat cush		Y					
E2620	WC planar back cush wd <22in		Y					
E2621	WC planar back cush wd>=22in		Y					
E8000	Posterior gait trainer		E					
E8001	Upright gait trainer		E					
E8002	Anterior gait trainer		E					
G0008	Admin influenza virus vac		S	0350	0.3810	$25.03		
G0009	Admin pneumococcal vaccine		S	0350	0.3810	$25.03		
G0010	Admin hepatitis b vaccine		B					
G0027	Semen analysis		A					
G0101	CA screen;pelvic/breast exam		V	0604	0.8425	$55.34		$11.07

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G0102	Prostate ca screening; dre		N					
G0103	PSA screening		A					
G0104	CA screen;flexi sigmoidscope		S	0159	5.0526	$331.87		$82.97
G0105	Colorectal scrn; hi risk ind		T	0158	7.9982	$525.35		$131.34
G0106	Colon CA screen;barium enema		S	0157	2.6593	$174.67		$34.94
G0108	Diab manage trn per indiv		A					
G0109	Diab manage trn ind/group		A					
G0117	Glaucoma scrn hgh risk direc		S	0698	0.9139	$60.03		$12.01
G0118	Glaucoma scrn hgh risk direc		S	0230	0.6359	$41.77		$8.36
G0120	Colon ca scrn; barium enema		S	0157	2.6593	$174.67		$34.94
G0121	Colon ca scrn not hi rsk ind		T	0158	7.9982	$525.35		$131.34
G0122	Colon ca scrn; barium enema		E					
G0123	Screen cerv/vag thin layer		A					
G0124	Screen c/v thin layer by MD		B					
G0127	Trim nail(s)		T	0013	0.8332	$54.73		$10.95
G0128	CORF skilled nursing service		B					
G0129	Partial hosp prog service	CH	P					
G0130	Single energy x-ray study		X	0260	0.6979	$45.84		$9.17
G0141	Scr c/v cyto,autosys and md		B					
G0143	Scr c/v cyto,thinlayer,rescr		A					
G0144	Scr c/v cyto,thinlayer,rescr		A					
G0145	Scr c/v cyto,thinlayer,rescr		A					
G0147	Scr c/v cyto, automated sys		A					
G0148	Scr c/v cyto, autosys, rescr		A					
G0151	HHCP-serv of pt,ea 15 min		B					
G0152	HHCP-serv of ot,ea 15 min		B					
G0153	HHCP-svs of s/l path,ea 15mn		B					
G0154	HHCP-svs of rn,ea 15 min		B					
G0155	HHCP-svs of csw,ea 15 min		B					
G0156	HHCP-svs of aide,ea 15 min		B					
G0166	Extrnl counterpulse, per tx		T	0678	1.5515	$101.91		$20.39

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
G0168	Wound closure by adhesive		B					
G0173	Linear acc stereo radsur com		S	0067	55.7874	$3,664.34		$732.87
G0175	OPPS Service,sched team conf	CH	V	0606	1.3354	$87.71		$17.55
G0176	OPPS/PHP;activity therapy	CH	P					
G0177	OPPS/PHP; train & educ serv		N					
G0179	MD recertification HHA PT		M					
G0180	MD certification HHA patient		M					
G0181	Home health care supervision		M					
G0182	Hospice care supervision		M					
G0186	Dstry eye lesn,fdr vssl tech		T	0235	5.8210	$382.35		$76.47
G0202	Screeningmammographydigital		A					
G0204	Diagnosticmammographydigital		A					
G0206	Diagnosticmammographydigital		A					
G0219	PET img wholbod melano nonco		E					
G0235	PET not otherwise specified		E					
G0237	Therapeutic procd strg endur		S	0077	0.3971	$26.08	$7.74	$5.22
G0238	Oth resp proc, indiv		S	0077	0.3971	$26.08	$7.74	$5.22
G0239	Oth resp proc, group		S	0077	0.3971	$26.08	$7.74	$5.22
G0245	Initial foot exam pt lops		V	0604	0.8425	$55.34		$11.07
G0246	Followup eval of foot pt lop		V	0605	1.0387	$68.23		$13.65
G0247	Routine footcare pt w lops		T	0013	0.8332	$54.73		$10.95
G0248	Demonstrate use home inr mon		V	0607	1.7777	$116.77		$23.36
G0249	Provide test material,equipm		V	0607	1.7777	$116.77		$23.36
G0250	MD review interpret of test		M					
G0251	Linear acc based stero radio		S	0065	15.1533	$995.33		$199.07
G0252	PET imaging initial dx		E					
G0255	Current percep threshold tst		E					
G0257	Unsched dialysis ESRD pt hos		S	0170	6.5091	$427.54		$85.51
G0259	Inject for sacroiliac joint		N					
G0260	Inj for sacroiliac jt anesth		T	0207	7.3510	$482.84		$96.57
G0268	Removal of impacted wax md		N					

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G0269	Occlusive device in vein art		N					
G0270	MNT subs tx for change dx		A					
G0271	Group MNT 2 or more 30 mins		A					
G0275	Renal angio, cardiac cath		N					
G0278	Iliac art angio,cardiac cath		N					
G0281	Elec stim unattend for press		A					
G0282	Elect stim wound care not pd		E					
G0283	Elec stim other than wound		A					
G0288	Recon, CTA for surg plan		N					
G0289	Arthro, loose body + chondro		N					
G0290	Drug-eluting stents, single		T	0656	113.6926	$7,467.78		$1,493.56
G0291	Drug-eluting stents,each add		T	0656	113.6926	$7,467.78		$1,493.56
G0293	Non-cov surg proc,clin trial		X	0340	0.6481	$42.57		$8.52
G0294	Non-cov proc, clinical trial		X	0340	0.6481	$42.57		$8.52
G0295	Electromagnetic therapy onc		E					
G0302	Pre-op service LVRS complete		S	0209	11.4227	$750.29	$268.73	$150.06
G0303	Pre-op service LVRS 10-15dos		S	0209	11.4227	$750.29	$268.73	$150.06
G0304	Pre-op service LVRS 1-9 dos		S	0213	2.3220	$152.52	$53.58	$30.51
G0305	Post op service LVRS min 6		S	0213	2.3220	$152.52	$53.58	$30.51
G0306	CBC/diffwbc w/o platelet		A					
G0307	CBC without platelet		A					
G0308	ESRD related svc 4+mo < 2yrs		B					
G0309	ESRD related svc 2-3mo <2yrs		B					
G0310	ESRD related svc 1 vst <2yrs		B					
G0311	ESRD related svs 4+mo 2-11yr		B					
G0312	ESRD relate svs 2-3 mo 2-11y		B					
G0313	ESRD related svs 1 mon 2-11y		B					
G0314	ESRD related svs 4+ mo 12-19		B					
G0315	ESRD related svs 2-3mo/12-19		B					
G0316	ESRD related svs 1vis/12-19y		B					
G0317	ESRD related svs 4+mo 20+yrs		B					

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G0318	ESRD related svs 2-3 mo 20+y		B					
G0319	ESRD related svs 1visit 20+y		B					
G0320	ESD related svs home undr 2		B					
G0321	ESRDrelatedsvs home mo 2-11y		B					
G0322	ESRD related svs hom mo12-19		B					
G0323	ESRD related svs home mo 20+		B					
G0324	ESRD relate svs home/dy <2yr		B					
G0325	ESRD relate home/day/ 2-11yr		B					
G0326	ESRD relate home/dy 12-19yr		B					
G0327	ESRD relate home/dy 20+yrs		B					
G0328	Fecal blood scrn immunoassay		A					
G0329	Electromagntic tx for ulcers		A					
G0332	Preadmin IV immunoglobulin	CH	N					
G0333	Dispense fee initial 30 day		M					
G0337	Hospice evaluation preelecti		B					
G0339	Robot lin-radsurg com, first		S	0067	55.7874	$3,664.34		$732.87
G0340	Robt lin-radsurg fractx 2-5		S	0066	40.4116	$2,654.40		$530.88
G0341	Percutaneous islet celltrans		C					
G0342	Laparoscopy islet cell trans		C					
G0343	Laparotomy islet cell transp		C					
G0344	Initial preventive exam		V	0605	1.0387	$68.23		$13.65
G0364	Bone marrow aspirate &biopsy	CH	X	0340	0.6481	$42.57		$8.52
G0365	Vessel mapping hemo access		S	0267	2.3495	$154.32	$60.50	$30.87
G0366	EKG for initial prevent exam		B					
G0367	EKG tracing for initial prev		S	0099	0.4021	$26.41		$5.29
G0368	EKG interpret & report preve		M					
G0372	MD service required for PMD		M					
G0378	Hospital observation per hr		N					
G0379	Direct admit hospital observ		Q3	0604	0.8425	$55.34		$11.07
G0380	Lev 1 hosp type B ED visit	CH	V	0626	0.7385	$48.51		$9.71
G0381	Lev 2 hosp type B ED visit	CH	V	0627	0.9869	$64.82		$12.97

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G0382	Lev 3 hosp type B ED visit	CH	V	0628	1.4056	$92.33		$18.47
G0383	Lev 4 hosp type B ED visit	CH	V	0629	2.3836	$156.56		$31.32
G0384	Lev 5 hosp type B ED visit	CH	Q3	0616	4.9566	$325.57	$72.86	$65.12
G0389	Ultrasound exam AAA screen		S	0266	1.5058	$98.91	$37.80	$19.79
G0390	Trauma Respons w/hosp criti		S	0618	15.0884	$991.07		$198.22
G0392	AV fistula or graft arterial		T	0083	48.2679	$3,170.43		$634.09
G0393	AV fistula or graft venous		T	0083	48.2679	$3,170.43		$634.09
G0394	Blood occult test,colorectal		A					
G0396	Alcohol/subs interv 15-30mn		S	0432	0.4341	$28.51		$5.71
G0397	Alcohol/subs interv >30 min		S	0432	0.4341	$28.51		$5.71
G3001	Admin + supply, tositumomab		S	0442	29.7403	$1,953.46		$390.70
G8006	AMI pt recd aspirin at arriv		M					
G8007	AMI pt did not receiv aspiri		M					
G8008	AMI pt ineligible for aspiri		M					
G8009	AMI pt recd Bblock at arr		M					
G8010	AMI pt did not rec bblock		M					
G8011	AMI pt inelig Bbloc at arriv		M					
G8012	Pneum pt recv antibiotic 4 h		M					
G8013	Pneum pt w/o antibiotic 4 hr		M					
G8014	Pneum pt not elig antibiotic		M					
G8015	Diabetic pt w/ HBA1c>9%		M					
G8016	Diabetic pt w/ HBA1c<or=9%		M					
G8017	DM pt inelig for HBA1c measu		M					
G8018	Care not provided for HbA1c		M					
G8019	Diabetic pt w/LDL>= 100mg/dl		M					
G8020	Diab pt w/LDL< 100mg/dl		M					
G8021	Diab pt inelig for LDL meas		M					
G8022	Care not provided for LDL		M					
G8023	DM pt w BP>=140/80		M					
G8024	Diabetic pt wBP<140/80		M					
G8025	Diabetic pt inelig for BP me		M					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
G8026	Diabet pt w no care re BP me		M					
G8027	HF p w/LVSD on ACE-I/ARB		M					
G8028	HF pt w/LVSD not on ACE-I/AR		M					
G8029	HF pt not elig for ACE-I/ARB		M					
G8030	HF pt w/LVSD on Bblocker		M					
G8031	HF pt w/LVSD not on Bblocker		M					
G8032	HF pt not elig for Bblocker		M					
G8033	PMI-CAD pt on Bblocker		M					
G8034	PMI-CAD pt not on Bblocker		M					
G8035	PMI-CAD pt inelig Bblocker		M					
G8036	AMI-CAD pt doc on antiplatel		M					
G8037	AMI-CAD pt not docu on antip		M					
G8038	AMI-CAD inelig antiplate mea		M					
G8039	CAD pt w/LDL>100mg/dl		M					
G8040	CAD pt w/LDL<or=100mg/dl		M					
G8041	CAD pt not eligible for LDL		M					
G8051	Osteoporosis assess		M					
G8052	Osteopor pt not assess		M					
G8053	Pt inelig for osteopor meas		M					
G8054	Falls assess not docum 12 mo		M					
G8055	Falls assess w/ 12 mon		M					
G8056	Not elig for falls assessmen		M					
G8057	Hearing assess receive		M					
G8058	Pt w/o hearing assess		M					
G8059	Pt inelig for hearing assess		M					
G8060	Urinary incont pt assess		M					
G8061	Pt not assess for urinary in		M					
G8062	Pt not elig for urinary inco		M					
G8075	ESRD pt w/ dialy of URR>=65%		M					
G8076	ESRD pt w/ dialy of URR<65%		M					
G8077	ESRD pt not elig for URR/KtV		M					

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G8078	ESRD pt w/Hct>or=33		M					
G8079	ESRD pt w/Hct<33		M					
G8080	ESRD pt inelig for HCT/Hgb		M					
G8081	ESRD pt w/ auto AV fistula		M					
G8082	ESRD pt w other fistula		M					
G8085	ESRD PT inelig auto AV FISTU		M					
G8093	COPD pt rec smoking cessat		M					
G8094	COPD pt w/o smoke cessat int		M					
G8099	Osteopo pt given Ca+VitD sup		M					
G8100	Osteop pt inelig for Ca+VitD		M					
G8103	New dx osteo pt w/antiresorp		M					
G8104	Osteo pt inelig for antireso		M					
G8106	Bone dens meas test perf		M					
G8107	Bone dens meas test inelig		M					
G8108	Pt receiv influenza vacc		M					
G8109	Pt w/o influenza vacc		M					
G8110	Pt inelig for influenza vacc		M					
G8111	Pt receiv mammogram		M					
G8112	Pt not doc mammogram		M					
G8113	Pt ineligible mammography		M					
G8114	Care not provided for mamogr		M					
G8115	Pt receiv pneumo vacc		M					
G8116	Pt did not rec pneumo vacc		M					
G8117	Pt was inelig for pneumo vac		M					
G8126	Pt treat w/antidepress12wks		M					
G8127	Pt not treat w/antidepres12w		M					
G8128	Pt inelig for antidepres med		M					
G8129	Pt treat w/antidepres for 6m		M					
G8130	Pt not treat w/antidepres 6m		M					
G8131	Pt inelig for antidepres med		M					
G8152	Pt w/AB 1 hr prior to incisi		M					

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G8153	Pt not doc for AB 1 hr prior		M					
G8154	Pt ineligi for AB therapy		M					
G8155	Pt recd thromboemb prophylax		M					
G8156	Pt did not rec thromboembo		M					
G8157	Pt ineligi for thrombolism		M					
G8159	Pt w/CABG w/o IMA		M					
G8162	Iso CABG pt w/o preop Bblock		M					
G8164	Iso CABG pt w/prolng intub		M					
G8165	Iso CABG pt w/o prolng intub		M					
G8166	Iso CABG req surg rexpo		M					
G8167	Iso CABG w/o surg explo		M					
G8170	CEA/ext bypass pt on aspirin		M					
G8171	Pt w/carot endarct/ext bypas		M					
G8172	CEA/ext bypass pt not on asp		M					
G8182	CAD pt care not prov LDL		M					
G8183	HF/atrial fib pt on warfarin		M					
G8184	HF/atrial fib pt inelig warf		M					
G8185	Osteoarth pt w/ assess pain		M					
G8186	Osteoarth pt inelig assess		M					
G8193	Antibio not doc prior surg		M					
G8196	Antibio not docum prior surg		M					
G8200	Cefazolin not docum prophy		M					
G8204	MD not doc order to d/c anti		M					
G8209	Clinician did not doc		M					
G8214	Clini not doc order VTE		M					
G8217	Pt not received DVT proph		M					
G8219	Received DVT proph day 2		M					
G8220	Pt not rec DVT proph day 2		M					
G8221	Pt inelig for DVT proph		M					
G8223	Pt not doc for presc antipla		M					
G8226	Pt no prescr anticoa at D/C		M					

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G8231	Pt not doc for admin t-PA		M					
G8234	Pt not doc dysphagia screen		M					
G8238	Pt not doc to rec rehab serv		M					
G8240	Inter carotid stenosis30-99%		M					
G8243	Pt not doc MRI/CT w/o lesion		M					
G8246	Pt inelig hx w new/chg mole		M					
G8248	Pt w/one alarm symp not doc		M					
G8251	Pt not doc w/Barretts, endo		M					
G8254	Pt w/no doc order for barium		M					
G8257	Pt not doc rev meds D/C		M					
G8260	Pt not doc to have dec maker		M					
G8263	Pt not doc assess urinary in		M					
G8266	Pt not doc charc urin incon		M					
G8268	Pt not doc rec care urin inc		M					
G8271	Pt no doc screen fall		M					
G8274	Clini not doc pres/abs alarm		M					
G8276	Pt not doc mole change		M					
G8279	Pt not doc rec PE		M					
G8282	Pt not doc to rec couns		M					
G8285	Pt did not rec pres osteo		M					
G8289	Pt not doc rec Ca/Vit D		M					
G8293	COPD pt w/o spir results		M					
G8296	COPD pt not doc bronch ther		M					
G8298	Pt doc optic nerve eval		M					
G8299	Pt not doc optic nerv eval		M					
G8302	Pt doc w/ target IOP		M					
G8303	Pt not doc w/ IOP		M					
G8304	Clin doc pt inelig IOP		M					
G8305	Clin not prov care POAG		M					
G8306	POAG w/ IOP rec care plan		M					
G8307	POAG w/ IOP no care plan		M					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
G8308	POAG w/ IOP not doc plan		M					
G8310	Pt not doc rec antiox		M					
G8314	Pt not doc to rec mac exam		M					
G8318	Pt doc not have visual func		M					
G8322	Pt not doc pre axial leng		M					
G8326	Pt not doc rec fundus exam		M					
G8330	Pt not doc rec dilated mac		M					
G8334	Doc of macular not giv MD		M					
G8338	Clin not doc pt test osteo		M					
G8341	Pt not doc for DEXA		M					
G8345	Pt not doc have DEXA		M					
G8351	Pt not doc ECG		M					
G8354	Pt not rec aspirin prior ER		M					
G8357	Pt not doc to have ECG		M					
G8360	Pt not doc vital signs recor		M					
G8362	Pt not doc 02 SAT assess		M					
G8365	Pt not doc mental status		M					
G8367	Pt not doc have empiric AB		M					
G8370	Asthma pt w survey not docum		M					
G8371	Chemother not rec stg3 colon		M					
G8372	Chemother rec stg 3 colon ca		M					
G8373	Chemo plan docum prior chemo		M					
G8374	Chemo plan not doc prior che		M					
G8375	CLL pt w/o doc flow cytometr		M					
G8376	Brst ca pt inelig tamoxifen		M					
G8377	MD doc colon ca pt inelig ch		M					
G8378	MD doc pt inelig rad therapy		M					
G8379	Radiat tx recom doc12mo ov		M					
G8380	Pt w stgIC-3Brst ca w/o tam		M					
G8381	Pt w stgIC-3Brst ca rec tam		M					
G8382	MM pt w/o doc IV bisphophon		M					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
G8383	Radiation rec not doc 12 mo		M					
G8384	MDS pt w/o base cytogen test		M					
G8385	Diab pt w nodoc Hgb A1c 12m		M					
G8386	Diab pt w nodoc LDL 12m		M					
G8387	ESRD pt w Hct/Hgb not docume		M					
G8388	ESRD pt w URR/Ktv not doc el		M					
G8389	MDS pt no doc Fe prior EPO		M					
G8390	Diabetic w/o document BP 12m		M					
G8391	Pt w asthma no doc med or tx		M					
G8395	LVEF>=40% doc normal or mild		M					
G8396	LVEF not performed		M					
G8397	Dil macula/fundus exam/w doc		M					
G8398	Dil macular/fundus not perfo		M					
G8399	Pt w/DXA document or order		M					
G8400	Pt w/DXA no document or orde		M					
G8401	Pt inelig osteo screen measu		M					
G8402	Smoke preven interven counse		M					
G8403	Smoke preven nocounsel		M					
G8404	Low extremity neur exam docum		M					
G8405	Low extemity neur not perfor		M					
G8406	Pt inelig lower extrem neuro		M					
G8407	ABI documented		M					
G8408	ABI not documented		M					
G8409	Pt inelig for ABI measure		M					
G8410	Eval on foot documented		M					
G8415	Eval on foot not performed		M					
G8416	Pt inelig footwear evaluatio		M					
G8417	BMI >=30 calcuate w/followup		M					
G8418	BMI < 22 calcuate w/followup		M					
G8419	BMI>=30or<22 cal no followup		M					
G8420	BMI<30 and >=22 calc & docu		M					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
G8421	BMI not calculated		M					
G8422	Pt inelig BMI calculation		M					
G8423	Pt screen flu vac & counsel		M					
G8424	Flu vaccine not screen		M					
G8425	Flu vaccine screen not curre		M					
G8426	Pt not approp screen & counc		M					
G8427	Doc meds verified w/pt or re		M					
G8428	Meds document w/o verifica		M					
G8429	Incomplete doc pt on meds		M					
G8430	Pt inelig med check		M					
G8431	Clin depression screen doc		M					
G8432	Clin depression screen not d		M					
G8433	Pt inelig for depression scr		M					
G8434	Cognitive impairment screen		M					
G8435	Cognitive screen not documen		M					
G8436	Pt inelig for cognitive impa		M					
G8437	Tx plan develop & document		M					
G8438	Tx plan develop & not docum		M					
G8439	Pt inelig for co-develp tx p		M					
G8440	Pain assessment document		M					
G8441	No document of pain assess		M					
G8442	Pt inelig pain assessment		M					
G8443	Prescription by E-Prescrib s		M					
G8445	Prescrip not gen at encounte		M					
G8446	Some prescrib handwritten or		M					
G8447	Pt visit doc using CCHIT cer		M					
G8448	Pt visit docum w/non-CCHIT c		M					
G8449	Pt not doc w/EMR due to syst		M					
G8450	Beta-bloc rx pt w/abn lvef		M					
G8451	Pt w/abn lvef inelig b-bloc		M					
G8452	Pt w/abn lvef b-bloc no rx		M					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
G8453	Tob use cess int counsel		M					
G8454	Tob use cess int no counsel		M					
G8455	Current tobacco smoker		M					
G8456	Smokeless tobacco user		M					
G8457	Tobacco non-user		M					
G8458	Pt inelig geno no antvir tx		M					
G8459	Doc pt rec antivir treat		M					
G8460	Pt inelig RNA no antvir tx		M					
G8461	Pt rec antivir treat hep c		M					
G8462	Pt inelig couns no antvir tx		M					
G8463	Pt rec antiviral treat doc		M					
G8464	Pt inelig; lo to no dter rsk		M					
G8465	High risk recurrence pro ca		M					
G8466	Pt inelig suic; MDD remis		M					
G8467	New dx init/rec episode MDD		M					
G8468	ACE/ARB rx pt w/abn lvef		M					
G8469	Pt w/abn lvef inelig ACE/ARB		M					
G8470	Pt w/ normal lvef		M					
G8471	LVEF not performed/doc		M					
G8472	ACE/ARB no rx pt w/abn lvef		M					
G8473	ACE/ARB thxpy rx'd		M					
G8474	ACE/ARB not rx'd; doc reas		M					
G8475	ACE/ARB thxpy not rx'd		M					
G8476	BP sys <130 and dias <80		M					
G8477	BP sys>=130 and/or dias >=80		M					
G8478	BP not performed/doc		M					
G8479	MD rx'd ACE/ARB thxpy		M					
G8480	Pt inelig ACE/ARB thxpy		M					
G8481	MD not rx'd ACE/ARB thxpy		M					
G8482	Flu immunize order/admin		M					
G8483	Flu imm no ord/admin doc rea		M					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
G8484	Flu immunize no order/admin		M					
G9001	MCCD, initial rate		B					
G9002	MCCD,maintenance rate		B					
G9003	MCCD, risk adj hi, initial		B					
G9004	MCCD, risk adj lo, initial		B					
G9005	MCCD, risk adj, maintenance		B					
G9006	MCCD, Home monitoring		B					
G9007	MCCD, sch team conf		B					
G9008	Mccd,phys coor-care ovrsght		B					
G9009	MCCD, risk adj, level 3		B					
G9010	MCCD, risk adj, level 4		B					
G9011	MCCD, risk adj, level 5		B					
G9012	Other Specified Case Mgmt		B					
G9013	ESRD demo bundle level I		E					
G9014	ESRD demo bundle-level II		E					
G9016	Demo-smoking cessation coun		E					
G9017	Amantadine HCL 100mg oral		A					
G9018	Zanamivir,inhalation pwd 10m		A					
G9019	Oseltamivir phosphate 75mg		A					
G9020	Rimantadine HCL 100mg oral		A					
G9033	Amantadine HCL oral brand		A					
G9034	Zanamivir, inh pwdr, brand		A					
G9035	Oseltamivir phosp, brand		A					
G9036	Rimantadine HCL, brand		A					
G9041	Low vision rehab occupationa		A					
G9042	Low vision rehab orient/mobi		A					
G9043	Low vision lowvision therapi		A					
G9044	Low vision rehabilate teache		A					
G9050	Oncology work-up evaluation		E					
G9051	Oncology tx decision-mgmt		E					
G9052	Onc surveillance for disease		E					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
G9053	Onc expectant management pt		E					
G9054	Onc supervision palliative		E					
G9055	Onc visit unspecified NOS		E					
G9056	Onc prac mgmt adheres guide		E					
G9057	Onc pract mgmt differs trial		E					
G9058	Onc prac mgmt disagree w/gui		E					
G9059	Onc prac mgmt pt opt alterna		E					
G9060	Onc prac mgmt dif pt comorb		E					
G9061	Onc prac cond noadd by guide		E					
G9062	Onc prac guide differs nos		E					
G9063	Onc dx nsclc stgI no progres		M					
G9064	Onc dx nsclc stg2 no progres		M					
G9065	Onc dx nsclc stg3A no progre		M					
G9066	Onc dx nsclc stg3B-4 metasta		M					
G9067	Onc dx nsclc dx unknown nos		M					
G9068	Onc dx sclc/nsclc limited		M					
G9069	Onc dx sclc/nsclc ext at dx		M					
G9070	Onc dx sclc/nsclc ext unknwn		M					
G9071	Onc dx brst stg1-2B HR,nopro		M					
G9072	Onc dx brst stg1-2 noprogres		M					
G9073	Onc dx brst stg3-HR, no pro		M					
G9074	Onc dx brst stg3-noprogress		M					
G9075	Onc dx brst metastic/ recur		M					
G9077	Onc dx prostate T1no progres		M					
G9078	Onc dx prostate T2no progres		M					
G9079	Onc dx prostate T3b-T4noprog		M					
G9080	Onc dx prostate w/rise PSA		M					
G9083	Onc dx prostate unknwn nos		M					
G9084	Onc dx colon t1-3,n1-2,no pr		M					
G9085	Onc dx colon T4, N0 w/o prog		M					
G9086	Onc dx colon T1-4 no dx prog		M					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
G9087	Onc dx colon metas evid dx		M					
G9088	Onc dx colon metas noevid dx		M					
G9089	Onc dx colon extent unknown		M					
G9090	Onc dx rectal T1-2 no progr		M					
G9091	Onc dx rectal T3 N0 no prog		M					
G9092	Onc dx rectal T1-3,N1-2noprg		M					
G9093	Onc dx rectal T4,N,M0 no prg		M					
G9094	Onc dx rectal M1 w/mets prog		M					
G9095	Onc dx rectal extent unknwn		M					
G9096	Onc dx esophag T1-T3 noprog		M					
G9097	Onc dx esophageal T4 no prog		M					
G9098	Onc dx esophageal mets recur		M					
G9099	Onc dx esophageal unknown		M					
G9100	Onc dx gastric no recurrence		M					
G9101	Onc dx gastric p R1-R2noprog		M					
G9102	Onc dx gastric unresectable		M					
G9103	Onc dx gastric recurrent		M					
G9104	Onc dx gastric unknown NOS		M					
G9105	Onc dx pancreatc p R0 res no		M					
G9106	Onc dx pancreatc p R1/R2 no		M					
G9107	Onc dx pancreatic unresectab		M					
G9108	Onc dx pancreatic unknwn NOS		M					
G9109	Onc dx head/neck T1-T2no prg		M					
G9110	Onc dx head/neck T3-4 noprog		M					
G9111	Onc dx head/neck M1 mets rec		M					
G9112	Onc dx head/neck ext unknown		M					
G9113	Onc dx ovarian stg1A-B no pr		M					
G9114	Onc dx ovarian stg1A-B or 2		M					
G9115	Onc dx ovarian stg3/4 noprog		M					
G9116	Onc dx ovarian recurrence		M					
G9117	Onc dx ovarian unknown NOS		M					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
G9123	Onc dx CML chronic phase		M					
G9124	Onc dx CML acceler phase		M					
G9125	Onc dx CML blast phase		M					
G9126	Onc dx CML remission		M					
G9128	Onc dx multi myeloma stage I		M					
G9129	Onc dx mult myeloma stg2 hig		M					
G9130	Onc dx multi myeloma unknown		M					
G9131	Onc dx brst unknown NOS		M					
G9132	Onc dx prostate mets no cast		M					
G9133	Onc dx prostate clinical met		M					
G9134	Onc NHLstg 1-2 no relap no		M					
G9135	Onc dx NHL stg 3-4 not relap		M					
G9136	Onc dx NHL trans to lg Bcell		M					
G9137	Onc dx NHL relapse/refractor		M					
G9138	Onc dx NHL stg unknown		M					
G9139	Onc dx CML dx status unknown		M					
G9140	Frontier extended stay demo		A					
J0120	Tetracyclin injection		N					
J0128	Abarelix injection		K	9216		$67.33		$13.47
J0129	Abatacept injection	CH	K	9230		$18.34		$3.67
J0130	Abciximab injection		K	1605		$415.06		$83.02
J0132	Acetylcysteine injection	CH	K	1186		$2.13		$0.43
J0133	Acyclovir injection		N					
J0135	Adalimumab injection		K	1083		$324.32		$64.87
J0150	Injection adenosine 6 MG		K	0379		$12.60		$2.52
J0152	Adenosine injection		K	0917		$66.89		$13.38
J0170	Adrenalin epinephrin inject		N					
J0180	Agalsidase beta injection		K	9208		$127.14		$25.43
J0190	Inj biperiden lactate/5 mg	CH	N					
J0200	Alatrofloxacin mesylate		N					
J0205	Alglucerase injection		K	0900		$38.92		$7.79

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
J0207	Amifostine		K	7000		$501.57		$100.32
J0210	Methyldopate hcl injection		K	2210		$14.91		$2.99
J0215	Alefacept		K	1633		$26.16		$5.24
J0220	Alglucosidase alfa injection		K	9234		$124.80		$24.96
J0256	Alpha 1 proteinase inhibitor		K	0901		$3.59		$0.72
J0270	Alprostadil for injection		B					
J0275	Alprostadil urethral suppos		B					
J0278	Amikacin sulfate injection		N					
J0280	Aminophyllin 250 MG inj		N					
J0282	Amiodarone HCl		N					
J0285	Amphotericin B		N					
J0287	Amphotericin b lipid complex		K	9024		$10.26		$2.06
J0288	Ampho b cholesteryl sulfate		K	0735		$11.77		$2.36
J0289	Amphotericin b liposome inj		K	0736		$16.84		$3.37
J0290	Ampicillin 500 MG inj		N					
J0295	Ampicillin sodium per 1.5 gm		N					
J0300	Amobarbital 125 MG inj		N					
J0330	Succinycholine chloride inj		N					
J0348	Anadulafungin injection	CH	K	0760		$1.50		$0.30
J0350	Injection anistreplase 30 u	CH	N					
J0360	Hydralazine hcl injection		N					
J0364	Apomorphine hydrochloride		N					
J0365	Aprotonin, 10,000 kiu		K	1682		$2.60		$0.52
J0380	Inj metaraminol bitartrate		N					
J0390	Chloroquine injection		N					
J0395	Arbutamine HCl injection		N					
J0400	Aripiprazole injection	CH	N					
J0456	Azithromycin		N					
J0460	Atropine sulfate injection		N					
J0470	Dimecaprol injection	CH	K	1206		$26.17		$5.24
J0475	Baclofen 10 MG injection		K	9032		$187.25		$37.45

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
J0476	Baclofen intrathecal trial		K	1631		$68.44		$13.69
J0480	Basiliximab		K	1683		$1,471.15		$294.23
J0500	Dicyclomine injection		N					
J0515	Inj benztropine mesylate		N					
J0520	Bethanechol chloride inject		N					
J0530	Penicillin g benzathine inj		N					
J0540	Penicillin g benzathine inj		N					
J0550	Penicillin g benzathine inj	CH	K	1217		$32.28		$6.46
J0560	Penicillin g benzathine inj		N					
J0570	Penicillin g benzathine inj		N					
J0580	Penicillin g benzathine inj		N					
J0583	Bivalirudin		K	3041		$2.04		$0.41
J0585	Botulinum toxin a per unit		K	0902		$5.12		$1.03
J0587	Botulinum toxin type B		K	9018		$8.55		$1.71
J0592	Buprenorphine hydrochloride		N					
J0594	Busulfan injection		K	1178		$9.53		$1.91
J0595	Butorphanol tartrate 1 mg		N					
J0600	Edetate calcium disodium inj		K	0999		$49.28		$9.86
J0610	Calcium gluconate injection		N					
J0620	Calcium glycer & lact/10 ML		N					
J0630	Calcitonin salmon injection		N					
J0636	Inj calcitriol per 0.1 mcg		N					
J0637	Caspofungin acetate		K	9019		$17.53		$3.51
J0640	Leucovorin calcium injection		N					
J0670	Inj mepivacaine HCL/10 ml		N					
J0690	Cefazolin sodium injection		N					
J0692	Cefepime HCl for injection		N					
J0694	Cefoxitin sodium injection		N					
J0696	Ceftriaxone sodium injection		N					
J0697	Sterile cefuroxime injection		N					
J0698	Cefotaxime sodium injection		N					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
J0702	Betamethasone acet&sod phosp		N					
J0704	Betamethasone sod phosp/4 MG		N					
J0706	Caffeine citrate injection		N					
J0710	Cephapirin sodium injection		N					
J0713	Inj ceftazidime per 500 mg		N					
J0715	Ceftizoxime sodium / 500 MG		N					
J0720	Chloramphenicol sodium injec		N					
J0725	Chorionic gonadotropin/1000u		N					
J0735	Clonidine hydrochloride		K	0935		$54.95		$10.99
J0740	Cidofovir injection		K	9033		$748.06		$149.62
J0743	Cilastatin sodium injection		N					
J0744	Ciprofloxacin iv		N					
J0745	Inj codeine phosphate /30 MG		N					
J0760	Colchicine injection		N					
J0770	Colistimethate sodium inj		N					
J0780	Prochlorperazine injection		N					
J0795	Corticorelin ovine triflutal		K	1684		$4.19		$0.84
J0800	Corticotropin injection		K	1280		$2,311.08		$462.22
J0835	Inj cosyntropin per 0.25 MG		K	0835		$64.36		$12.88
J0850	Cytomegalovirus imm IV /vial		K	0903		$862.24		$172.45
J0878	Daptomycin injection		K	9124		$0.34		$0.07
J0881	Darbepoetin alfa, non-esrd		K	1685		$2.72		$0.55
J0882	Darbepoetin alfa, esrd use		A					
J0885	Epoetin alfa, non-esrd		K	1686		$8.90		$1.78
J0886	Epoetin alfa 1000 units ESRD		A					
J0894	Decitabine injection	CH	K	9231		$26.60		$5.32
J0895	Deferoxamine mesylate inj		N					
J0900	Testosterone enanthate inj		N					
J0945	Brompheniramine maleate inj		N					
J0970	Estradiol valerate injection		N					
J1000	Depo-estradiol cypionate inj		N					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
J1020	Methylprednisolone 20 MG inj		N					
J1030	Methylprednisolone 40 MG inj		N					
J1040	Methylprednisolone 80 MG inj		N					
J1051	Medroxyprogesterone inj		N					
J1055	Medrxyprogester acetate inj		E					
J1056	MA/EC contraceptiveinjection		E					
J1060	Testosterone cypionate 1 ML		N					
J1070	Testosterone cypionat 100 MG		N					
J1080	Testosterone cypionat 200 MG		N					
J1094	Inj dexamethasone acetate		N					
J1100	Dexamethasone sodium phos		N					
J1110	Inj dihydroergotamine mesylt		N					
J1120	Acetazolamid sodium injectio		N					
J1160	Digoxin injection		N					
J1162	Digoxin immune fab (ovine)		K	1687		$479.14		$95.83
J1165	Phenytoin sodium injection		N					
J1170	Hydromorphone injection		N					
J1180	Dyphylline injection		N					
J1190	Dexrazoxane HCl injection		K	0726		$177.53		$35.51
J1200	Diphenhydramine hcl injectio		N					
J1205	Chlorothiazide sodium inj		K	0747		$162.00		$32.40
J1212	Dimethyl sulfoxide 50% 50 ML		N					
J1230	Methadone injection		N					
J1240	Dimenhydrinate injection		N					
J1245	Dipyridamole injection		N					
J1250	Inj dobutamine HCL/250 mg		N					
J1260	Dolasetron mesylate		K	0750		$4.11		$0.83
J1265	Dopamine injection		N					
J1270	Injection, doxercalciferol		N					
J1300	Eculizumab injection		G	9236		$173.06		$33.96
J1320	Amitriptyline injection		N					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
J1324	Enfuvirtide injection	CH	N					
J1325	Epoprostenol injection		N					
J1327	Eptifibatide injection		K	1607		$16.70		$3.34
J1330	Ergonovine maleate injection		N					
J1335	Ertapenem injection		N					
J1364	Erythro lactobionate /500 MG		N					
J1380	Estradiol valerate 10 MG inj		N					
J1390	Estradiol valerate 20 MG inj		N					
J1410	Inj estrogen conjugate 25 MG		K	9038		$69.91		$13.99
J1430	Ethanolamine oleate 100 mg		K	1688		$118.22		$23.65
J1435	Injection estrone per 1 MG		N					
J1436	Etidronate disodium inj		K	1436		$70.06		$14.02
J1438	Etanercept injection		K	1608		$163.89		$32.78
J1440	Filgrastim 300 mcg injection		K	0728		$195.48		$39.10
J1441	Filgrastim 480 mcg injection		K	7049		$300.85		$60.17
J1450	Fluconazole		N					
J1451	Fomepizole, 15 mg		K	1689		$13.85		$2.77
J1452	Intraocular Fomivirsen na		N					
J1455	Foscarnet sodium injection	CH	K	1189		$10.19		$2.04
J1457	Gallium nitrate injection		K	0878		$1.59		$0.32
J1458	Galsulfase injection		K	9224		$314.00		$62.80
J1460	Gamma globulin 1 CC inj		K	3043		$11.34		$2.27
J1470	Gamma globulin 2 CC inj		K	0898		$22.67		$4.54
J1480	Gamma globulin 3 CC inj		K	0899		$34.00		$6.80
J1490	Gamma globulin 4 CC inj		K	0904		$45.34		$9.07
J1500	Gamma globulin 5 CC inj		K	0919		$56.68		$11.34
J1510	Gamma globulin 6 CC inj		K	0920		$68.02		$13.61
J1520	Gamma globulin 7 CC inj		K	0921		$79.31		$15.87
J1530	Gamma globulin 8 CC inj		K	0922		$90.68		$18.14
J1540	Gamma globulin 9 CC inj		K	0923		$102.05		$20.41
J1550	Gamma globulin 10 CC inj		K	0924		$113.35		$22.67

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
J1560	Gamma globulin > 10 CC inj		K	0933		$113.35		$22.67
J1561	Gamunex injection		K	0948		$32.82		$6.57
J1562	Vivaglobin, inj		K	0804		$6.94		$1.39
J1565	RSV-ivig		K	0906		$15.87		$3.18
J1566	Immune globulin, powder		K	2731		$27.54		$5.51
J1568	Octagam injection		K	0943		$33.43		$6.69
J1569	Gammagard liquid injection		K	0944		$31.19		$6.24
J1570	Ganciclovir sodium injection		N					
J1571	HepaGam B IM injection		K	0946		$47.43		$9.49
J1572	Flebogamma injection		K	0947		$31.92		$6.39
J1573	Hepagam B intravenous, inj		K	1138		$47.43		$9.49
J1580	Garamycin gentamicin inj		N					
J1590	Gatifloxacin injection		N					
J1595	Injection glatiramer acetate		K	1015		$54.24		$10.85
J1600	Gold sodium thiomaleate inj		N					
J1610	Glucagon hydrochloride/1 MG		K	9042		$67.37		$13.48
J1620	Gonadorelin hydroch/ 100 mcg		K	7005		$176.89		$35.38
J1626	Granisetron HCl injection		K	0764		$4.86		$0.98
J1630	Haloperidol injection		N					
J1631	Haloperidol decanoate inj		N					
J1640	Hemin, 1 mg		K	1690		$7.23		$1.45
J1642	Inj heparin sodium per 10 u		N					
J1644	Inj heparin sodium per 1000u		N					
J1645	Dalteparin sodium		N					
J1650	Inj enoxaparin sodium		N					
J1652	Fondaparinux sodium		K	0883		$5.61		$1.13
J1655	Tinzaparin sodium injection		N					
J1670	Tetanus immune globulin inj		K	1670		$97.86		$19.58
J1675	Histrelin acetate		B					
J1700	Hydrocortisone acetate inj		N					
J1710	Hydrocortisone sodium ph inj		N					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
J1720	Hydrocortisone sodium succ i		N					
J1730	Diazoxide injection		K	1740		$112.16		$22.44
J1740	Ibandronate sodium injection	CH	K	9229		$136.35		$27.27
J1742	Ibutilide fumarate injection		K	9044		$317.20		$63.44
J1743	Idursulfase injection	CH	K	9232		$446.44		$89.29
J1745	Infliximab injection		K	7043		$54.00		$10.80
J1751	Iron dextran 165 injection		E					
J1752	Iron dextran 267 injection		E					
J1756	Iron sucrose injection		K	9046		$0.35		$0.07
J1785	Injection imiglucerase /unit		K	0916		$3.93		$0.79
J1790	Droperidol injection		N					
J1800	Propranolol injection		N					
J1810	Droperidol/fentanyl inj		E					
J1815	Insulin injection		N					
J1817	Insulin for insulin pump use		N					
J1825	Interferon beta-1a		E					
J1830	Interferon beta-1b / .25 MG		K	0910		$114.42		$22.89
J1835	Itraconazole injection		K	9047		$39.15		$7.83
J1840	Kanamycin sulfate 500 MG inj		N					
J1850	Kanamycin sulfate 75 MG inj		N					
J1885	Ketorolac tromethamine inj		N					
J1890	Cephalothin sodium injection		N					
J1931	Laronidase injection		K	9209		$23.89		$4.78
J1940	Furosemide injection		N					
J1945	Lepirudin		K	1693		$157.97		$31.60
J1950	Leuprolide acetate /3.75 MG		K	0800		$433.32		$86.67
J1955	Inj levocarnitine per 1 gm		B					
J1956	Levofloxacin injection		N					
J1960	Levorphanol tartrate inj		N					
J1980	Hyoscyamine sulfate inj		N					
J1990	Chlordiazepoxide injection		N					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
J2001	Lidocaine injection		N					
J2010	Lincomycin injection		N					
J2020	Linezolid injection		K	9001		$27.56		$5.52
J2060	Lorazepam injection		N					
J2150	Mannitol injection		N					
J2170	Mecasermin injection	CH	N					
J2175	Meperidine hydrochl /100 MG		N					
J2180	Meperidine/promethazine inj		N					
J2185	Meropenem		N					
J2210	Methylergonovin maleate inj		N					
J2248	Micafungin sodium injection	CH	K	9227		$1.32		$0.27
J2250	Inj midazolam hydrochloride		N					
J2260	Inj milrinone lactate / 5 MG		N					
J2270	Morphine sulfate injection		N					
J2271	Morphine so4 injection 100mg		N					
J2275	Morphine sulfate injection		N					
J2278	Ziconotide injection		K	1694		$6.39		$1.28
J2280	Inj, moxifloxacin 100 mg		N					
J2300	Inj nalbuphine hydrochloride		N					
J2310	Inj naloxone hydrochloride		N					
J2315	Naltrexone, depot form		K	0759		$1.85		$0.37
J2320	Nandrolone decanoate 50 MG		N					
J2321	Nandrolone decanoate 100 MG		N					
J2322	Nandrolone decanoate 200 MG		N					
J2323	Natalizumab injection	CH	K	9126		$7.39		$1.48
J2325	Nesiritide injection		K	1695		$32.86		$6.58
J2353	Octreotide injection, depot		K	1207		$99.84		$19.97
J2354	Octreotide inj, non-depot		N					
J2355	Oprelvekin injection		K	7011		$242.32		$48.47
J2357	Omalizumab injection		K	9300		$17.48		$3.50
J2360	Orphenadrine injection		N					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
J2370	Phenylephrine hcl injection		N					
J2400	Chloroprocaine hcl injection		N					
J2405	Ondansetron hcl injection		K	0768		$0.22		$0.05
J2410	Oxymorphone hcl injection		N					
J2425	Palifermin injection		K	1696		$11.15		$2.23
J2430	Pamidronate disodium /30 MG		K	0730		$27.79		$5.56
J2440	Papaverin hcl injection		N					
J2460	Oxytetracycline injection	CH	K	1211	2.5729	$169.00		$33.80
J2469	Palonosetron HCl		K	9210		$16.89		$3.38
J2501	Paricalcitol		N					
J2503	Pegaptanib sodium injection		K	1697		$1,011.57		$202.32
J2504	Pegademase bovine, 25 iu		K	1739		$195.62		$39.13
J2505	Injection, pegfilgrastim 6mg		K	9119		$2,158.59		$431.72
J2510	Penicillin g procaine inj		N					
J2513	Pentastarch 10% solution	CH	N					
J2515	Pentobarbital sodium inj		N					
J2540	Penicillin g potassium inj		N					
J2543	Piperacillin/tazobactam		N					
J2545	Pentamidine non-comp unit		B					
J2550	Promethazine hcl injection		N					
J2560	Phenobarbital sodium inj		N					
J2590	Oxytocin injection		N					
J2597	Inj desmopressin acetate		N					
J2650	Prednisolone acetate inj		N					
J2670	Totazoline hcl injection		N					
J2675	Inj progesterone per 50 MG		N					
J2680	Fluphenazine decanoate 25 MG		N					
J2690	Procainamide hcl injection		N					
J2700	Oxacillin sodium injeciton		N					
J2710	Neostigmine methylslfte inj		N					
J2720	Inj protamine sulfate/10 MG		N					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
J2724	Protein C concentrate		K	1139		$11.96		$2.40
J2725	Inj protirelin per 250 mcg		N					
J2730	Pralidoxime chloride inj		K	1023		$86.41		$17.29
J2760	Phentolaine mesylate inj		N					
J2765	Metoclopramide hcl injection		N					
J2770	Quinupristin/dalfopristin		K	2770		$125.56		$25.12
J2778	Ranibizumab injection	CH	K	9233		$397.53		$79.51
J2780	Ranitidine hydrochloride inj		N					
J2783	Rasburicase		K	0738		$147.46		$29.50
J2788	Rho d immune globulin 50 mcg		K	9023		$27.89		$5.58
J2790	Rho d immune globulin inj		K	0884		$88.01		$17.61
J2791	Rhophylac injection		K	0945		$5.22		$1.05
J2792	Rho(D) immune globulin h, sd		K	1609		$15.32		$3.07
J2794	Risperidone, long acting		K	9125		$4.84		$0.97
J2795	Ropivacaine HCl injection		N					
J2800	Methocarbamol injection		N					
J2805	Sincalide injection		N					
J2810	Inj theophylline per 40 MG		N					
J2820	Sargramostim injection		K	0731		$24.63		$4.93
J2850	Inj secretin synthetic human		K	1700		$19.93		$3.99
J2910	Aurothioglucose injeciton		N					
J2916	Na ferric gluconate complex		N					
J2920	Methylprednisolone injection		N					
J2930	Methylprednisolone injection		N					
J2940	Somatrem injection	CH	N					
J2941	Somatropin injection		K	7034		$47.18		$9.44
J2950	Promazine hcl injection		N					
J2993	Reteplase injection		K	9005		$818.01		$163.61
J2995	Inj streptokinase /250000 IU	CH	N					
J2997	Alteplase recombinant		K	7048		$31.57		$6.32
J3000	Streptomycin injection		N					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
J3010	Fentanyl citrate injeciton		N					
J3030	Sumatriptan succinate / 6 MG		K	3030		$65.35		$13.07
J3070	Pentazocine injection		N					
J3100	Tenecteplase injection		K	9002		$2,007.72		$401.55
J3105	Terbutaline sulfate inj		N					
J3110	Teriparatide injection		B					
J3120	Testosterone enanthate inj		N					
J3130	Testosterone enanthate inj		N					
J3140	Testosterone suspension inj		N					
J3150	Testosteron propionate inj		N					
J3230	Chlorpromazine hcl injection		N					
J3240	Thyrotropin injection		K	9108		$823.13		$164.63
J3243	Tigecycline injection	CH	K	9228		$1.00		$0.20
J3246	Tirofiban HCl		K	7041		$7.28		$1.46
J3250	Trimethobenzamide hcl inj		N					
J3260	Tobramycin sulfate injection		N					
J3265	Injection torsemide 10 mg/ml		N					
J3280	Thiethylperazine maleate inj		N					
J3285	Treprostinil injection		K	1701		$54.83		$10.97
J3301	Triamcinolone acetonide inj		N					
J3302	Triamcinolone diacetate inj		N					
J3303	Triamcinolone hexacetonl inj		N					
J3305	Inj trimetrexate glucoronate		K	7045		$146.89		$29.38
J3310	Perphenazine injeciton		N					
J3315	Triptorelin pamoate		K	9122		$146.35		$29.27
J3320	Spectinomycn di-hcl inj		N					
J3350	Urea injection	CH	N					
J3355	Urofollitropin, 75 iu		K	1741		$48.25		$9.65
J3360	Diazepam injection		N					
J3364	Urokinase 5000 IU injection		N					
J3365	Urokinase 250,000 IU inj		K	7036		$449.09		$89.82

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
J3370	Vancomycin hcl injection		N					
J3396	Verteporfin injection		K	1203		$8.98		$1.80
J3400	Triflupromazine hcl inj	CH	K	1218	0.3066	$20.14		$4.03
J3410	Hydroxyzine hcl injection		N					
J3411	Thiamine hcl 100 mg		N					
J3415	Pyridoxine hcl 100 mg		N					
J3420	Vitamin b12 injection		N					
J3430	Vitamin k phytonadione inj		N					
J3465	Injection, voriconazole		K	1052		$5.14		$1.03
J3470	Hyaluronidase injection		N					
J3471	Ovine, up to 999 USP units		N					
J3472	Ovine, 1000 USP units		K	1703		$132.50		$26.50
J3473	Hyaluronidase recombinant	CH	N					
J3475	Inj magnesium sulfate		N					
J3480	Inj potassium chloride		N					
J3485	Zidovudine		N					
J3486	Ziprasidone mesylate		N					
J3487	Zoledronic acid		K	9115		$206.68		$41.34
J3488	Reclast injection		G	0951		$216.61		$42.50
J3490	Drugs unclassified injection		N					
J3520	Edetate disodium per 150 mg		E					
J3530	Nasal vaccine inhalation		N					
J3535	Metered dose inhaler drug		E					
J3570	Laetrile amygdalin vit B17		E					
J3590	Unclassified biologics		N					
J7030	Normal saline solution infus		N					
J7040	Normal saline solution infus		N					
J7042	5% dextrose/normal saline		N					
J7050	Normal saline solution infus		N					
J7060	5% dextrose/water		N					
J7070	D5w infusion		N					

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J7100	Dextran 40 infusion		N					
J7110	Dextran 75 infusion		N					
J7120	Ringers lactate infusion		N					
J7130	Hypertonic saline solution		N					
J7187	Humate-P, inj		K	1704		$0.88		$0.18
J7189	Factor viia		K	1705		$1.17		$0.24
J7190	Factor viii		K	0925		$0.74		$0.15
J7191	Factor VIII (porcine)	CH	K	1208	0.0178	$1.17		$0.24
J7192	Factor viii recombinant		K	0927		$1.06		$0.22
J7193	Factor IX non-recombinant		K	0931		$0.88		$0.18
J7194	Factor ix complex		K	0928		$0.79		$0.16
J7195	Factor IX recombinant		K	0932		$1.05		$0.21
J7197	Antithrombin iii injection	CH	N					
J7198	Anti-inhibitor		K	0929		$1.41		$0.29
J7199	Hemophilia clot factor noc		B					
J7300	Intraut copper contraceptive		E					
J7302	Levonorgestrel iu contracept		E					
J7303	Contraceptive vaginal ring		E					
J7304	Contraceptive hormone patch		E					
J7306	Levonorgestrel implant sys		E					
J7307	Etonogestrel implant system		E					
J7308	Aminolevulinic acid hcl top		K	7308		$107.67		$21.54
J7310	Ganciclovir long act implant		K	0913		$4,680.00		$936.00
J7311	Fluocinolone acetonide implt		K	9225		$18,980.00		$3,796.00
J7321	Hyalgan/supartz inj per dose		K	0873		$99.33		$19.87
J7322	Synvisc inj per dose		K	0874		$176.66		$35.34
J7323	Euflexxa inj per dose		K	0875		$107.97		$21.60
J7324	Orthovisc inj per dose		K	0877		$174.32		$34.87
J7330	Cultured chondrocytes implnt		B					
J7340	Metabolic active D/E tissue		K	1632		$29.60		$5.92
J7341	Non-human, metabolic tissue		N					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
J7342	Metabolically active tissue		K	9054		$36.02		$7.21
J7343	Nonmetabolic act d/e tissue		K	1629		$10.61		$2.13
J7344	Nonmetabolic active tissue		K	9156		$84.67		$16.94
J7346	Injectable human tissue		K	9222		$764.93		$152.99
J7347	Integra matrix tissue		K	1140		$18.94		$3.79
J7348	Tissuemend tissue	CH	N					
J7349	Primatrix tissue	CH	K	1141		$37.74		$7.55
J7500	Azathioprine oral 50mg		N					
J7501	Azathioprine parenteral		K	0887		$49.10		$9.82
J7502	Cyclosporine oral 100 mg		K	0888		$3.59		$0.72
J7504	Lymphocyte immune globulin		K	0890		$376.55		$75.31
J7505	Monoclonal antibodies		K	7038		$968.26		$193.66
J7506	Prednisone oral		N					
J7507	Tacrolimus oral per 1 MG		K	0891		$3.84		$0.77
J7509	Methylprednisolone oral		N					
J7510	Prednisolone oral per 5 mg		N					
J7511	Antithymocyte globuln rabbit		K	9104		$338.22		$67.65
J7513	Daclizumab, parenteral		K	1612		$309.72		$61.95
J7515	Cyclosporine oral 25 mg		N					
J7516	Cyclosporin parenteral 250mg	CH	K	1204		$19.44		$3.89
J7517	Mycophenolate mofetil oral		K	9015		$2.85		$0.57
J7518	Mycophenolic acid		K	9219		$2.41		$0.49
J7520	Sirolimus, oral		K	9020		$7.78		$1.56
J7525	Tacrolimus injection		K	9006		$137.38		$27.48
J7599	Immunosuppressive drug noc		N					
J7602	Albuterol inh non-comp con		E					
J7603	Albuterol inh non-comp u d		E					
J7604	Acetylcysteine comp unit		M					
J7605	Arformoterol non-comp unit		M					
J7607	Levalbuterol comp con		M					
J7608	Acetylcysteine non-comp unit		M					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
J7609	Albuterol comp unit		M					
J7610	Albuterol comp con		M					
J7611	Albuterol non-comp con		M					
J7612	Levalbuterol non-comp con		M					
J7613	Albuterol non-comp unit		M					
J7614	Levalbuterol non-comp unit		M					
J7615	Levalbuterol comp unit		M					
J7620	Albuterol ipratrop non-comp		M					
J7622	Beclomethasone comp unit		M					
J7624	Betamethasone comp unit		M					
J7626	Budesonide non-comp unit		M					
J7627	Budesonide comp unit		M					
J7628	Bitolterol mesylate comp con		M					
J7629	Bitolterol mesylate comp unt		M					
J7631	Cromolyn sodium noncomp unit		M					
J7632	Cromolyn sodium comp unit		M					
J7633	Budesonide non-comp con		M					
J7634	Budesonide comp con		M					
J7635	Atropine comp con		M					
J7636	Atropine comp unit		M					
J7637	Dexamethasone comp con		M					
J7638	Dexamethasone comp unit		M					
J7639	Dornase alpha non-comp unit		M					
J7640	Formoterol comp unit		E					
J7641	Flunisolide comp unit		M					
J7642	Glycopyrrolate comp con		M					
J7643	Glycopyrrolate comp unit		M					
J7644	Ipratropium bromide non-comp		M					
J7645	Ipratropium bromide comp		M					
J7647	Isoetharine comp con		M					
J7648	Isoetharine non-comp con		M					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
J7649	Isoetharine non-comp unit		M					
J7650	Isoetharine comp unit		M					
J7657	Isoproterenol comp con		M					
J7658	Isoproterenol non-comp con		M					
J7659	Isoproterenol non-comp unit		M					
J7660	Isoproterenol comp unit		M					
J7667	Metaproterenol comp con		M					
J7668	Metaproterenol non-comp con		M					
J7669	Metaproterenol non-comp unit		M					
J7670	Metaproterenol comp unit		M					
J7674	Methacholine chloride, neb		N					
J7676	Pentamidine comp unit dose		M					
J7680	Terbutaline sulf comp con		M					
J7681	Terbutaline sulf comp unit		M					
J7682	Tobramycin non-comp unit		M					
J7683	Triamcinolone comp con		M					
J7684	Triamcinolone comp unit		M					
J7685	Tobramycin comp unit		M					
J7699	Inhalation solution for DME		M					
J7799	Non-inhalation drug for DME		N					
J8498	Antiemetic rectal/supp NOS		B					
J8499	Oral prescrip drug non chemo		E					
J8501	Oral aprepitant		K	0868		$5.17		$1.04
J8510	Oral busulfan		K	7015		$2.45		$0.49
J8515	Cabergoline, oral 0.25mg		E					
J8520	Capecitabine, oral, 150 mg		K	7042		$4.52		$0.91
J8521	Capecitabine, oral, 500 mg		K	0934		$15.00		$3.00
J8530	Cyclophosphamide oral 25 MG		N					
J8540	Oral dexamethasone		N					
J8560	Etoposide oral 50 MG		K	0802		$28.99		$5.80
J8565	Gefitinib oral		E					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
J8597	Antiemetic drug oral NOS		N					
J8600	Melphalan oral 2 MG	CH	N					
J8610	Methotrexate oral 2.5 MG		N					
J8650	Nabilone oral	CH	N					
J8700	Temozolomide		K	1086		$7.52		$1.51
J8999	Oral prescription drug chemo		B					
J9000	Doxorubic hcl 10 MG vl chemo		N					
J9001	Doxorubicin hcl liposome inj		K	7046		$405.69		$81.14
J9010	Alemtuzumab injection		K	9110		$540.67		$108.14
J9015	Aldesleukin/single use vial		K	0807		$752.92		$150.59
J9017	Arsenic trioxide		K	9012		$33.83		$6.77
J9020	Asparaginase injection		K	0814		$55.94		$11.19
J9025	Azacitidine injection		K	1709		$4.39		$0.88
J9027	Clofarabine injection		K	1710		$113.00		$22.60
J9031	Bcg live intravesical vac		K	0809		$111.60		$22.32
J9035	Bevacizumab injection		K	9214		$56.35		$11.27
J9040	Bleomycin sulfate injection	CH	N					
J9041	Bortezomib injection		K	9207		$33.78		$6.76
J9045	Carboplatin injection	CH	N					
J9050	Carmus bischl nitro inj		K	0812		$153.87		$30.78
J9055	Cetuximab injection		K	9215		$48.87		$9.78
J9060	Cisplatin 10 MG injection		N					
J9062	Cisplatin 50 MG injection		N					
J9065	Inj cladribine per 1 MG		K	0858		$30.05		$6.01
J9070	Cyclophosphamide 100 MG inj		N					
J9080	Cyclophosphamide 200 MG inj		N					
J9090	Cyclophosphamide 500 MG inj		N					
J9091	Cyclophosphamide 1.0 grm inj		N					
J9092	Cyclophosphamide 2.0 grm inj		N					
J9093	Cyclophosphamide lyophilized		N					
J9094	Cyclophosphamide lyophilized		N					

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J9095	Cyclophosphamide lyophilized		N					
J9096	Cyclophosphamide lyophilized		N					
J9097	Cyclophosphamide lyophilized		N					
J9098	Cytarabine liposome		K	1166		$407.12		$81.43
J9100	Cytarabine hcl 100 MG inj		N					
J9110	Cytarabine hcl 500 MG inj		N					
J9120	Dactinomycin actinomycin d		K	0752		$484.12		$96.83
J9130	Dacarbazine 100 mg inj		N					
J9140	Dacarbazine 200 MG inj		N					
J9150	Daunorubicin		K	0820		$16.82		$3.37
J9151	Daunorubicin citrate liposom		K	0821		$55.01		$11.01
J9160	Denileukin diftitox, 300 mcg		K	1084		$1,383.43		$276.69
J9165	Diethylstilbestrol injection	CH	K	1209	1.2964	$85.15		$17.03
J9170	Docetaxel		K	0823		$319.70		$63.94
J9175	Elliotts b solution per ml		N					
J9178	Inj, epirubicin hcl, 2 mg		K	1167		$6.12		$1.23
J9181	Etoposide 10 MG inj		N					
J9182	Etoposide 100 MG inj		N					
J9185	Fludarabine phosphate inj		K	0842		$196.97		$39.40
J9190	Fluorouracil injection		N					
J9200	Floxuridine injection		K	0827		$50.16		$10.04
J9201	Gemcitabine HCl		K	0828		$129.29		$25.86
J9202	Goserelin acetate implant		K	0810		$186.15		$37.23
J9206	Irinotecan injection		K	0830		$123.85		$24.77
J9208	Ifosfomide injection		K	0831		$37.21		$7.45
J9209	Mesna injection		K	0732		$7.72		$1.55
J9211	Idarubicin hcl injection		K	0832		$270.86		$54.18
J9212	Interferon alfacon-1	CH	N					
J9213	Interferon alfa-2a inj		K	0834		$40.15		$8.03
J9214	Interferon alfa-2b inj		K	0836		$13.89		$2.78
J9215	Interferon alfa-n3 inj		K	0865		$8.95		$1.79

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J9216	Interferon gamma 1-b inj		K	0838		$303.74		$60.75
J9217	Leuprolide acetate suspnsion		K	9217		$216.69		$43.34
J9218	Leuprolide acetate injeciton		K	0861		$7.32		$1.47
J9219	Leuprolide acetate implant		K	7051		$1,577.83		$315.57
J9225	Vantas implant		K	1711		$1,479.64		$295.93
J9226	Supprelin LA implant		G	1142		$14,379.26		$2,821.59
J9230	Mechlorethamine hcl inj		K	0751		$141.72		$28.35
J9245	Inj melphalan hydrochl 50 MG		K	0840		$1,534.12		$306.83
J9250	Methotrexate sodium inj		N					
J9260	Methotrexate sodium inj		N					
J9261	Nelarabine injection		G	0825		$89.95		$17.66
J9263	Oxaliplatin		K	1738		$9.31		$1.87
J9264	Paclitaxel protein bound		K	1712		$8.69		$1.74
J9265	Paclitaxel injection		K	0863		$11.72		$2.35
J9266	Pegaspargase/singl dose vial		K	0843		$2,054.11		$410.83
J9268	Pentostatin injection		K	0844		$1,794.41		$358.89
J9270	Plicamycin (mithramycin) inj	CH	N					
J9280	Mitomycin 5 MG inj	CH	N					
J9290	Mitomycin 20 MG inj	CH	N					
J9291	Mitomycin 40 MG inj	CH	N					
J9293	Mitoxantrone hydrochl / 5 MG		K	0864		$87.02		$17.41
J9300	Gemtuzumab ozogamicin		K	9004		$2,383.14		$476.63
J9303	Panitumumab injection		K	9235		$80.70		$16.14
J9305	Pemetrexed injection		K	9213		$45.33		$9.07
J9310	Rituximab cancer treatment		K	0849		$510.74		$102.15
J9320	Streptozocin injection		K	0850		$187.04		$37.41
J9340	Thiotepa injection		K	0851		$39.63		$7.93
J9350	Topotecan		K	0852		$881.59		$176.32
J9355	Trastuzumab		K	1613		$58.95		$11.79
J9357	Valrubicin, 200 mg	CH	N					
J9360	Vinblastine sulfate inj		N					

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J9370	Vincristine sulfate 1 MG inj		N					
J9375	Vincristine sulfate 2 MG inj		N					
J9380	Vincristine sulfate 5 MG inj		N					
J9390	Vinorelbine tartrate/10 mg		K	0855		$15.91		$3.19
J9395	Injection, Fulvestrant		K	9120		$79.83		$15.97
J9600	Porfimer sodium		K	0856		$2,456.31		$491.27
J9999	Chemotherapy drug		N					
K0001	Standard wheelchair		Y					
K0002	Stnd hemi (low seat) whlchr		Y					
K0003	Lightweight wheelchair		Y					
K0004	High strength ltwt whlchr		Y					
K0005	Ultralightweight wheelchair		Y					
K0006	Heavy duty wheelchair		Y					
K0007	Extra heavy duty wheelchair		Y					
K0009	Other manual wheelchair/base		Y					
K0010	Stnd wt frame power whlchr		Y					
K0011	Stnd wt pwr whlchr w control		Y					
K0012	Ltwt portbl power whlchr		Y					
K0014	Other power whlchr base		Y					
K0015	Detach non-adjus hght armrst		Y					
K0017	Detach adjust armrest base		Y					
K0018	Detach adjust armrst upper		Y					
K0019	Arm pad each		Y					
K0020	Fixed adjust armrest pair		Y					
K0037	High mount flip-up footrest		Y					
K0038	Leg strap each		Y					
K0039	Leg strap h style each		Y					
K0040	Adjustable angle footplate		Y					
K0041	Large size footplate each		Y					
K0042	Standard size footplate each		Y					
K0043	Ftrst lower extension tube		Y					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
K0044	Ftrst upper hanger bracket		Y					
K0045	Footrest complete assembly		Y					
K0046	Elevat legrst low extension		Y					
K0047	Elevat legrst up hangr brack		Y					
K0050	Ratchet assembly		Y					
K0051	Cam relese assem ftrst/lgrst		Y					
K0052	Swingaway detach footrest		Y					
K0053	Elevate footrest articulate		Y					
K0056	Seat ht <17 or >=21 ltwt wc		Y					
K0065	Spoke protectors		Y					
K0069	Rear whl complete solid tire		Y					
K0070	Rear whl compl pneum tire		Y					
K0071	Front castr compl pneum tire		Y					
K0072	Frnt cstr cmpl sem-pneum tir		Y					
K0073	Caster pin lock each		Y					
K0077	Front caster assem complete		Y					
K0098	Drive belt power wheelchair		Y					
K0105	Iv hanger		Y					
K0108	W/c component-accessory NOS		Y					
K0195	Elevating whlchair leg rests		Y					
K0455	Pump uninterrupted infusion		Y					
K0462	Temporary replacement eqpmnt		Y					
K0552	Supply/ext inf pump syr type		Y					
K0601	Repl batt silver oxide 1.5 v		Y					
K0602	Repl batt silver oxide 3 v		Y					
K0603	Repl batt alkaline 1.5 v		Y					
K0604	Repl batt lithium 3.6 v		Y					
K0605	Repl batt lithium 4.5 v		Y					
K0606	AED garment w elec analysis		Y					
K0607	Repl batt for AED		Y					
K0608	Repl garment for AED		Y					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
K0609	Repl electrode for AED		Y					
K0669	Seat/back cus no sadmerc ver		Y					
K0672	Remove soft interface, repl		A					
K0730	Ctrl dose inh drug deliv sys		Y					
K0733	12-24hr sealed lead acid		Y					
K0734	Adj skin pro w/c cus wd<22in		Y					
K0735	Adj skin pro wc cus wd>=22in		Y					
K0736	Adj skin pro/pos wc cus<22in		Y					
K0737	Adj skin pro/pos wc cus>=22ö		Y					
K0738	Portable gas oxygen system		Y					
K0800	POV group 1 std up to 300lbs		Y					
K0801	POV group 1 hd 301-450 lbs		Y					
K0802	POV group 1 vhd 451-600 lbs		Y					
K0806	POV group 2 std up to 300lbs		Y					
K0807	POV group 2 hd 301-450 lbs		Y					
K0808	POV group 2 vhd 451-600 lbs		Y					
K0812	Power operated vehicle NOC		Y					
K0813	PWC gp 1 std port seat/back		Y					
K0814	PWC gp 1 std port cap chair		Y					
K0815	PWC gp 1 std seat/back		Y					
K0816	PWC gp 1 std cap chair		Y					
K0820	PWC gp 2 std port seat/back		Y					
K0821	PWC gp 2 std port cap chair		Y					
K0822	PWC gp 2 std seat/back		Y					
K0823	PWC gp 2 std cap chair		Y					
K0824	PWC gp 2 hd seat/back		Y					
K0825	PWC gp 2 hd cap chair		Y					
K0826	PWC gp 2 vhd seat/back		Y					
K0827	PWC gp vhd cap chair		Y					
K0828	PWC gp 2 xtra hd seat/back		Y					
K0829	PWC gp 2 xtra hd cap chair		Y					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
K0830	PWC gp2 std seat elevate s/b		Y					
K0831	PWC gp2 std seat elevate cap		Y					
K0835	PWC gp2 std sing pow opt s/b		Y					
K0836	PWC gp2 std sing pow opt cap		Y					
K0837	PWC gp 2 hd sing pow opt s/b		Y					
K0838	PWC gp 2 hd sing pow opt cap		Y					
K0839	PWC gp2 vhd sing pow opt s/b		Y					
K0840	PWC gp2 xhd sing pow opt s/b		Y					
K0841	PWC gp2 std mult pow opt s/b		Y					
K0842	PWC gp2 std mult pow opt cap		Y					
K0843	PWC gp2 hd mult pow opt s/b		Y					
K0848	PWC gp 3 std seat/back		Y					
K0849	PWC gp 3 std cap chair		Y					
K0850	PWC gp 3 hd seat/back		Y					
K0851	PWC gp 3 hd cap chair		Y					
K0852	PWC gp 3 vhd seat/back		Y					
K0853	PWC gp 3 vhd cap chair		Y					
K0854	PWC gp 3 xhd seat/back		Y					
K0855	PWC gp 3 xhd cap chair		Y					
K0856	PWC gp3 std sing pow opt s/b		Y					
K0857	PWC gp3 std sing pow opt cap		Y					
K0858	PWC gp3 hd sing pow opt s/b		Y					
K0859	PWC gp3 hd sing pow opt cap		Y					
K0860	PWC gp3 vhd sing pow opt s/b		Y					
K0861	PWC gp3 std mult pow opt s/b		Y					
K0862	PWC gp3 hd mult pow opt s/b		Y					
K0863	PWC gp3 vhd mult pow opt s/b		Y					
K0864	PWC gp3 xhd mult pow opt s/b		Y					
K0868	PWC gp 4 std seat/back		Y					
K0869	PWC gp 4 std cap chair		Y					
K0870	PWC gp 4 hd seat/back		Y					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
K0871	PWC gp 4 vhd seat/back		Y					
K0877	PWC gp4 std sing pow opt s/b		Y					
K0878	PWC gp4 std sing pow opt cap		Y					
K0879	PWC gp4 hd sing pow opt s/b		Y					
K0880	PWC gp4 vhd sing pow opt s/b		Y					
K0884	PWC gp4 std mult pow opt s/b		Y					
K0885	PWC gp4 std mult pow opt cap		Y					
K0886	PWC gp4 hd mult pow s/b		Y					
K0890	PWC gp5 ped sing pow opt s/b		Y					
K0891	PWC gp5 ped mult pow opt s/b		Y					
K0898	Power wheelchair NOC		Y					
K0899	Pow mobil dev no SADMERC		Y					
L0112	Cranial cervical orthosis		A					
L0120	Cerv flexible non-adjustable		A					
L0130	Flex thermoplastic collar mo		A					
L0140	Cervical semi-rigid adjustab		A					
L0150	Cerv semi-rig adj molded chn		A					
L0160	Cerv semi-rig wire occ/mand		A					
L0170	Cervical collar molded to pt		A					
L0172	Cerv col thermplas foam 2 pi		A					
L0174	Cerv col foam 2 piece w thor		A					
L0180	Cer post col occ/man sup adj		A					
L0190	Cerv collar supp adj cerv ba		A					
L0200	Cerv col supp adj bar & thor		A					
L0210	Thoracic rib belt		A					
L0220	Thor rib belt custom fabrica		A					
L0430	Dewall posture protector		A					
L0450	TLSO flex prefab thoracic		A					
L0452	tlso flex custom fab thoraci		A					
L0454	TLSO flex prefab sacrococ-T9		A					
L0456	TLSO flex prefab		A					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L0458	TLSO 2Mod symphis-xipho pre		A					
L0460	TLSO2Mod symphysis-stern pre		A					
L0462	TLSO 3Mod sacro-scap pre		A					
L0464	TLSO 4Mod sacro-scap pre		A					
L0466	TLSO rigid frame pre soft ap		A					
L0468	TLSO rigid frame prefab pelv		A					
L0470	TLSO rigid frame pre subclav		A					
L0472	TLSO rigid frame hyperex pre		A					
L0480	TLSO rigid plastic custom fa		A					
L0482	TLSO rigid lined custom fab		A					
L0484	TLSO rigid plastic cust fab		A					
L0486	TLSO rigidlined cust fab two		A					
L0488	TLSO rigid lined pre one pie		A					
L0490	TLSO rigid plastic pre one		A					
L0491	TLSO 2 piece rigid shell		A					
L0492	TLSO 3 piece rigid shell		A					
L0621	SIO flex pelvisacral prefab		A					
L0622	SIO flex pelvisacral custom		A					
L0623	SIO panel prefab		A					
L0624	SIO panel custom		A					
L0625	LO flexibl L1-below L5 pre		A					
L0626	LO sag stays/panels pre-fab		A					
L0627	LO sagitt rigid panel prefab		A					
L0628	LO flex w/o rigid stays pre		A					
L0629	LSO flex w/rigid stays cust		A					
L0630	LSO post rigid panel pre		A					
L0631	LSO sag-coro rigid frame pre		A					
L0632	LSO sag rigid frame cust		A					
L0633	LSO flexion control prefab		A					
L0634	LSO flexion control custom		A					
L0635	LSO sagit rigid panel prefab		A					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L0636	LSO sagittal rigid panel cus		A					
L0637	LSO sag-coronal panel prefab		A					
L0638	LSO sag-coronal panel custom		A					
L0639	LSO s/c shell/panel prefab		A					
L0640	LSO s/c shell/panel custom		A					
L0700	Ctlso a-p-l control molded		A					
L0710	Ctlso a-p-l control w/ inter		A					
L0810	Halo cervical into jckt vest		A					
L0820	Halo cervical into body jack		A					
L0830	Halo cerv into milwaukee typ		A					
L0859	MRI compatible system		A					
L0861	Halo repl liner/interface		A					
L0970	Tlso corset front		A					
L0972	Lso corset front		A					
L0974	Tlso full corset		A					
L0976	Lso full corset		A					
L0978	Axillary crutch extension		A					
L0980	Peroneal straps pair		A					
L0982	Stocking supp grips set of f		A					
L0984	Protective body sock each		A					
L0999	Add to spinal orthosis NOS		A					
L1000	Ctlso milwauke initial model		A					
L1001	CTLSO infant immobilizer		A					
L1005	Tension based scoliosis orth		A					
L1010	Ctlso axilla sling		A					
L1020	Kyphosis pad		A					
L1025	Kyphosis pad floating		A					
L1030	Lumbar bolster pad		A					
L1040	Lumbar or lumbar rib pad		A					
L1050	Sternal pad		A					
L1060	Thoracic pad		A					

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L1070	Trapezius sling		A					
L1080	Outrigger		A					
L1085	Outrigger bil w/ vert extens		A					
L1090	Lumbar sling		A					
L1100	Ring flange plastic/leather		A					
L1110	Ring flange plas/leather mol		A					
L1120	Covers for upright each		A					
L1200	Furnsh initial orthosis only		A					
L1210	Lateral thoracic extension		A					
L1220	Anterior thoracic extension		A					
L1230	Milwaukee type superstructur		A					
L1240	Lumbar derotation pad		A					
L1250	Anterior asis pad		A					
L1260	Anterior thoracic derotation		A					
L1270	Abdominal pad		A					
L1280	Rib gusset (elastic) each		A					
L1290	Lateral trochanteric pad		A					
L1300	Body jacket mold to patient		A					
L1310	Post-operative body jacket		A					
L1499	Spinal orthosis NOS		A					
L1500	Thkao mobility frame		A					
L1510	Thkao standing frame		A					
L1520	Thkao swivel walker		A					
L1600	Abduct hip flex frejka w cvr		A					
L1610	Abduct hip flex frejka covr		A					
L1620	Abduct hip flex pavlik harne		A					
L1630	Abduct control hip semi-flex		A					
L1640	Pelv band/spread bar thigh c		A					
L1650	HO abduction hip adjustable		A					
L1652	HO bi thighcuffs w sprdr bar		A					
L1660	HO abduction static plastic		A					

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L1680	Pelvic & hip control thigh c		A					
L1685	Post-op hip abduct custom fa		A					
L1686	HO post-op hip abduction		A					
L1690	Combination bilateral HO		A					
L1700	Leg perthes orth toronto typ		A					
L1710	Legg perthes orth newington		A					
L1720	Legg perthes orthosis trilat		A					
L1730	Legg perthes orth scottish r		A					
L1755	Legg perthes patten bottom t		A					
L1800	Knee orthoses elas w stays		A					
L1810	Ko elastic with joints		A					
L1815	Elastic with condylar pads		A					
L1820	Ko elas w/ condyle pads & jo		A					
L1825	Ko elastic knee cap		A					
L1830	Ko immobilizer canvas longit		A					
L1831	Knee orth pos locking joint		A					
L1832	KO adj jnt pos rigid support		A					
L1834	Ko w/0 joint rigid molded to		A					
L1836	Rigid KO wo joints		A					
L1840	Ko derot ant cruciate custom		A					
L1843	KO single upright custom fit		A					
L1844	Ko w/adj jt rot cntrl molded		A					
L1845	Ko w/ adj flex/ext rotat cus		A					
L1846	Ko w adj flex/ext rotat mold		A					
L1847	KO adjustable w air chambers		A					
L1850	Ko swedish type		A					
L1860	Ko supracondylar socket mold		A					
L1900	Afo sprng wir drsflx calf bd		A					
L1901	Prefab ankle orthosis		A					
L1902	Afo ankle gauntlet		A					
L1904	Afo molded ankle gauntlet		A					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L1906	Afo multiligamentus ankle su		A					
L1907	AFO supramalleolar custom		A					
L1910	Afo sing bar clasp attach sh		A					
L1920	Afo sing upright w/ adjust s		A					
L1930	Afo plastic		A					
L1932	Afo rig ant tib prefab TCF/=		A					
L1940	Afo molded to patient plasti		A					
L1945	Afo molded plas rig ant tib		A					
L1950	Afo spiral molded to pt plas		A					
L1951	AFO spiral prefabricated		A					
L1960	Afo pos solid ank plastic mo		A					
L1970	Afo plastic molded w/ankle j		A					
L1971	AFO w/ankle joint, prefab		A					
L1980	Afo sing solid stirrup calf		A					
L1990	Afo doub solid stirrup calf		A					
L2000	Kafo sing fre stirr thi/calf		A					
L2005	KAFO sng/dbl mechanical act		A					
L2010	Kafo sng solid stirrup w/o j		A					
L2020	Kafo dbl solid stirrup band/		A					
L2030	Kafo dbl solid stirrup w/o j		A					
L2034	KAFO pla sin up w/wo k/a cus		A					
L2035	KAFO plastic pediatric size		A					
L2036	Kafo plas doub free knee mol		A					
L2037	Kafo plas sing free knee mol		A					
L2038	Kafo w/o joint multi-axis an		A					
L2040	Hkafo torsion bil rot straps		A					
L2050	Hkafo torsion cable hip pelv		A					
L2060	Hkafo torsion ball bearing j		A					
L2070	Hkafo torsion unilat rot str		A					
L2080	Hkafo unilat torsion cable		A					
L2090	Hkafo unilat torsion ball br		A					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L2106	Afo tib fx cast plaster mold		A					
L2108	Afo tib fx cast molded to pt		A					
L2112	Afo tibial fracture soft		A					
L2114	Afo tib fx semi-rigid		A					
L2116	Afo tibial fracture rigid		A					
L2126	Kafo fem fx cast thermoplas		A					
L2128	Kafo fem fx cast molded to p		A					
L2132	Kafo femoral fx cast soft		A					
L2134	Kafo fem fx cast semi-rigid		A					
L2136	Kafo femoral fx cast rigid		A					
L2180	Plas shoe insert w ank joint		A					
L2182	Drop lock knee		A					
L2184	Limited motion knee joint		A					
L2186	Adj motion knee jnt lerman t		A					
L2188	Quadrilateral brim		A					
L2190	Waist belt		A					
L2192	Pelvic band & belt thigh fla		A					
L2200	Limited ankle motion ea jnt		A					
L2210	Dorsiflexion assist each joi		A					
L2220	Dorsi & plantar flex ass/res		A					
L2230	Split flat caliper stirr & p		A					
L2232	Rocker bottom, contact AFO		A					
L2240	Round caliper and plate atta		A					
L2250	Foot plate molded stirrup at		A					
L2260	Reinforced solid stirrup		A					
L2265	Long tongue stirrup		A					
L2270	Varus/valgus strap padded/li		A					
L2275	Plastic mod low ext pad/line		A					
L2280	Molded inner boot		A					
L2300	Abduction bar jointed adjust		A					
L2310	Abduction bar-straight		A					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L2320	Non-molded lacer		A					
L2330	Lacer molded to patient mode		A					
L2335	Anterior swing band		A					
L2340	Pre-tibial shell molded to p		A					
L2350	Prosthetic type socket molde		A					
L2360	Extended steel shank		A					
L2370	Patten bottom		A					
L2375	Torsion ank & half solid sti		A					
L2380	Torsion straight knee joint		A					
L2385	Straight knee joint heavy du		A					
L2387	Add LE poly knee custom KAFO		A					
L2390	Offset knee joint each		A					
L2395	Offset knee joint heavy duty		A					
L2397	Suspension sleeve lower ext		A					
L2405	Knee joint drop lock ea jnt		A					
L2415	Knee joint cam lock each joi		A					
L2425	Knee disc/dial lock/adj flex		A					
L2430	Knee jnt ratchet lock ea jnt		A					
L2492	Knee lift loop drop lock rin		A					
L2500	Thi/glut/ischia wgt bearing		A					
L2510	Th/wght bear quad-lat brim m		A					
L2520	Th/wght bear quad-lat brim c		A					
L2525	Th/wght bear nar m-l brim mo		A					
L2526	Th/wght bear nar m-l brim cu		A					
L2530	Thigh/wght bear lacer non-mo		A					
L2540	Thigh/wght bear lacer molded		A					
L2550	Thigh/wght bear high roll cu		A					
L2570	Hip clevis type 2 posit jnt		A					
L2580	Pelvic control pelvic sling		A					
L2600	Hip clevis/thrust bearing fr		A					
L2610	Hip clevis/thrust bearing lo		A					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L2620	Pelvic control hip heavy dut		A					
L2622	Hip joint adjustable flexion		A					
L2624	Hip adj flex ext abduct cont		A					
L2627	Plastic mold recipro hip & c		A					
L2628	Metal frame recipro hip & ca		A					
L2630	Pelvic control band & belt u		A					
L2640	Pelvic control band & belt b		A					
L2650	Pelv & thor control gluteal		A					
L2660	Thoracic control thoracic ba		A					
L2670	Thorac cont paraspinal uprig		A					
L2680	Thorac cont lat support upri		A					
L2750	Plating chrome/nickel pr bar		A					
L2755	Carbon graphite lamination		A					
L2760	Extension per extension per		A					
L2768	Ortho sidebar disconnect		A					
L2770	Low ext orthosis per bar/jnt		A					
L2780	Non-corrosive finish		A					
L2785	Drop lock retainer each		A					
L2795	Knee control full kneecap		A					
L2800	Knee cap medial or lateral p		A					
L2810	Knee control condylar pad		A					
L2820	Soft interface below knee se		A					
L2830	Soft interface above knee se		A					
L2840	Tibial length sock fx or equ		A					
L2850	Femoral lgth sock fx or equa		A					
L2860	Torsion mechanism knee/ankle		A					
L2999	Lower extremity orthosis NOS		A					
L3000	Ft insert ucb berkeley shell		A					
L3001	Foot insert remov molded spe		A					
L3002	Foot insert plastazote or eq		A					
L3003	Foot insert silicone gel eac		A					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L3010	Foot longitudinal arch suppo		A					
L3020	Foot longitud/metatarsal sup		A					
L3030	Foot arch support remov prem		A					
L3031	Foot lamin/prepreg composite		A					
L3040	Ft arch suprt premold longit		A					
L3050	Foot arch supp premold metat		A					
L3060	Foot arch supp longitud/meta		A					
L3070	Arch suprt att to sho longit		A					
L3080	Arch supp att to shoe metata		A					
L3090	Arch supp att to shoe long/m		A					
L3100	Hallus-valgus nght dynamic s		A					
L3140	Abduction rotation bar shoe		A					
L3150	Abduct rotation bar w/o shoe		A					
L3160	Shoe styled positioning dev		A					
L3170	Foot plastic heel stabilizer		A					
L3201	Oxford w supinat/pronat inf		A					
L3202	Oxford w/ supinat/pronator c		A					
L3203	Oxford w/ supinator/pronator		A					
L3204	Hightop w/ supp/pronator inf		A					
L3206	Hightop w/ supp/pronator chi		A					
L3207	Hightop w/ supp/pronator jun		A					
L3208	Surgical boot each infant		A					
L3209	Surgical boot each child		A					
L3211	Surgical boot each junior		A					
L3212	Benesch boot pair infant		A					
L3213	Benesch boot pair child		A					
L3214	Benesch boot pair junior		A					
L3215	Orthopedic ftwear ladies oxf		E					
L3216	Orthoped ladies shoes dpth i		E					
L3217	Ladies shoes hightop depth i		E					
L3219	Orthopedic mens shoes oxford		E					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L3221	Orthopedic mens shoes dpth i		E					
L3222	Mens shoes hightop depth inl		E					
L3224	Woman's shoe oxford brace		A					
L3225	Man's shoe oxford brace		A					
L3230	Custom shoes depth inlay		A					
L3250	Custom mold shoe remov prost		A					
L3251	Shoe molded to pt silicone s		A					
L3252	Shoe molded plastazote cust		A					
L3253	Shoe molded plastazote cust		A					
L3254	Orth foot non-stndard size/w		A					
L3255	Orth foot non-standard size/		A					
L3257	Orth foot add charge split s		A					
L3260	Ambulatory surgical boot eac		E					
L3265	Plastazote sandal each		A					
L3300	Sho lift taper to metatarsal		A					
L3310	Shoe lift elev heel/sole neo		A					
L3320	Shoe lift elev heel/sole cor		A					
L3330	Lifts elevation metal extens		A					
L3332	Shoe lifts tapered to one-ha		A					
L3334	Shoe lifts elevation heel /i		A					
L3340	Shoe wedge sach		A					
L3350	Shoe heel wedge		A					
L3360	Shoe sole wedge outside sole		A					
L3370	Shoe sole wedge between sole		A					
L3380	Shoe clubfoot wedge		A					
L3390	Shoe outflare wedge		A					
L3400	Shoe metatarsal bar wedge ro		A					
L3410	Shoe metatarsal bar between		A					
L3420	Full sole/heel wedge btween		A					
L3430	Sho heel count plast reinfor		A					
L3440	Heel leather reinforced		A					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L3450	Shoe heel sach cushion type		A					
L3455	Shoe heel new leather standa		A					
L3460	Shoe heel new rubber standar		A					
L3465	Shoe heel thomas with wedge		A					
L3470	Shoe heel thomas extend to b		A					
L3480	Shoe heel pad & depress for		A					
L3485	Shoe heel pad removable for		A					
L3500	Ortho shoe add leather insol		A					
L3510	Orthopedic shoe add rub insl		A					
L3520	O shoe add felt w leath insl		A					
L3530	Ortho shoe add half sole		A					
L3540	Ortho shoe add full sole		A					
L3550	O shoe add standard toe tap		A					
L3560	O shoe add horseshoe toe tap		A					
L3570	O shoe add instep extension		A					
L3580	O shoe add instep velcro clo		A					
L3590	O shoe convert to sof counte		A					
L3595	Ortho shoe add march bar		A					
L3600	Trans shoe calip plate exist		A					
L3610	Trans shoe caliper plate new		A					
L3620	Trans shoe solid stirrup exi		A					
L3630	Trans shoe solid stirrup new		A					
L3640	Shoe dennis browne splint bo		A					
L3649	Orthopedic shoe modifica NOS		A					
L3650	Shlder fig 8 abduct restrain		A					
L3651	Prefab shoulder orthosis		A					
L3652	Prefab dbl shoulder orthosis		A					
L3660	Abduct restrainer canvas&web		A					
L3670	Acromio/clavicular canvas&we		A					
L3671	SO cap design w/o jnts CF		A					
L3672	SO airplane w/o jnts CF		A					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L3673	SO airplane w/joint CF		A					
L3675	Canvas vest SO		A					
L3677	SO hard plastic stabilizer		E					
L3700	Elbow orthoses elas w stays		A					
L3701	Prefab elbow orthosis		A					
L3702	EO w/o joints CF		A					
L3710	Elbow elastic with metal joi		A					
L3720	Forearm/arm cuffs free motio		A					
L3730	Forearm/arm cuffs ext/flex a		A					
L3740	Cuffs adj lock w/ active con		A					
L3760	EO withjoint, Prefabricated		A					
L3762	Rigid EO wo joints		A					
L3763	EWHO rigid w/o jnts CF		A					
L3764	EWHO w/joint(s) CF		A					
L3765	EWHFO rigid w/o jnts CF		A					
L3766	EWHFO w/joint(s) CF		A					
L3806	WHFO w/joint(s) custom fab		A					
L3807	WHFO,no joint, prefabricated		A					
L3808	WHFO, rigid w/o joints		A					
L3890	Torsion mechanism wrist/elbo		B					
L3900	Hinge extension/flex wrist/f		A					
L3901	Hinge ext/flex wrist finger		A					
L3904	Whfo electric custom fitted		A					
L3905	WHO w/nontorsion jnt(s) CF		A					
L3906	WHO w/o joints CF		A					
L3908	Wrist cock-up non-molded		A					
L3909	Prefab wrist orthosis		A					
L3911	Prefab hand finger orthosis		A					
L3912	Flex glove w/elastic finger		A					
L3913	HFO w/o joints CF		A					
L3915	WHO w nontor jnt(s) prefab		A					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L3917	Prefab metacarpl fx orthosis		A					
L3919	HO w/o joints CF		A					
L3921	HFO w/joint(s) CF		A					
L3923	HFO w/o joints PF		A					
L3925	FO pip/dip with joint/spring		A					
L3927	FO pip/dip w/o joint/spring		A					
L3929	HFO nontorsion joint, prefab		A					
L3931	WHFO nontorsion joint prefab		A					
L3933	FO w/o joints CF		A					
L3935	FO nontorsion joint CF		A					
L3956	Add joint upper ext orthosis		A					
L3960	Sewho airplan desig abdu pos		A					
L3961	SEWHO cap design w/o jnts CF		A					
L3962	Sewho erbs palsey design abd		A					
L3964	Seo mobile arm sup att to wc		Y					
L3965	Arm supp att to wc rancho ty		Y					
L3966	Mobile arm supports reclinin		Y					
L3967	SEWHO airplane w/o jnts CF		A					
L3968	Friction dampening arm supp		Y					
L3969	Monosuspension arm/hand supp		Y					
L3970	Elevat proximal arm support		Y					
L3971	SEWHO cap design w/jnt(s) CF		A					
L3972	Offset/lat rocker arm w/ ela		Y					
L3973	SEWHO airplane w/jnt(s) CF		A					
L3974	Mobile arm support supinator		Y					
L3975	SEWHFO cap design w/o jnt CF		A					
L3976	SEWHFO airplane w/o jnts CF		A					
L3977	SEWHFO cap desgn w/jnt(s) CF		A					
L3978	SEWHFO airplane w/jnt(s) CF		A					
L3980	Upp ext fx orthosis humeral		A					
L3982	Upper ext fx orthosis rad/ul		A					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L3984	Upper ext fx orthosis wrist		A					
L3995	Sock fracture or equal each		A					
L3999	Upper limb orthosis NOS		A					
L4000	Repl girdle milwaukee orth		A					
L4002	Replace strap, any orthosis		A					
L4010	Replace trilateral socket br		A					
L4020	Replace quadlat socket brim		A					
L4030	Replace socket brim cust fit		A					
L4040	Replace molded thigh lacer		A					
L4045	Replace non-molded thigh lac		A					
L4050	Replace molded calf lacer		A					
L4055	Replace non-molded calf lace		A					
L4060	Replace high roll cuff		A					
L4070	Replace prox & dist upright		A					
L4080	Repl met band kafo-afo prox		A					
L4090	Repl met band kafo-afo calf/		A					
L4100	Repl leath cuff kafo prox th		A					
L4110	Repl leath cuff kafo-afo cal		A					
L4130	Replace pretibial shell		A					
L4205	Ortho dvc repair per 15 min		A					
L4210	Orth dev repair/repl minor p		A					
L4350	Ankle control orthosi prefab		A					
L4360	Pneumati walking boot prefab		A					
L4370	Pneumatic full leg splint		A					
L4380	Pneumatic knee splint		A					
L4386	Non-pneum walk boot prefab		A					
L4392	Replace AFO soft interface		A					
L4394	Replace foot drop spint		A					
L4396	Static AFO		A					
L4398	Foot drop splint recumbent		A					
L5000	Sho insert w arch toe filler		A					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L5010	Mold socket ank hgt w/ toe f		A					
L5020	Tibial tubercle hgt w/ toe f		A					
L5050	Ank symes mold sckt sach ft		A					
L5060	Symes met fr leath socket ar		A					
L5100	Molded socket shin sach foot		A					
L5105	Plast socket jts/thgh lacer		A					
L5150	Mold sckt ext knee shin sach		A					
L5160	Mold socket bent knee shin s		A					
L5200	Kne sing axis fric shin sach		A					
L5210	No knee/ankle joints w/ ft b		A					
L5220	No knee joint with artic ali		A					
L5230	Fem focal defic constant fri		A					
L5250	Hip canad sing axi cons fric		A					
L5270	Tilt table locking hip sing		A					
L5280	Hemipelvect canad sing axis		A					
L5301	BK mold socket SACH ft endo		A					
L5311	Knee disart, SACH ft, endo		A					
L5321	AK open end SACH		A					
L5331	Hip disart canadian SACH ft		A					
L5341	Hemipelvectomy canadian SACH		A					
L5400	Postop dress & 1 cast chg bk		A					
L5410	Postop dsg bk ea add cast ch		A					
L5420	Postop dsg & 1 cast chg ak/d		A					
L5430	Postop dsg ak ea add cast ch		A					
L5450	Postop app non-wgt bear dsg		A					
L5460	Postop app non-wgt bear dsg		A					
L5500	Init bk ptb plaster direct		A					
L5505	Init ak ischal plstr direct		A					
L5510	Prep BK ptb plaster molded		A					
L5520	Perp BK ptb thermopls direct		A					
L5530	Prep BK ptb thermopls molded		A					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L5535	Prep BK ptb open end socket		A					
L5540	Prep BK ptb laminated socket		A					
L5560	Prep AK ischial plast molded		A					
L5570	Prep AK ischial direct form		A					
L5580	Prep AK ischial thermo mold		A					
L5585	Prep AK ischial open end		A					
L5590	Prep AK ischial laminated		A					
L5595	Hip disartic sach thermopls		A					
L5600	Hip disart sach laminat mold		A					
L5610	Above knee hydracadence		A					
L5611	Ak 4 bar link w/fric swing		A					
L5613	Ak 4 bar ling w/hydraul swig		A					
L5614	4-bar link above knee w/swng		A					
L5616	Ak univ multiplex sys frict		A					
L5617	AK/BK self-aligning unit ea		A					
L5618	Test socket symes		A					
L5620	Test socket below knee		A					
L5622	Test socket knee disarticula		A					
L5624	Test socket above knee		A					
L5626	Test socket hip disarticulat		A					
L5628	Test socket hemipelvectomy		A					
L5629	Below knee acrylic socket		A					
L5630	Syme typ expandabl wall sckt		A					
L5631	Ak/knee disartic acrylic soc		A					
L5632	Symes type ptb brim design s		A					
L5634	Symes type poster opening so		A					
L5636	Symes type medial opening so		A					
L5637	Below knee total contact		A					
L5638	Below knee leather socket		A					
L5639	Below knee wood socket		A					
L5640	Knee disarticulat leather so		A					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L5642	Above knee leather socket		A					
L5643	Hip flex inner socket ext fr		A					
L5644	Above knee wood socket		A					
L5645	Bk flex inner socket ext fra		A					
L5646	Below knee cushion socket		A					
L5647	Below knee suction socket		A					
L5648	Above knee cushion socket		A					
L5649	Isch containmt/narrow m-l so		A					
L5650	Tot contact ak/knee disart s		A					
L5651	Ak flex inner socket ext fra		A					
L5652	Suction susp ak/knee disart		A					
L5653	Knee disart expand wall sock		A					
L5654	Socket insert symes		A					
L5655	Socket insert below knee		A					
L5656	Socket insert knee articulat		A					
L5658	Socket insert above knee		A					
L5661	Multi-durometer symes		A					
L5665	Multi-durometer below knee		A					
L5666	Below knee cuff suspension		A					
L5668	Socket insert w/o lock lower		A					
L5670	Bk molded supracondylar susp		A					
L5671	BK/AK locking mechanism		A					
L5672	Bk removable medial brim sus		A					
L5673	Socket insert w lock mech		A					
L5676	Bk knee joints single axis p		A					
L5677	Bk knee joints polycentric p		A					
L5678	Bk joint covers pair		A					
L5679	Socket insert w/o lock mech		A					
L5680	Bk thigh lacer non-molded		A					
L5681	Intl custm cong/latyp insert		A					
L5682	Bk thigh lacer glut/ischia m		A					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L5683	Initial custom socket insert		A					
L5684	Bk fork strap		A					
L5685	Below knee sus/seal sleeve		A					
L5686	Bk back check		A					
L5688	Bk waist belt webbing		A					
L5690	Bk waist belt padded and lin		A					
L5692	Ak pelvic control belt light		A					
L5694	Ak pelvic control belt pad/l		A					
L5695	Ak sleeve susp neoprene/equa		A					
L5696	Ak/knee disartic pelvic join		A					
L5697	Ak/knee disartic pelvic band		A					
L5698	Ak/knee disartic silesian ba		A					
L5699	Shoulder harness		A					
L5700	Replace socket below knee		A					
L5701	Replace socket above knee		A					
L5702	Replace socket hip		A					
L5703	Symes ankle w/o (SACH) foot		A					
L5704	Custom shape cover BK		A					
L5705	Custom shape cover AK		A					
L5706	Custom shape cvr knee disart		A					
L5707	Custom shape cvr hip disart		A					
L5710	Kne-shin exo sng axi mnl loc		A					
L5711	Knee-shin exo mnl lock ultra		A					
L5712	Knee-shin exo frict swg & st		A					
L5714	Knee-shin exo variable frict		A					
L5716	Knee-shin exo mech stance ph		A					
L5718	Knee-shin exo frct swg & sta		A					
L5722	Knee-shin pneum swg frct exo		A					
L5724	Knee-shin exo fluid swing ph		A					
L5726	Knee-shin ext jnts fld swg e		A					
L5728	Knee-shin fluid swg & stance		A					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L5780	Knee-shin pneum/hydra pneum		A					
L5781	Lower limb pros vacuum pump		A					
L5782	HD low limb pros vacuum pump		A					
L5785	Exoskeletal bk ultralt mater		A					
L5790	Exoskeletal ak ultra-light m		A					
L5795	Exoskel hip ultra-light mate		A					
L5810	Endoskel knee-shin mnl lock		A					
L5811	Endo knee-shin mnl lck ultra		A					
L5812	Endo knee-shin frct swg & st		A					
L5814	Endo knee-shin hydral swg ph		A					
L5816	Endo knee-shin polyc mch sta		A					
L5818	Endo knee-shin frct swg & st		A					
L5822	Endo knee-shin pneum swg frc		A					
L5824	Endo knee-shin fluid swing p		A					
L5826	Miniature knee joint		A					
L5828	Endo knee-shin fluid swg/sta		A					
L5830	Endo knee-shin pneum/swg pha		A					
L5840	Multi-axial knee/shin system		A					
L5845	Knee-shin sys stance flexion		A					
L5848	Knee-shin sys hydraul stance		A					
L5850	Endo ak/hip knee extens assi		A					
L5855	Mech hip extension assist		A					
L5856	Elec knee-shin swing/stance		A					
L5857	Elec knee-shin swing only		A					
L5858	Stance phase only		A					
L5910	Endo below knee alignable sy		A					
L5920	Endo ak/hip alignable system		A					
L5925	Above knee manual lock		A					
L5930	High activity knee frame		A					
L5940	Endo bk ultra-light material		A					
L5950	Endo ak ultra-light material		A					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L5960	Endo hip ultra-light materia		A					
L5962	Below knee flex cover system		A					
L5964	Above knee flex cover system		A					
L5966	Hip flexible cover system		A					
L5968	Multiaxial ankle w dorsiflex		A					
L5970	Foot external keel sach foot		A					
L5971	SACH foot, replacement		A					
L5972	Flexible keel foot		A					
L5974	Foot single axis ankle/foot		A					
L5975	Combo ankle/foot prosthesis		A					
L5976	Energy storing foot		A					
L5978	Ft prosth multiaxial ankl/ft		A					
L5979	Multi-axial ankle/ft prosth		A					
L5980	Flex foot system		A					
L5981	Flex-walk sys low ext prosth		A					
L5982	Exoskeletal axial rotation u		A					
L5984	Endoskeletal axial rotation		A					
L5985	Lwr ext dynamic prosth pylon		A					
L5986	Multi-axial rotation unit		A					
L5987	Shank ft w vert load pylon		A					
L5988	Vertical shock reducing pylo		A					
L5990	User adjustable heel height		A					
L5993	Heavy duty feature, foot		A					
L5994	Heavy duty feature, knee		A					
L5995	Lower ext pros heavyduty fea		A					
L5999	Lowr extremity prosthes NOS		A					
L6000	Par hand robin-aids thum rem		A					
L6010	Hand robin-aids little/ring		A					
L6020	Part hand robin-aids no fing		A					
L6025	Part hand disart myoelectric		A					
L6050	Wrst MLd sck flx hng tri pad		A					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L6055	Wrst mold sock w/exp interfa		A					
L6100	Elb mold sock flex hinge pad		A					
L6110	Elbow mold sock suspension t		A					
L6120	Elbow mold doub splt soc ste		A					
L6130	Elbow stump activated lock h		A					
L6200	Elbow mold outsid lock hinge		A					
L6205	Elbow molded w/ expand inter		A					
L6250	Elbow inter loc elbow forarm		A					
L6300	Shlder disart int lock elbow		A					
L6310	Shoulder passive restor comp		A					
L6320	Shoulder passive restor cap		A					
L6350	Thoracic intern lock elbow		A					
L6360	Thoracic passive restor comp		A					
L6370	Thoracic passive restor cap		A					
L6380	Postop dsg cast chg wrst/elb		A					
L6382	Postop dsg cast chg elb dis/		A					
L6384	Postop dsg cast chg shlder/t		A					
L6386	Postop ea cast chg & realign		A					
L6388	Postop applicat rigid dsg on		A					
L6400	Below elbow prosth tiss shap		A					
L6450	Elb disart prosth tiss shap		A					
L6500	Above elbow prosth tiss shap		A					
L6550	Shldr disar prosth tiss shap		A					
L6570	Scap thorac prosth tiss shap		A					
L6580	Wrist/elbow bowden cable mol		A					
L6582	Wrist/elbow bowden cbl dir f		A					
L6584	Elbow fair lead cable molded		A					
L6586	Elbow fair lead cable dir fo		A					
L6588	Shdr fair lead cable molded		A					
L6590	Shdr fair lead cable direct		A					
L6600	Polycentric hinge pair		A					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L6605	Single pivot hinge pair		A					
L6610	Flexible metal hinge pair		A					
L6611	Additional switch, ext power		A					
L6615	Disconnect locking wrist uni		A					
L6616	Disconnect insert locking wr		A					
L6620	Flexion/extension wrist unit		A					
L6621	Flex/ext wrist w/wo friction		A					
L6623	Spring-ass rot wrst w/ latch		A					
L6624	Flex/ext/rotation wrist unit		A					
L6625	Rotation wrst w/ cable lock		A					
L6628	Quick disconn hook adapter o		A					
L6629	Lamination collar w/ couplin		A					
L6630	Stainless steel any wrist		A					
L6632	Latex suspension sleeve each		A					
L6635	Lift assist for elbow		A					
L6637	Nudge control elbow lock		A					
L6638	Elec lock on manual pw elbow		A					
L6639	Heavy duty elbow feature		A					
L6640	Shoulder abduction joint pai		A					
L6641	Excursion amplifier pulley t		A					
L6642	Excursion amplifier lever ty		A					
L6645	Shoulder flexion-abduction j		A					
L6646	Multipo locking shoulder jnt		A					
L6647	Shoulder lock actuator		A					
L6648	Ext pwrd shlder lock/unlock		A					
L6650	Shoulder universal joint		A					
L6655	Standard control cable extra		A					
L6660	Heavy duty control cable		A					
L6665	Teflon or equal cable lining		A					
L6670	Hook to hand cable adapter		A					
L6672	Harness chest/shlder saddle		A					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L6675	Harness figure of 8 sing con		A					
L6676	Harness figure of 8 dual con		A					
L6677	UE triple control harness		A					
L6680	Test sock wrist disart/bel e		A					
L6682	Test sock elbw disart/above		A					
L6684	Test socket shldr disart/tho		A					
L6686	Suction socket		A					
L6687	Frame typ socket bel elbow/w		A					
L6688	Frame typ sock above elb/dis		A					
L6689	Frame typ socket shoulder di		A					
L6690	Frame typ sock interscap-tho		A					
L6691	Removable insert each		A					
L6692	Silicone gel insert or equal		A					
L6693	Lockingelbow forearm cntrbal		A					
L6694	Elbow socket ins use w/lock		A					
L6695	Elbow socket ins use w/o lck		A					
L6696	Cus elbo skt in for con/atyp		A					
L6697	Cus elbo skt in not con/atyp		A					
L6698	Below/above elbow lock mech		A					
L6703	Term dev, passive hand mitt		A					
L6704	Term dev, sport/rec/work att		A					
L6706	Term dev mech hook vol open		A					
L6707	Term dev mech hook vol close		A					
L6708	Term dev mech hand vol open		A					
L6709	Term dev mech hand vol close		A					
L6805	Term dev modifier wrist unit		A					
L6810	Term dev precision pinch dev		A					
L6881	Term dev auto grasp feature		A					
L6882	Microprocessor control uplmb		A					
L6883	Replc sockt below e/w disa		A					
L6884	Replc sockt above elbow disa		A					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L6885	Replc sockt shldr dis/interc		A					
L6890	Prefab glove for term device		A					
L6895	Custom glove for term device		A					
L6900	Hand restorat thumb/1 finger		A					
L6905	Hand restoration multiple fi		A					
L6910	Hand restoration no fingers		A					
L6915	Hand restoration replacmnt g		A					
L6920	Wrist disaricul switch ctrl		A					
L6925	Wrist disart myoelectronic c		A					
L6930	Below elbow switch control		A					
L6935	Below elbow myoelectronic ct		A					
L6940	Elbow disarticulation switch		A					
L6945	Elbow disart myoelectronic c		A					
L6950	Above elbow switch control		A					
L6955	Above elbow myoelectronic ct		A					
L6960	Shldr disartic switch contro		A					
L6965	Shldr disartic myoelectronic		A					
L6970	Interscapular-thor switch ct		A					
L6975	Interscap-thor myoelectronic		A					
L7007	Adult electric hand		A					
L7008	Pediatric electric hand		A					
L7009	Adult electric hook		A					
L7040	Prehensile actuator		A					
L7045	Pediatric electric hook		A					
L7170	Electronic elbow hosmer swit		A					
L7180	Electronic elbow sequential		A					
L7181	Electronic elbo simultaneous		A					
L7185	Electron elbow adolescent sw		A					
L7186	Electron elbow child switch		A					
L7190	Elbow adolescent myoelectron		A					
L7191	Elbow child myoelectronic ct		A					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L7260	Electron wrist rotator otto		A					
L7261	Electron wrist rotator utah		A					
L7266	Servo control steeper or equ		A					
L7272	Analogue control unb or equa		A					
L7274	Proportional ctl 12 volt uta		A					
L7360	Six volt bat otto bock/eq ea		A					
L7362	Battery chrgr six volt otto		A					
L7364	Twelve volt battery utah/equ		A					
L7366	Battery chrgr 12 volt utah/e		A					
L7367	Replacemnt lithium ionbatter		A					
L7368	Lithium ion battery charger		A					
L7400	Add UE prost be/wd, ultlite		A					
L7401	Add UE prost a/e ultlite mat		A					
L7402	Add UE prost s/d ultlite mat		A					
L7403	Add UE prost b/e acrylic		A					
L7404	Add UE prost a/e acrylic		A					
L7405	Add UE prost s/d acrylic		A					
L7499	Upper extremity prosthes NOS		A					
L7500	Prosthetic dvc repair hourly		A					
L7510	Prosthetic device repair rep		A					
L7520	Repair prosthesis per 15 min		A					
L7600	Prosthetic donning sleeve		E					
L7611	Ped term dev, hook, vol open		A					
L7612	Ped term dev, hook, vol clos		A					
L7613	Ped term dev, hand, vol open		A					
L7614	Ped term dev, hand, vol clos		A					
L7621	Hook/hand, hvy dty, vol open		A					
L7622	Hook/hand, hvy dty, vol clos		A					
L7900	Male vacuum erection system		A					
L8000	Mastectomy bra		A					
L8001	Breast prosthesis bra & form		A					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L8002	Brst prsth bra & bilat form		A					
L8010	Mastectomy sleeve		A					
L8015	Ext breastprosthesis garment		A					
L8020	Mastectomy form		A					
L8030	Breast prosthesis silicone/e		A					
L8035	Custom breast prosthesis		A					
L8039	Breast prosthesis NOS		A					
L8040	Nasal prosthesis		A					
L8041	Midfacial prosthesis		A					
L8042	Orbital prosthesis		A					
L8043	Upper facial prosthesis		A					
L8044	Hemi-facial prosthesis		A					
L8045	Auricular prosthesis		A					
L8046	Partial facial prosthesis		A					
L8047	Nasal septal prosthesis		A					
L8048	Unspec maxillofacial prosth		A					
L8049	Repair maxillofacial prosth		A					
L8300	Truss single w/ standard pad		A					
L8310	Truss double w/ standard pad		A					
L8320	Truss addition to std pad wa		A					
L8330	Truss add to std pad scrotal		A					
L8400	Sheath below knee		A					
L8410	Sheath above knee		A					
L8415	Sheath upper limb		A					
L8417	Pros sheath/sock w gel cushn		A					
L8420	Prosthetic sock multi ply BK		A					
L8430	Prosthetic sock multi ply AK		A					
L8435	Pros sock multi ply upper lm		A					
L8440	Shrinker below knee		A					
L8460	Shrinker above knee		A					
L8465	Shrinker upper limb		A					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L8470	Pros sock single ply BK		A					
L8480	Pros sock single ply AK		A					
L8485	Pros sock single ply upper l		A					
L8499	Unlisted misc prosthetic ser		A					
L8500	Artificial larynx		A					
L8501	Tracheostomy speaking valve		A					
L8505	Artificial larynx, accessory		A					
L8507	Trach-esoph voice pros pt in		A					
L8509	Trach-esoph voice pros md in		A					
L8510	Voice amplifier		A					
L8511	Indwelling trach insert		A					
L8512	Gel cap for trach voice pros		A					
L8513	Trach pros cleaning device		A					
L8514	Repl trach puncture dilator		A					
L8515	Gel cap app device for trach		A					
L8600	Implant breast silicone/eq		N					
L8603	Collagen imp urinary 2.5 ml		N					
L8606	Synthetic implnt urinary 1ml		N					
L8609	Artificial cornea		N					
L8610	Ocular implant		N					
L8612	Aqueous shunt prosthesis		N					
L8613	Ossicular implant		N					
L8614	Cochlear device		N					
L8615	Coch implant headset replace		A					
L8616	Coch implant microphone repl		A					
L8617	Coch implant trans coil repl		A					
L8618	Coch implant tran cable repl		A					
L8619	Replace cochlear processor		A					
L8621	Repl zinc air battery		A					
L8622	Repl alkaline battery		A					
L8623	Lith ion batt CID,non-earlvl		A					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L8624	Lith ion batt CID, ear level		A					
L8630	Metacarpophalangeal implant		N					
L8631	MCP joint repl 2 pc or more		N					
L8641	Metatarsal joint implant		N					
L8642	Hallux implant		N					
L8658	Interphalangeal joint spacer		N					
L8659	Interphalangeal joint repl		N					
L8670	Vascular graft, synthetic		N					
L8680	Implt neurostim elctr each		B					
L8681	Pt prgrm for implt neurostim		A					
L8682	Implt neurostim radiofq rec		N					
L8683	Radiofq trsmtr for implt neu		A					
L8684	Radiof trsmtr implt scrl neu		A					
L8685	Implt nrostm pls gen sng rec		B					
L8686	Implt nrostm pls gen sng non		B					
L8687	Implt nrostm pls gen dua rec		B					
L8688	Implt nrostm pls gen dua non		B					
L8689	External recharg sys intern		A					
L8690	Aud osseo dev, int/ext comp	CH	N					
L8691	Aud osseo dev ext snd proces		A					
L8695	External recharg sys extern		A					
L8699	Prosthetic implant NOS		N					
L9900	O&P supply/accessory/service		A					
M0064	Visit for drug monitoring		Q3	0606	1.3354	$87.71		$17.55
M0075	Cellular therapy		E					
M0076	Prolotherapy		E					
M0100	Intragastric hypothermia		E					
M0300	IV chelationtherapy		E					
M0301	Fabric wrapping of aneurysm		E					
P2028	Cephalin floculation test		A					
P2029	Congo red blood test		A					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
P2031	Hair analysis		E					
P2033	Blood thymol turbidity		A					
P2038	Blood mucoprotein		A					
P3000	Screen pap by tech w md supv		A					
P3001	Screening pap smear by phys		B					
P7001	Culture bacterial urine		E					
P9010	Whole blood for transfusion		R	0950	3.6167	$237.56		$47.52
P9011	Blood split unit		R	0967	0.4667	$30.65		$6.13
P9012	Cryoprecipitate each unit		R	0952	0.6677	$43.86		$8.78
P9016	RBC leukocytes reduced		R	0954	2.9296	$192.43		$38.49
P9017	Plasma 1 donor frz w/in 8 hr		R	9508	1.1757	$77.22		$15.45
P9019	Platelets, each unit		R	0957	1.2019	$78.95		$15.79
P9020	Plaelet rich plasma unit		R	0958	5.8879	$386.74		$77.35
P9021	Red blood cells unit		R	0959	2.1306	$139.95		$27.99
P9022	Washed red blood cells unit		R	0960	4.7822	$314.11		$62.83
P9023	Frozen plasma, pooled, sd		R	0949	0.9487	$62.31		$12.47
P9031	Platelets leukocytes reduced		R	1013	1.6253	$106.76		$21.36
P9032	Platelets, irradiated		R	9500	2.5730	$169.00		$33.80
P9033	Platelets leukoreduced irrad		R	0968	2.1748	$142.85		$28.57
P9034	Platelets, pheresis		R	9507	7.2005	$472.96		$94.60
P9035	Platelet pheres leukoreduced		R	9501	7.8915	$518.35		$103.67
P9036	Platelet pheresis irradiated		R	9502	7.0111	$460.52		$92.11
P9037	Plate pheres leukoredu irrad		R	1019	10.0323	$658.96		$131.80
P9038	RBC irradiated		R	9505	3.9231	$257.68		$51.54
P9039	RBC deglycerolized		R	9504	5.5204	$362.60		$72.52
P9040	RBC leukoreduced irradiated		R	0969	3.9175	$257.32		$51.47
P9041	Albumin (human),5%, 50ml		K	0961	0.3094	$20.32		$4.07
P9043	Plasma protein fract,5%,50ml		R	0956	1.1645	$76.49		$15.30
P9044	Cryoprecipitatereducedplasma		R	1009	1.3214	$86.79		$17.36
P9045	Albumin (human), 5%, 250 ml		K	0963	1.1065	$72.68		$14.54
P9046	Albumin (human), 25%, 20 ml		K	0964	0.3777	$24.81		$4.97

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
P9047	Albumin (human), 25%, 50ml		K	0965	1.0888	$71.52		$14.31
P9048	Plasmaprotein fract,5%,250ml		R	0966	3.2250	$211.83		$42.37
P9050	Granulocytes, pheresis unit		R	9506	25.5369	$1,677.37		$335.48
P9051	Blood, l/r, cmv-neg		R	1010	2.4044	$157.93		$31.59
P9052	Platelets, hla-m, l/r, unit		R	1011	10.3632	$680.70		$136.14
P9053	Plt, pher, l/r cmv-neg, irr		R	1020	9.9964	$656.60		$131.32
P9054	Blood, l/r, froz/degly/wash		R	1016	4.5799	$300.83		$60.17
P9055	Plt, aph/pher, l/r, cmv-neg		R	1017	7.3121	$480.29		$96.06
P9056	Blood, l/r, irradiated		R	1018	3.6066	$236.90		$47.38
P9057	RBC, frz/deg/wsh, l/r, irrad		R	1021	7.2738	$477.77		$95.56
P9058	RBC, l/r, cmv-neg, irrad		R	1022	4.5604	$299.55		$59.91
P9059	Plasma, frz between 8-24hour		R	0955	1.1188	$73.49		$14.70
P9060	Fr frz plasma donor retested		R	9503	1.0046	$65.99		$13.20
P9603	One-way allow prorated miles		A					
P9604	One-way allow prorated trip		A					
P9612	Catheterize for urine spec		A					
P9615	Urine specimen collect mult		N					
Q0035	Cardiokymography		X	0100	2.5931	$170.33	$41.44	$34.07
Q0081	Infusion ther other than che		B					
Q0083	Chemo by other than infusion		B					
Q0084	Chemotherapy by infusion		B					
Q0085	Chemo by both infusion and o		B					
Q0091	Obtaining screen pap smear		T	0191	0.1824	$11.98		$2.40
Q0092	Set up port xray equipment		N					
Q0111	Wet mounts/ w preparations		A					
Q0112	Potassium hydroxide preps		A					
Q0113	Pinworm examinations		A					
Q0114	Fern test		A					
Q0115	Post-coital mucous exam		A					
Q0144	Azithromycin dihydrate, oral		E					
Q0163	Diphenhydramine HCl 50mg		N					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
Q0164	Prochlorperazine maleate 5mg		N					
Q0165	Prochlorperazine maleate10mg		B					
Q0166	Granisetron HCl 1 mg oral		K	0765		$46.07		$9.22
Q0167	Dronabinol 2.5mg oral		N					
Q0168	Dronabinol 5mg oral		B					
Q0169	Promethazine HCl 12.5mg oral		N					
Q0170	Promethazine HCl 25 mg oral		B					
Q0171	Chlorpromazine HCl 10mg oral		N					
Q0172	Chlorpromazine HCl 25mg oral		B					
Q0173	Trimethobenzamide HCl 250mg		N					
Q0174	Thiethylperazine maleate10mg		N					
Q0175	Perphenazine 4mg oral		N					
Q0176	Perphenazine 8mg oral		B					
Q0177	Hydroxyzine pamoate 25mg		N					
Q0178	Hydroxyzine pamoate 50mg		B					
Q0179	Ondansetron HCl 8mg oral		K	0769		$4.52		$0.91
Q0180	Dolasetron mesylate oral		K	0763		$48.24		$9.65
Q0181	Unspecified oral anti-emetic		E					
Q0480	Driver pneumatic vad, rep		A					
Q0481	Microprcsr cu elec vad, rep		A					
Q0482	Microprcsr cu combo vad, rep		A					
Q0483	Monitor elec vad, rep		A					
Q0484	Monitor elec or comb vad rep		A					
Q0485	Monitor cable elec vad, rep		A					
Q0486	Mon cable elec/pneum vad rep		A					
Q0487	Leads any type vad, rep only		A					
Q0488	Pwr pack base elec vad, rep		A					
Q0489	Pwr pck base combo vad, rep		A					
Q0490	Emr pwr source elec vad, rep		A					
Q0491	Emr pwr source combo vad rep		A					
Q0492	Emr pwr cbl elec vad, rep		A					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
Q0493	Emr pwr cbl combo vad, rep		A					
Q0494	Emr hd pmp elec/combo, rep		A					
Q0495	Charger elec/combo vad, rep		A					
Q0496	Battery elec/combo vad, rep		A					
Q0497	Bat clps elec/comb vad, rep		A					
Q0498	Holster elec/combo vad, rep		A					
Q0499	Belt/vest elec/combo vad rep		A					
Q0500	Filters elec/combo vad, rep		A					
Q0501	Shwr cov elec/combo vad, rep		A					
Q0502	Mobility cart pneum vad, rep		A					
Q0503	Battery pneum vad replacemnt		A					
Q0504	Pwr adpt pneum vad, rep veh		A					
Q0505	Miscl supply/accessory vad		A					
Q0510	Dispens fee immunosupressive		B					
Q0511	Sup fee antiem,antica,immuno		B					
Q0512	Px sup fee anti-can sub pres		B					
Q0513	Disp fee inhal drugs/30 days		B					
Q0514	Disp fee inhal drugs/90 days		B					
Q0515	Sermorelin acetate injection		K	3050		$1.72		$0.35
Q1003	Ntiol category 3		N					
Q1004	Ntiol category 4		E					
Q1005	Ntiol category 5		E					
Q2004	Bladder calculi irrig sol		N					
Q2009	Fosphenytoin, 50 mg	CH	N					
Q2017	Teniposide, 50 mg		K	7035		$281.98		$56.40
Q3001	Brachytherapy Radioelements		B					
Q3014	Telehealth facility fee		A					
Q3025	IM inj interferon beta 1-a		K	9022		$129.80		$25.96
Q3026	Subc inj interferon beta-1a		E					
Q3031	Collagen skin test		N					
Q4001	Cast sup body cast plaster		B					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
Q4002	Cast sup body cast fiberglas		B					
Q4003	Cast sup shoulder cast plstr		B					
Q4004	Cast sup shoulder cast fbrgl		B					
Q4005	Cast sup long arm adult plst		B					
Q4006	Cast sup long arm adult fbrg		B					
Q4007	Cast sup long arm ped plster		B					
Q4008	Cast sup long arm ped fbrgls		B					
Q4009	Cast sup sht arm adult plstr		B					
Q4010	Cast sup sht arm adult fbrgl		B					
Q4011	Cast sup sht arm ped plaster		B					
Q4012	Cast sup sht arm ped fbrglas		B					
Q4013	Cast sup gauntlet plaster		B					
Q4014	Cast sup gauntlet fiberglass		B					
Q4015	Cast sup gauntlet ped plster		B					
Q4016	Cast sup gauntlet ped fbrgls		B					
Q4017	Cast sup lng arm splint plst		B					
Q4018	Cast sup lng arm splint fbrg		B					
Q4019	Cast sup lng arm splnt ped p		B					
Q4020	Cast sup lng arm splnt ped f		B					
Q4021	Cast sup sht arm splint plst		B					
Q4022	Cast sup sht arm splint fbrg		B					
Q4023	Cast sup sht arm splnt ped p		B					
Q4024	Cast sup sht arm splnt ped f		B					
Q4025	Cast sup hip spica plaster		B					
Q4026	Cast sup hip spica fiberglas		B					
Q4027	Cast sup hip spica ped plstr		B					
Q4028	Cast sup hip spica ped fbrgl		B					
Q4029	Cast sup long leg plaster		B					
Q4030	Cast sup long leg fiberglass		B					
Q4031	Cast sup lng leg ped plaster		B					
Q4032	Cast sup lng leg ped fbrgls		B					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
Q4033	Cast sup lng leg cylinder pl		B					
Q4034	Cast sup lng leg cylinder fb		B					
Q4035	Cast sup lngleg cylndr ped p		B					
Q4036	Cast sup lngleg cylndr ped f		B					
Q4037	Cast sup shrt leg plaster		B					
Q4038	Cast sup shrt leg fiberglass		B					
Q4039	Cast sup shrt leg ped plster		B					
Q4040	Cast sup shrt leg ped fbrgls		B					
Q4041	Cast sup lng leg splnt plstr		B					
Q4042	Cast sup lng leg splnt fbrgl		B					
Q4043	Cast sup lng leg splnt ped p		B					
Q4044	Cast sup lng leg splnt ped f		B					
Q4045	Cast sup sht leg splnt plstr		B					
Q4046	Cast sup sht leg splnt fbrgl		B					
Q4047	Cast sup sht leg splnt ped p		B					
Q4048	Cast sup sht leg splnt ped f		B					
Q4049	Finger splint, static		B					
Q4050	Cast supplies unlisted		B					
Q4051	Splint supplies misc		B					
Q4080	Iloprost non-comp unit dose		Y					
Q4081	Epoetin alfa, 100 units ESRD		A					
Q4082	Drug/bio NOC part B drug CAP		B					
Q4096	VWF complex, not Humate-P		K	1213		$0.64		$0.13
Q4097	Inj IVIG Privigen 500 mg		K	1214		$33.54		$6.71
Q4098	Inj iron dextran		K	1215		$11.38		$2.28
Q5001	Hospice in patient home		B					
Q5002	Hospice in assisted living		B					
Q5003	Hospice in LT/non-skilled NF		B					
Q5004	Hospice in SNF		B					
Q5005	Hospice, inpatient hospital		B					
Q5006	Hospice in hospice facility		B					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
Q5007	Hospice in LTCH		B					
Q5008	Hospice in inpatient psych		B					
Q5009	Hospice care, NOS		B					
Q9951	LOCM >= 400 mg/ml iodine,1ml		N					
Q9953	Inj Fe-based MR contrast,1ml		N					
Q9954	Oral MR contrast, 100 ml		N					
Q9955	Inj perflexane lip micros,ml		N					
Q9956	Inj octafluoropropane mic,ml		N					
Q9957	Inj perflutren lip micros,ml		N					
Q9958	HOCM <=149 mg/ml iodine, 1ml		N					
Q9959	HOCM 150-199mg/ml iodine,1ml		N					
Q9960	HOCM 200-249mg/ml iodine,1ml		N					
Q9961	HOCM 250-299mg/ml iodine,1ml		N					
Q9962	HOCM 300-349mg/ml iodine,1ml		N					
Q9963	HOCM 350-399mg/ml iodine,1ml		N					
Q9964	HOCM>= 400mg/ml iodine, 1ml		N					
Q9965	LOCM 100-199mg/ml iodine,1ml		N					
Q9966	LOCM 200-299mg/ml iodine,1ml		N					
Q9967	LOCM 300-399mg/ml iodine,1ml		N					
R0070	Transport portable x-ray		B					
R0075	Transport port x-ray multipl		B					
R0076	Transport portable EKG		B					
V2020	Vision svcs frames purchases		A					
V2025	Eyeglasses delux frames		E					
V2100	Lens spher single plano 4.00		A					
V2101	Single visn sphere 4.12-7.00		A					
V2102	Singl visn sphere 7.12-20.00		A					
V2103	Spherocylindr 4.00d/12-2.00d		A					
V2104	Spherocylindr 4.00d/2.12-4d		A					
V2105	Spherocylinder 4.00d/4.25-6d		A					
V2106	Spherocylinder 4.00d/>6.00d		A					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
V2107	Spherocylinder 4.25d/12-2d		A					
V2108	Spherocylinder 4.25d/2.12-4d		A					
V2109	Spherocylinder 4.25d/4.25-6d		A					
V2110	Spherocylinder 4.25d/over 6d		A					
V2111	Spherocylindr 7.25d/.25-2.25		A					
V2112	Spherocylindr 7.25d/2.25-4d		A					
V2113	Spherocylindr 7.25d/4.25-6d		A					
V2114	Spherocylinder over 12.00d		A					
V2115	Lens lenticular bifocal		A					
V2118	Lens aniseikonic single		A					
V2121	Lenticular lens, single		A					
V2199	Lens single vision not oth c		A					
V2200	Lens spher bifoc plano 4.00d		A					
V2201	Lens sphere bifocal 4.12-7.0		A					
V2202	Lens sphere bifocal 7.12-20.		A					
V2203	Lens sphcyl bifocal 4.00d/.1		A					
V2204	Lens sphcy bifocal 4.00d/2.1		A					
V2205	Lens sphcy bifocal 4.00d/4.2		A					
V2206	Lens sphcy bifocal 4.00d/ove		A					
V2207	Lens sphcy bifocal 4.25-7d/.		A					
V2208	Lens sphcy bifocal 4.25-7/2.		A					
V2209	Lens sphcy bifocal 4.25-7/4.		A					
V2210	Lens sphcy bifocal 4.25-7/ov		A					
V2211	Lens sphcy bifo 7.25-12/.25-		A					
V2212	Lens sphcyl bifo 7.25-12/2.2		A					
V2213	Lens sphcyl bifo 7.25-12/4.2		A					
V2214	Lens sphcyl bifocal over 12.		A					
V2215	Lens lenticular bifocal		A					
V2218	Lens aniseikonic bifocal		A					
V2219	Lens bifocal seg width over		A					
V2220	Lens bifocal add over 3.25d		A					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
V2221	Lenticular lens, bifocal		A					
V2299	Lens bifocal speciality		A					
V2300	Lens sphere trifocal 4.00d		A					
V2301	Lens sphere trifocal 4.12-7.		A					
V2302	Lens sphere trifocal 7.12-20		A					
V2303	Lens sphcy trifocal 4.0/.12-		A					
V2304	Lens sphcy trifocal 4.0/2.25		A					
V2305	Lens sphcy trifocal 4.0/4.25		A					
V2306	Lens sphcyl trifocal 4.00/>6		A					
V2307	Lens sphcy trifocal 4.25-7/.		A					
V2308	Lens sphc trifocal 4.25-7/2.		A					
V2309	Lens sphc trifocal 4.25-7/4.		A					
V2310	Lens sphc trifocal 4.25-7/>6		A					
V2311	Lens sphc trifo 7.25-12/.25-		A					
V2312	Lens sphc trifo 7.25-12/2.25		A					
V2313	Lens sphc trifo 7.25-12/4.25		A					
V2314	Lens sphcyl trifocal over 12		A					
V2315	Lens lenticular trifocal		A					
V2318	Lens aniseikonic trifocal		A					
V2319	Lens trifocal seg width > 28		A					
V2320	Lens trifocal add over 3.25d		A					
V2321	Lenticular lens, trifocal		A					
V2399	Lens trifocal speciality		A					
V2410	Lens variab asphericity sing		A					
V2430	Lens variable asphericity bi		A					
V2499	Variable asphericity lens		A					
V2500	Contact lens pmma spherical		A					
V2501	Cntct lens pmma-toric/prism		A					
V2502	Contact lens pmma bifocal		A					
V2503	Cntct lens pmma color vision		A					
V2510	Cntct gas permeable spherical		A					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
V2511	Cntct toric prism ballast		A					
V2512	Cntct lens gas permbl bifocl		A					
V2513	Contact lens extended wear		A					
V2520	Contact lens hydrophilic		A					
V2521	Cntct lens hydrophilic toric		A					
V2522	Cntct lens hydrophil bifocl		A					
V2523	Cntct lens hydrophil extend		A					
V2530	Contact lens gas impermeable		A					
V2531	Contact lens gas permeable		A					
V2599	Contact lens/es other type		A					
V2600	Hand held low vision aids		A					
V2610	Single lens spectacle mount		A					
V2615	Telescop/othr compound lens		A					
V2623	Plastic eye prosth custom		A					
V2624	Polishing artifical eye		A					
V2625	Enlargemnt of eye prosthesis		A					
V2626	Reduction of eye prosthesis		A					
V2627	Scleral cover shell		A					
V2628	Fabrication & fitting		A					
V2629	Prosthetic eye other type		A					
V2630	Anter chamber intraocul lens		N					
V2631	Iris support intraoclr lens		N					
V2632	Post chmbr intraocular lens		N					
V2700	Balance lens		A					
V2702	Deluxe lens feature		E					
V2710	Glass/plastic slab off prism		A					
V2715	Prism lens/es		A					
V2718	Fresnell prism press-on lens		A					
V2730	Special base curve		A					
V2744	Tint photochromatic lens/es		A					
V2745	Tint, any color/solid/grad		A					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
V2750	Anti-reflective coating		A					
V2755	UV lens/es		A					
V2756	Eye glass case		E					
V2760	Scratch resistant coating		A					
V2761	Mirror coating		B					
V2762	Polarization, any lens		A					
V2770	Occluder lens/es		A					
V2780	Oversize lens/es		A					
V2781	Progressive lens per lens		B					
V2782	Lens, 1.54-1.65 p/1.60-1.79g		A					
V2783	Lens, >= 1.66 p/>=1.80 g		A					
V2784	Lens polycarb or equal		A					
V2785	Corneal tissue processing		F					
V2786	Occupational multifocal lens		A					
V2787	Astigmatism-correct function		E					
V2788	Presbyopia-correct function		E					
V2790	Amniotic membrane		N					
V2797	Vis item/svc in other code		A					
V2799	Miscellaneous vision service		A					
V5008	Hearing screening		E					
V5010	Assessment for hearing aid		E					
V5011	Hearing aid fitting/checking		E					
V5014	Hearing aid repair/modifying		E					
V5020	Conformity evaluation		E					
V5030	Body-worn hearing aid air		E					
V5040	Body-worn hearing aid bone		E					
V5050	Hearing aid monaural in ear		E					
V5060	Behind ear hearing aid		E					
V5070	Glasses air conduction		E					
V5080	Glasses bone conduction		E					
V5090	Hearing aid dispensing fee		E					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
V5095	Implant mid ear hearing pros		E					
V5100	Body-worn bilat hearing aid		E					
V5110	Hearing aid dispensing fee		E					
V5120	Body-worn binaur hearing aid		E					
V5130	In ear binaural hearing aid		E					
V5140	Behind ear binaur hearing ai		E					
V5150	Glasses binaural hearing aid		E					
V5160	Dispensing fee binaural		E					
V5170	Within ear cros hearing aid		E					
V5180	Behind ear cros hearing aid		E					
V5190	Glasses cros hearing aid		E					
V5200	Cros hearing aid dispens fee		E					
V5210	In ear bicros hearing aid		E					
V5220	Behind ear bicros hearing ai		E					
V5230	Glasses bicros hearing aid		E					
V5240	Dispensing fee bicros		E					
V5241	Dispensing fee, monaural		E					
V5242	Hearing aid, monaural, cic		E					
V5243	Hearing aid, monaural, itc		E					
V5244	Hearing aid, prog, mon, cic		E					
V5245	Hearing aid, prog, mon, itc		E					
V5246	Hearing aid, prog, mon, ite		E					
V5247	Hearing aid, prog, mon, bte		E					
V5248	Hearing aid, binaural, cic		E					
V5249	Hearing aid, binaural, itc		E					
V5250	Hearing aid, prog, bin, cic		E					
V5251	Hearing aid, prog, bin, itc		E					
V5252	Hearing aid, prog, bin, ite		E					
V5253	Hearing aid, prog, bin, bte		E					
V5254	Hearing id, digit, mon, cic		E					
V5255	Hearing aid, digit, mon, itc		E					

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
V5256	Hearing aid, digit, mon, ite		E					
V5257	Hearing aid, digit, mon, bte		E					
V5258	Hearing aid, digit, bin, cic		E					
V5259	Hearing aid, digit, bin, itc		E					
V5260	Hearing aid, digit, bin, ite		E					
V5261	Hearing aid, digit, bin, bte		E					
V5262	Hearing aid, disp, monaural		E					
V5263	Hearing aid, disp, binaural		E					
V5264	Ear mold/insert		E					
V5265	Ear mold/insert, disp		E					
V5266	Battery for hearing device		E					
V5267	Hearing aid supply/accessory		E					
V5268	ALD Telephone Amplifier		E					
V5269	Alerting device, any type		E					
V5270	ALD, TV amplifier, any type		E					
V5271	ALD, TV caption decoder		E					
V5272	Tdd		E					
V5273	ALD for cochlear implant		E					
V5274	ALD unspecified		E					
V5275	Ear impression		E					
V5298	Hearing aid noc		E					
V5299	Hearing service		B					
V5336	Repair communication device		E					
V5362	Speech screening		E					
V5363	Language screening		E					
V5364	Dysphagia screening		E					

ADDENDUM BB.--PROPOSED ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2009 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Comment Indicator	Payment Indicator	CY 2009 Second Year Transition Payment Weight	CY 2009 Second Year Transition Payment
0028T	Dexa body composition study		N1		
0042T	Ct perfusion w/contrast, cbf		N1		
0067T	Ct colonography;dx		Z2	2.9160	$120.68
0071T	U/s leiomyomata ablate <200		Z2	54.4100	$2,251.68
0072T	U/s leiomyomata ablate >200		Z2	54.4100	$2,251.68
0073T	Delivery, comp imrt		Z2	5.3910	$223.09
0126T	Chd risk imt study		N1		
0144T	Ct heart wo dye; qual calc		Z2	1.5720	$65.05
0145T	Ct heart w/wo dye funct		Z2	4.2210	$174.69
0146T	Ccta w/wo dye		Z2	4.2210	$174.69
0147T	Ccta w/wo, quan calcium		Z2	4.2210	$174.69
0148T	Ccta w/wo, strxr		Z2	4.2210	$174.69
0149T	Ccta w/wo, strxr quan calc		Z2	4.2210	$174.69
0150T	Ccta w/wo, disease strxr		Z2	4.2210	$174.69
0151T	Ct heart funct add-on		Z2	1.5720	$65.05
0159T	Cad breast mri		N1		
0174T	Cad cxr with interp		N1		
0175T	Cad cxr remote		N1		
0182T	Hdr elect brachytherapy		Z2	25.9850	$1,075.35
0185T	Comptr probability analysis		N1		
70010	Contrast x-ray of brain		N1		
70015	Contrast x-ray of brain		N1		
70030	X-ray eye for foreign body		Z3	0.4050	$16.76
70100	X-ray exam of jaw		Z3	0.4440	$18.37
70110	X-ray exam of jaw		Z3	0.5450	$22.56
70120	X-ray exam of mastoids		Z3	0.4990	$20.63
70130	X-ray exam of mastoids		Z2	0.6810	$28.17
70134	X-ray exam of middle ear		Z3	0.6080	$25.14
70140	X-ray exam of facial bones		Z3	0.4050	$16.76
70150	X-ray exam of facial bones	CH	Z3	0.6080	$25.14
70160	X-ray exam of nasal bones		Z3	0.4830	$19.98
70170	X-ray exam of tear duct		N1		
70190	X-ray exam of eye sockets		Z3	0.5060	$20.95
70200	X-ray exam of eye sockets	CH	Z3	0.6150	$25.46
70210	X-ray exam of sinuses		Z3	0.4360	$18.05
70220	X-ray exam of sinuses		Z3	0.5370	$22.24
70240	X-ray exam, pituitary saddle		Z3	0.4050	$16.76

Note: the Medicare program payment is 80 percent of the total payment amount and beneficiary coinsurance is 20 percent of the total payment amount, except for screening flexible sigmoidoscopies and screening colonoscopies for which the program payment is 75 percent and the beneficiary coinsurance is 25 percent.

HCPCS Code	Short Descriptor	Comment Indicator	Payment Indicator	CY 2009 Second Year Transition Payment Weight	CY 2009 Second Year Transition Payment
70250	X-ray exam of skull		Z3	0.4910	$20.30
70260	X-ray exam of skull		Z3	0.6230	$25.78
70300	X-ray exam of teeth		Z3	0.1710	$7.09
70310	X-ray exam of teeth	CH	Z2	0.5230	$21.63
70320	Full mouth x-ray of teeth		Z2	0.5230	$21.63
70328	X-ray exam of jaw joint		Z3	0.4280	$17.73
70330	X-ray exam of jaw joints		Z2	0.6810	$28.17
70332	X-ray exam of jaw joint		N1		
70336	Magnetic image, jaw joint		Z2	5.2940	$219.10
70350	X-ray head for orthodontia		Z3	0.2340	$9.67
70355	Panoramic x-ray of jaws		Z3	0.2490	$10.31
70360	X-ray exam of neck		Z3	0.3820	$15.79
70370	Throat x-ray & fluoroscopy		Z3	1.2070	$49.95
70371	Speech evaluation, complex	CH	Z3	1.1290	$46.73
70373	Contrast x-ray of larynx		N1		
70380	X-ray exam of salivary gland		Z3	0.5840	$24.17
70390	X-ray exam of salivary duct		N1		
70450	Ct head/brain w/o dye		Z2	2.9160	$120.68
70460	Ct head/brain w/dye		Z2	4.6100	$190.78
70470	Ct head/brain w/o & w/dye		Z2	5.1320	$212.38
70480	Ct orbit/ear/fossa w/o dye		Z2	2.9160	$120.68
70481	Ct orbit/ear/fossa w/dye		Z2	4.6100	$190.78
70482	Ct orbit/ear/fossa w/o&w/dye		Z2	5.1320	$212.38
70486	Ct maxillofacial w/o dye		Z2	2.9160	$120.68
70487	Ct maxillofacial w/dye		Z2	4.6100	$190.78
70488	Ct maxillofacial w/o & w/dye		Z2	5.1320	$212.38
70490	Ct soft tissue neck w/o dye		Z2	2.9160	$120.68
70491	Ct soft tissue neck w/dye		Z2	4.6100	$190.78
70492	Ct sft tsue nck w/o & w/dye		Z2	5.1320	$212.38
70496	Ct angiography, head		Z2	5.3100	$219.76
70498	Ct angiography, neck		Z2	5.3100	$219.76
70540	Mri orbit/face/neck w/o dye		Z2	5.2940	$219.10
70542	Mri orbit/face/neck w/dye		Z2	6.4120	$265.37
70543	Mri orbt/fac/nck w/o & w/dye		Z2	8.1120	$335.70
70544	Mr angiography head w/o dye		Z2	5.2940	$219.10
70545	Mr angiography head w/dye		Z2	6.4120	$265.37
70546	Mr angiograph head w/o&w/dye		Z2	8.1120	$335.70
70547	Mr angiography neck w/o dye		Z2	5.2940	$219.10
70548	Mr angiography neck w/dye		Z2	6.4120	$265.37
70549	Mr angiograph neck w/o&w/dye		Z2	8.1120	$335.70
70551	Mri brain w/o dye		Z2	5.2940	$219.10

Note: the Medicare program payment is 80 percent of the total payment amount and beneficiary coinsurance is 20 percent of the total payment amount, except for screening flexible sigmoidoscopies and screening colonoscopies for which the program payment is 75 percent and the beneficiary coinsurance is 25 percent.

HCPCS Code	Short Descriptor	Comment Indicator	Payment Indicator	CY 2009 Second Year Transition Payment Weight	CY 2009 Second Year Transition Payment
70552	Mri brain w/dye		Z2	6.4120	$265.37
70553	Mri brain w/o & w/dye		Z2	8.1120	$335.70
70554	Fmri brain by tech		Z2	5.2940	$219.10
70555	Fmri brain by phys/psych		Z2	5.2940	$219.10
70557	Mri brain w/o dye		Z2	5.2940	$219.10
70558	Mri brain w/dye		Z2	6.4120	$265.37
70559	Mri brain w/o & w/dye		Z2	8.1120	$335.70
71010	Chest x-ray		Z3	0.3120	$12.89
71015	Chest x-ray		Z3	0.3970	$16.44
71020	Chest x-ray		Z3	0.4210	$17.40
71021	Chest x-ray		Z3	0.5060	$20.95
71022	Chest x-ray	CH	Z3	0.6310	$26.11
71023	Chest x-ray and fluoroscopy		Z3	0.9970	$41.25
71030	Chest x-ray	CH	Z3	0.6310	$26.11
71034	Chest x-ray and fluoroscopy		Z2	1.2660	$52.41
71035	Chest x-ray		Z3	0.5300	$21.92
71040	Contrast x-ray of bronchi		N1		
71060	Contrast x-ray of bronchi		N1		
71090	X-ray & pacemaker insertion		N1		
71100	X-ray exam of ribs		Z3	0.4360	$18.05
71101	X-ray exam of ribs/chest		Z3	0.5300	$21.92
71110	X-ray exam of ribs		Z3	0.5610	$23.20
71111	X-ray exam of ribs/chest		Z3	0.7400	$30.62
71120	X-ray exam of breastbone		Z3	0.4590	$19.01
71130	X-ray exam of breastbone		Z3	0.5450	$22.56
71250	Ct thorax w/o dye		Z2	2.9160	$120.68
71260	Ct thorax w/dye		Z2	4.6100	$190.78
71270	Ct thorax w/o & w/dye		Z2	5.1320	$212.38
71275	Ct angiography, chest		Z2	5.3100	$219.76
71550	Mri chest w/o dye		Z2	5.2940	$219.10
71551	Mri chest w/dye		Z2	6.4120	$265.37
71552	Mri chest w/o & w/dye		Z2	8.1120	$335.70
72010	X-ray exam of spine	CH	Z3	0.9740	$40.29
72020	X-ray exam of spine		Z3	0.3270	$13.54
72040	X-ray exam of neck spine		Z3	0.5300	$21.92
72050	X-ray exam of neck spine		Z3	0.7480	$30.94
72052	X-ray exam of neck spine		Z3	0.9740	$40.29
72069	X-ray exam of trunk spine		Z3	0.4990	$20.63
72070	X-ray exam of thoracic spine		Z3	0.4590	$19.01
72072	X-ray exam of thoracic spine		Z3	0.5530	$22.88
72074	X-ray exam of thoracic spine		Z2	0.6810	$28.17

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72080	X-ray exam of trunk spine		Z3	0.4990	$20.63
72090	X-ray exam of trunk spine		Z3	0.6620	$27.39
72100	X-ray exam of lower spine		Z3	0.5690	$23.53
72110	X-ray exam of lower spine		Z3	0.7870	$32.55
72114	X-ray exam of lower spine	CH	Z3	1.0830	$44.80
72120	X-ray exam of lower spine		Z3	0.7630	$31.58
72125	Ct neck spine w/o dye		Z2	2.9160	$120.68
72126	Ct neck spine w/dye		Z2	4.6100	$190.78
72127	Ct neck spine w/o & w/dye		Z2	5.1320	$212.38
72128	Ct chest spine w/o dye		Z2	2.9160	$120.68
72129	Ct chest spine w/dye		Z2	4.6100	$190.78
72130	Ct chest spine w/o & w/dye		Z2	5.1320	$212.38
72131	Ct lumbar spine w/o dye		Z2	2.9160	$120.68
72132	Ct lumbar spine w/dye		Z2	4.6100	$190.78
72133	Ct lumbar spine w/o & w/dye		Z2	5.1320	$212.38
72141	Mri neck spine w/o dye		Z2	5.2940	$219.10
72142	Mri neck spine w/dye		Z2	6.4120	$265.37
72146	Mri chest spine w/o dye		Z2	5.2940	$219.10
72147	Mri chest spine w/dye		Z2	6.4120	$265.37
72148	Mri lumbar spine w/o dye		Z2	5.2940	$219.10
72149	Mri lumbar spine w/dye		Z2	6.4120	$265.37
72156	Mri neck spine w/o & w/dye		Z2	8.1120	$335.70
72157	Mri chest spine w/o & w/dye		Z2	8.1120	$335.70
72158	Mri lumbar spine w/o & w/dye		Z2	8.1120	$335.70
72170	X-ray exam of pelvis		Z3	0.3580	$14.83
72190	X-ray exam of pelvis		Z3	0.5840	$24.17
72191	Ct angiograph pelv w/o&w/dye		Z2	5.3100	$219.76
72192	Ct pelvis w/o dye		Z2	2.9160	$120.68
72193	Ct pelvis w/dye		Z2	4.6100	$190.78
72194	Ct pelvis w/o & w/dye		Z2	5.1320	$212.38
72195	Mri pelvis w/o dye		Z2	5.2940	$219.10
72196	Mri pelvis w/dye		Z2	6.4120	$265.37
72197	Mri pelvis w/o & w/dye		Z2	8.1120	$335.70
72200	X-ray exam sacroiliac joints		Z3	0.4210	$17.40
72202	X-ray exam sacroiliac joints		Z3	0.5140	$21.27
72220	X-ray exam of tailbone		Z3	0.4210	$17.40
72240	Contrast x-ray of neck spine		N1		
72255	Contrast x-ray, thorax spine		N1		
72265	Contrast x-ray, lower spine		N1		
72270	Contrast x-ray, spine		N1		
72275	Epidurography		N1		

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72285	X-ray c/t spine disk		N1		
72291	Perq vertebroplasty, fluor		N1		
72292	Perq vertebroplasty, ct		N1		
72295	X-ray of lower spine disk		N1		
73000	X-ray exam of collar bone		Z3	0.3970	$16.44
73010	X-ray exam of shoulder blade		Z3	0.4130	$17.08
73020	X-ray exam of shoulder		Z3	0.3190	$13.21
73030	X-ray exam of shoulder		Z3	0.4130	$17.08
73040	Contrast x-ray of shoulder		N1		
73050	X-ray exam of shoulders		Z3	0.5220	$21.59
73060	X-ray exam of humerus		Z3	0.4130	$17.08
73070	X-ray exam of elbow		Z3	0.3970	$16.44
73080	X-ray exam of elbow		Z3	0.5220	$21.59
73085	Contrast x-ray of elbow		N1		
73090	X-ray exam of forearm		Z3	0.3970	$16.44
73092	X-ray exam of arm, infant		Z3	0.4130	$17.08
73100	X-ray exam of wrist		Z3	0.4130	$17.08
73110	X-ray exam of wrist		Z3	0.5300	$21.92
73115	Contrast x-ray of wrist		N1		
73120	X-ray exam of hand		Z3	0.3890	$16.11
73130	X-ray exam of hand		Z3	0.4590	$19.01
73140	X-ray exam of finger(s)		Z3	0.4590	$19.01
73200	Ct upper extremity w/o dye		Z2	2.9160	$120.68
73201	Ct upper extremity w/dye		Z2	4.6100	$190.78
73202	Ct uppr extremity w/o&w/dye		Z2	5.1320	$212.38
73206	Ct angio upr extrm w/o&w/dye		Z2	5.3100	$219.76
73218	Mri upper extremity w/o dye		Z2	5.2940	$219.10
73219	Mri upper extremity w/dye		Z2	6.4120	$265.37
73220	Mri uppr extremity w/o&w/dye		Z2	8.1120	$335.70
73221	Mri joint upr extrem w/o dye		Z2	5.2940	$219.10
73222	Mri joint upr extrem w/dye		Z2	6.4120	$265.37
73223	Mri joint upr extr w/o&w/dye		Z2	8.1120	$335.70
73500	X-ray exam of hip		Z3	0.3430	$14.18
73510	X-ray exam of hip		Z3	0.5220	$21.59
73520	X-ray exam of hips		Z3	0.5450	$22.56
73525	Contrast x-ray of hip		N1		
73530	X-ray exam of hip		N1		
73540	X-ray exam of pelvis & hips		Z3	0.5450	$22.56
73542	X-ray exam, sacroiliac joint		N1		
73550	X-ray exam of thigh		Z3	0.3970	$16.44
73560	X-ray exam of knee, 1 or 2		Z3	0.4130	$17.08

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73562	X-ray exam of knee, 3		Z3	0.4990	$20.63
73564	X-ray exam, knee, 4 or more		Z3	0.5840	$24.17
73565	X-ray exam of knees		Z3	0.4360	$18.05
73580	Contrast x-ray of knee joint		N1		
73590	X-ray exam of lower leg		Z3	0.3820	$15.79
73592	X-ray exam of leg, infant		Z3	0.4130	$17.08
73600	X-ray exam of ankle		Z3	0.3890	$16.11
73610	X-ray exam of ankle		Z3	0.4670	$19.34
73615	Contrast x-ray of ankle		N1		
73620	X-ray exam of foot		Z3	0.3820	$15.79
73630	X-ray exam of foot		Z3	0.4590	$19.01
73650	X-ray exam of heel		Z3	0.3820	$15.79
73660	X-ray exam of toe(s)		Z3	0.4280	$17.73
73700	Ct lower extremity w/o dye		Z2	2.9160	$120.68
73701	Ct lower extremity w/dye		Z2	4.6100	$190.78
73702	Ct lwr extremity w/o&w/dye		Z2	5.1320	$212.38
73706	Ct angio lwr extr w/o&w/dye		Z2	5.3100	$219.76
73718	Mri lower extremity w/o dye		Z2	5.2940	$219.10
73719	Mri lower extremity w/dye		Z2	6.4120	$265.37
73720	Mri lwr extremity w/o&w/dye		Z2	8.1120	$335.70
73721	Mri jnt of lwr extre w/o dye		Z2	5.2940	$219.10
73722	Mri joint of lwr extr w/dye		Z2	6.4120	$265.37
73723	Mri joint lwr extr w/o&w/dye		Z2	8.1120	$335.70
74000	X-ray exam of abdomen		Z3	0.3430	$14.18
74010	X-ray exam of abdomen		Z3	0.5300	$21.92
74020	X-ray exam of abdomen		Z3	0.5450	$22.56
74022	X-ray exam series, abdomen		Z3	0.6620	$27.39
74150	Ct abdomen w/o dye		Z2	2.9160	$120.68
74160	Ct abdomen w/dye		Z2	4.6100	$190.78
74170	Ct abdomen w/o & w/dye		Z2	5.1320	$212.38
74175	Ct angio abdom w/o & w/dye		Z2	5.3100	$219.76
74181	Mri abdomen w/o dye		Z2	5.2940	$219.10
74182	Mri abdomen w/dye		Z2	6.4120	$265.37
74183	Mri abdomen w/o & w/dye		Z2	8.1120	$335.70
74190	X-ray exam of peritoneum		N1		
74210	Contrst x-ray exam of throat		Z3	1.2070	$49.95
74220	Contrast x-ray, esophagus		Z2	1.3380	$55.36
74230	Cine/vid x-ray, throat/esoph		Z2	1.3380	$55.36
74235	Remove esophagus obstruction		N1		
74240	X-ray exam, upper gi tract		Z2	1.3380	$55.36
74241	X-ray exam, upper gi tract		Z2	1.3380	$55.36

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74245	X-ray exam, upper gi tract		Z2	2.1730	$89.92
74246	Contrst x-ray uppr gi tract		Z2	1.3380	$55.36
74247	Contrst x-ray uppr gi tract		Z2	1.3380	$55.36
74249	Contrst x-ray uppr gi tract		Z2	2.1730	$89.92
74250	X-ray exam of small bowel		Z2	1.3380	$55.36
74251	X-ray exam of small bowel		Z2	2.1730	$89.92
74260	X-ray exam of small bowel		Z2	1.3380	$55.36
74270	Contrast x-ray exam of colon		Z2	1.3380	$55.36
74280	Contrast x-ray exam of colon		Z2	2.1730	$89.92
74283	Contrast x-ray exam of colon		Z2	1.3380	$55.36
74290	Contrast x-ray, gallbladder		Z3	1.0130	$41.90
74291	Contrast x-rays, gallbladder		Z3	0.9810	$40.61
74300	X-ray bile ducts/pancreas		N1		
74301	X-rays at surgery add-on		N1		
74305	X-ray bile ducts/pancreas		N1		
74320	Contrast x-ray of bile ducts		N1		
74327	X-ray bile stone removal		N1		
74328	X-ray bile duct endoscopy		N1		
74329	X-ray for pancreas endoscopy		N1		
74330	X-ray bile/panc endoscopy		N1		
74340	X-ray guide for gi tube		N1		
74355	X-ray guide, intestinal tube		N1		
74360	X-ray guide, gi dilation		N1		
74363	X-ray, bile duct dilation		N1		
74400	Contrst x-ray, urinary tract		Z3	1.7600	$72.84
74410	Contrst x-ray, urinary tract		Z3	1.8770	$77.67
74415	Contrst x-ray, urinary tract		Z3	2.2430	$92.82
74420	Contrst x-ray, urinary tract		Z2	2.6070	$107.87
74425	Contrst x-ray, urinary tract		N1		
74430	Contrast x-ray, bladder		N1		
74440	X-ray, male genital tract		N1		
74445	X-ray exam of penis		N1		
74450	X-ray, urethra/bladder		N1		
74455	X-ray, urethra/bladder		N1		
74470	X-ray exam of kidney lesion		N1		
74475	X-ray control, cath insert		N1		
74480	X-ray control, cath insert		N1		
74485	X-ray guide, gu dilation		N1		
74710	X-ray measurement of pelvis		Z3	0.5300	$21.92
74740	X-ray, female genital tract		N1		
74742	X-ray, fallopian tube		N1		

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74775	X-ray exam of perineum		Z2	2.6070	$107.87
75557	Cardiac mri for morph		Z2	5.2940	$219.10
75559	Cardiac mri w/stress img		Z2	5.2940	$219.10
75561	Cardiac mri for morph w/dye		Z2	8.1120	$335.70
75563	Card mri w/stress img & dye		Z2	8.1120	$335.70
75600	Contrast x-ray exam of aorta		N1		
75605	Contrast x-ray exam of aorta		N1		
75625	Contrast x-ray exam of aorta		N1		
75630	X-ray aorta, leg arteries		N1		
75635	Ct angio abdominal arteries		N1		
75650	Artery x-rays, head & neck		N1		
75658	Artery x-rays, arm		N1		
75660	Artery x-rays, head & neck		N1		
75662	Artery x-rays, head & neck		N1		
75665	Artery x-rays, head & neck		N1		
75671	Artery x-rays, head & neck		N1		
75676	Artery x-rays, neck		N1		
75680	Artery x-rays, neck		N1		
75685	Artery x-rays, spine		N1		
75705	Artery x-rays, spine		N1		
75710	Artery x-rays, arm/leg		N1		
75716	Artery x-rays, arms/legs		N1		
75722	Artery x-rays, kidney		N1		
75724	Artery x-rays, kidneys		N1		
75726	Artery x-rays, abdomen		N1		
75731	Artery x-rays, adrenal gland		N1		
75733	Artery x-rays, adrenals		N1		
75736	Artery x-rays, pelvis		N1		
75741	Artery x-rays, lung		N1		
75743	Artery x-rays, lungs		N1		
75746	Artery x-rays, lung		N1		
75756	Artery x-rays, chest		N1		
75774	Artery x-ray, each vessel		N1		
75790	Visualize a-v shunt		N1		
75801	Lymph vessel x-ray, arm/leg		N1		
75803	Lymph vessel x-ray,arms/legs		N1		
75805	Lymph vessel x-ray, trunk		N1		
75807	Lymph vessel x-ray, trunk		N1		
75809	Nonvascular shunt, x-ray		N1		
75810	Vein x-ray, spleen/liver		N1		
75820	Vein x-ray, arm/leg		N1		

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75822	Vein x-ray, arms/legs		N1		
75825	Vein x-ray, trunk		N1		
75827	Vein x-ray, chest		N1		
75831	Vein x-ray, kidney		N1		
75833	Vein x-ray, kidneys		N1		
75840	Vein x-ray, adrenal gland		N1		
75842	Vein x-ray, adrenal glands		N1		
75860	Vein x-ray, neck		N1		
75870	Vein x-ray, skull		N1		
75872	Vein x-ray, skull		N1		
75880	Vein x-ray, eye socket		N1		
75885	Vein x-ray, liver		N1		
75887	Vein x-ray, liver		N1		
75889	Vein x-ray, liver		N1		
75891	Vein x-ray, liver		N1		
75893	Venous sampling by catheter		N1		
75894	X-rays, transcath therapy		N1		
75896	X-rays, transcath therapy		N1		
75898	Follow-up angiography		N1		
75901	Remove cva device obstruct		N1		
75902	Remove cva lumen obstruct		N1		
75940	X-ray placement, vein filter		N1		
75945	Intravascular us		N1		
75946	Intravascular us add-on		N1		
75960	Transcath iv stent rs&i		N1		
75961	Retrieval, broken catheter		N1		
75962	Repair arterial blockage		N1		
75964	Repair artery blockage, each		N1		
75966	Repair arterial blockage		N1		
75968	Repair artery blockage, each		N1		
75970	Vascular biopsy		N1		
75978	Repair venous blockage		N1		
75980	Contrast xray exam bile duct		N1		
75982	Contrast xray exam bile duct		N1		
75984	Xray control catheter change		N1		
75989	Abscess drainage under x-ray		N1		
75992	Atherectomy, x-ray exam		N1		
75993	Atherectomy, x-ray exam		N1		
75994	Atherectomy, x-ray exam		N1		
75995	Atherectomy, x-ray exam		N1		
75996	Atherectomy, x-ray exam		N1		

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76000	Fluoroscope examination		N1		
76001	Fluoroscope exam, extensive		N1		
76010	X-ray, nose to rectum		Z3	0.3890	$16.11
76080	X-ray exam of fistula		N1		
76098	X-ray exam, breast specimen		Z3	0.2410	$9.99
76100	X-ray exam of body section		Z2	1.1270	$46.64
76101	Complex body section x-ray		Z2	2.8900	$119.59
76102	Complex body section x-rays		Z2	2.8900	$119.59
76120	Cine/video x-rays		Z3	1.1840	$48.99
76125	Cine/video x-rays add-on		N1		
76150	X-ray exam, dry process		Z3	0.3890	$16.11
76350	Special x-ray contrast study		N1		
76376	3d render w/o postprocess		N1		
76377	3d rendering w/postprocess		N1		
76380	Cat scan follow-up study		Z2	1.5720	$65.05
76496	Fluoroscopic procedure		Z2	1.2660	$52.41
76497	Ct procedure		Z2	1.5720	$65.05
76498	Mri procedure		Z2	5.2940	$219.10
76499	Radiographic procedure		Z2	0.6810	$28.17
76506	Echo exam of head		Z2	0.9410	$38.93
76510	Ophth us, b & quant a		Z3	1.4250	$58.98
76511	Ophth us, quant a only		Z3	0.9970	$41.25
76512	Ophth us, b w/non-quant a		Z3	0.8410	$34.81
76513	Echo exam of eye, water bath		Z3	1.0280	$42.54
76514	Echo exam of eye, thickness		Z3	0.0700	$2.90
76516	Echo exam of eye	CH	Z3	0.8100	$33.52
76519	Echo exam of eye		Z3	0.9040	$37.39
76529	Echo exam of eye		Z3	0.7870	$32.55
76536	Us exam of head and neck		Z2	1.4690	$60.78
76604	Us exam, chest		Z2	0.9410	$38.93
76645	Us exam, breast(s)		Z2	0.9410	$38.93
76700	Us exam, abdom, complete		Z2	1.4690	$60.78
76705	Echo exam of abdomen		Z2	1.4690	$60.78
76770	Us exam abdo back wall, comp		Z2	1.4690	$60.78
76775	Us exam abdo back wall, lim		Z2	1.4690	$60.78
76776	Us exam k transpl w/doppler		Z2	1.4690	$60.78
76800	Us exam, spinal canal		Z2	1.4690	$60.78
76801	Ob us < 14 wks, single fetus		Z2	1.4690	$60.78
76802	Ob us < 14 wks, add'l fetus		Z3	0.6230	$25.78
76805	Ob us >/= 14 wks, sngl fetus		Z2	1.4690	$60.78
76810	Ob us >/= 14 wks, addl fetus		Z3	0.9970	$41.25

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76811	Ob us, detailed, sngl fetus	CH	Z3	2.1650	$89.60
76812	Ob us, detailed, addl fetus		Z2	0.9410	$38.93
76813	Ob us nuchal meas, 1 gest		Z2	0.9410	$38.93
76814	Ob us nuchal meas, add-on		Z3	0.6700	$27.72
76815	Ob us, limited, fetus(s)		Z2	0.9410	$38.93
76816	Ob us, follow-up, per fetus		Z2	0.9410	$38.93
76817	Transvaginal us, obstetric		Z2	0.9410	$38.93
76818	Fetal biophys profile w/nst		Z2	1.4690	$60.78
76819	Fetal biophys profil w/o nst		Z3	1.1370	$47.05
76820	Umbilical artery echo		Z3	0.5610	$23.20
76821	Middle cerebral artery echo	CH	Z3	1.2930	$53.50
76825	Echo exam of fetal heart		Z2	1.4690	$60.78
76826	Echo exam of fetal heart		Z2	0.9410	$38.93
76827	Echo exam of fetal heart	CH	Z3	0.8640	$35.77
76828	Echo exam of fetal heart		Z3	0.4990	$20.63
76830	Transvaginal us, non-ob		Z2	1.4690	$60.78
76831	Echo exam, uterus		Z3	1.7830	$73.80
76856	Us exam, pelvic, complete		Z2	1.4690	$60.78
76857	Us exam, pelvic, limited		Z2	0.9410	$38.93
76870	Us exam, scrotum		Z2	1.4690	$60.78
76872	Us, transrectal		Z2	1.4690	$60.78
76873	Echograp trans r, pros study		Z2	1.4690	$60.78
76880	Us exam, extremity		Z2	1.4690	$60.78
76885	Us exam infant hips, dynamic		Z2	0.9410	$38.93
76886	Us exam infant hips, static		Z2	0.9410	$38.93
76930	Echo guide, cardiocentesis		N1		
76932	Echo guide for heart biopsy		N1		
76936	Echo guide for artery repair		N1		
76937	Us guide, vascular access		N1		
76940	Us guide, tissue ablation		N1		
76941	Echo guide for transfusion		N1		
76942	Echo guide for biopsy		N1		
76945	Echo guide, villus sampling		N1		
76946	Echo guide for amniocentesis		N1		
76948	Echo guide, ova aspiration		N1		
76950	Echo guidance radiotherapy		N1		
76965	Echo guidance radiotherapy		N1		
76970	Ultrasound exam follow-up		Z2	0.9410	$38.93
76975	Gi endoscopic ultrasound		N1		
76977	Us bone density measure		Z3	0.2180	$9.02
76998	Us guide, intraop		N1		

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76999	Echo examination procedure		Z2	0.9410	$38.93
77001	Fluoroguide for vein device		N1		
77002	Needle localization by xray		N1		
77003	Fluoroguide for spine inject		N1		
77011	Ct scan for localization		N1		
77012	Ct scan for needle biopsy		N1		
77013	Ct guide for tissue ablation		N1		
77014	Ct scan for therapy guide		N1		
77021	Mr guidance for needle place		N1		
77022	Mri for tissue ablation		N1		
77031	Stereotact guide for brst bx		N1		
77032	Guidance for needle, breast		N1		
77053	X-ray of mammary duct		N1		
77054	X-ray of mammary ducts		N1		
77071	X-ray stress view		Z3	0.4830	$19.98
77072	X-rays for bone age		Z3	0.2880	$11.92
77073	X-rays, bone length studies		Z3	0.4830	$19.98
77074	X-rays, bone survey, limited		Z3	0.9500	$39.32
77075	X-rays, bone survey complete		Z2	1.1270	$46.64
77076	X-rays, bone survey, infant		Z2	1.1270	$46.64
77077	Joint survey, single view	CH	Z3	0.5370	$22.24
77078	Ct bone density, axial		Z2	1.0870	$44.98
77079	Ct bone density, peripheral	CH	Z3	0.9890	$40.93
77080	Dxa bone density, axial		Z2	1.0870	$44.98
77081	Dxa bone density/peripheral	CH	Z3	0.3890	$16.11
77082	Dxa bone density, vert fx		Z3	0.4210	$17.40
77083	Radiographic absorptiometry		Z3	0.3350	$13.86
77084	Magnetic image, bone marrow		Z2	5.2940	$219.10
77280	Set radiation therapy field		Z2	1.5230	$63.04
77285	Set radiation therapy field		Z2	3.8890	$160.93
77290	Set radiation therapy field		Z2	3.8890	$160.93
77295	Set radiation therapy field	CH	Z3	8.8860	$367.73
77299	Radiation therapy planning		Z2	1.5230	$63.04
77300	Radiation therapy dose plan		Z3	0.8250	$34.16
77301	Radiotherapy dose plan, imrt		Z2	13.3710	$553.35
77305	Teletx isodose plan simple		Z3	0.7480	$30.94
77310	Teletx isodose plan intermed		Z3	0.9810	$40.61
77315	Teletx isodose plan complex		Z3	1.4250	$58.98
77321	Special teletx port plan		Z3	1.4800	$61.23
77326	Brachytx isodose calc simp		Z2	1.5230	$63.04
77327	Brachytx isodose calc interm		Z3	2.7800	$115.06

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77328	Brachytx isodose plan compl	CH	Z3	3.5980	$148.90
77331	Special radiation dosimetry		Z3	0.3970	$16.44
77332	Radiation treatment aid(s)		Z3	1.0510	$43.51
77333	Radiation treatment aid(s)		Z3	0.5060	$20.95
77334	Radiation treatment aid(s)		Z3	1.9700	$81.54
77336	Radiation physics consult	CH	Z3	1.2380	$51.24
77370	Radiation physics consult		Z2	1.5230	$63.04
77371	Srs, multisource		Z3	25.1540	$1,040.98
77399	External radiation dosimetry		Z2	1.5230	$63.04
77401	Radiation treatment delivery		Z3	0.6150	$25.46
77402	Radiation treatment delivery		Z2	1.3620	$56.35
77403	Radiation treatment delivery		Z2	1.3620	$56.35
77404	Radiation treatment delivery		Z2	1.3620	$56.35
77406	Radiation treatment delivery		Z2	2.1770	$90.08
77407	Radiation treatment delivery		Z2	1.3620	$56.35
77408	Radiation treatment delivery		Z2	1.3620	$56.35
77409	Radiation treatment delivery		Z2	1.3620	$56.35
77411	Radiation treatment delivery		Z2	2.1770	$90.08
77412	Radiation treatment delivery		Z2	2.1770	$90.08
77413	Radiation treatment delivery		Z2	2.1770	$90.08
77414	Radiation treatment delivery		Z2	2.1770	$90.08
77416	Radiation treatment delivery		Z2	2.1770	$90.08
77417	Radiology port film(s)		N1		
77418	Radiation tx delivery, imrt		Z2	5.3910	$223.09
77421	Stereoscopic x-ray guidance		N1		
77422	Neutron beam tx, simple		Z2	2.1770	$90.08
77423	Neutron beam tx, complex		Z2	2.1770	$90.08
77435	Sbrt management		N1		
77470	Special radiation treatment		Z3	2.8970	$119.89
77520	Proton trmt, simple w/o comp		Z2	13.7280	$568.12
77522	Proton trmt, simple w/comp		Z2	13.7280	$568.12
77523	Proton trmt, intermediate		Z2	16.4060	$678.93
77525	Proton treatment, complex		Z2	16.4060	$678.93
77600	Hyperthermia treatment		Z2	5.6790	$235.02
77605	Hyperthermia treatment		Z2	5.6790	$235.02
77610	Hyperthermia treatment		Z2	5.6790	$235.02
77615	Hyperthermia treatment		Z2	5.6790	$235.02
77620	Hyperthermia treatment		Z2	5.6790	$235.02
77750	Infuse radioactive materials		Z3	1.9470	$80.57
77761	Apply intrcav radiat simple		Z3	3.4190	$141.48
77762	Apply intrcav radiat interm		Z3	4.0420	$167.27

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77763	Apply intrcav radiat compl		Z3	5.2180	$215.93
77776	Apply interstit radiat simpl		Z3	3.7070	$153.41
77777	Apply interstit radiat inter		Z3	4.0730	$168.56
77778	Apply interstit radiat compl		Z3	5.4050	$223.67
77781	High intensity brachytherapy		Z3	6.2850	$260.08
77782	High intensity brachytherapy	CH	Z3	10.7390	$444.43
77783	High intensity brachytherapy		Z2	11.1980	$463.43
77784	High intensity brachytherapy		Z2	11.1980	$463.43
77789	Apply surface radiation		Z3	1.0130	$41.90
77790	Radiation handling		N1		
77799	Radium/radioisotope therapy		Z2	7.7530	$320.85
78000	Thyroid, single uptake		Z3	1.2620	$52.21
78001	Thyroid, multiple uptakes		Z3	1.5810	$65.42
78003	Thyroid suppress/stimul		Z3	1.2690	$52.53
78006	Thyroid imaging with uptake		Z2	3.3350	$137.99
78007	Thyroid image, mult uptakes		Z3	2.2200	$91.85
78010	Thyroid imaging		Z2	2.0240	$83.74
78011	Thyroid imaging with flow		Z2	2.0240	$83.74
78015	Thyroid met imaging		Z3	3.5820	$148.25
78016	Thyroid met imaging/studies		Z2	4.5270	$187.35
78018	Thyroid met imaging, body		Z2	4.5270	$187.35
78020	Thyroid met uptake		N1		
78070	Parathyroid nuclear imaging		Z3	2.7490	$113.77
78075	Adrenal nuclear imaging		Z3	7.8270	$323.90
78099	Endocrine nuclear procedure		Z2	2.0240	$83.74
78102	Bone marrow imaging, ltd		Z3	2.7960	$115.70
78103	Bone marrow imaging, mult	CH	Z2	3.8460	$159.18
78104	Bone marrow imaging, body		Z2	3.8460	$159.18
78110	Plasma volume, single		Z3	1.4250	$58.98
78111	Plasma volume, multiple		Z3	1.7990	$74.45
78120	Red cell mass, single		Z3	1.5650	$64.78
78121	Red cell mass, multiple		Z3	1.8530	$76.70
78122	Blood volume		Z3	2.1880	$90.56
78130	Red cell survival study		Z3	2.5540	$105.71
78135	Red cell survival kinetics		Z2	5.9070	$244.46
78140	Red cell sequestration		Z3	2.3990	$99.26
78185	Spleen imaging		Z3	3.5120	$145.35
78190	Platelet survival, kinetics		Z2	2.7400	$113.38
78191	Platelet survival		Z2	2.7400	$113.38
78195	Lymph system imaging		Z2	3.8460	$159.18
78199	Blood/lymph nuclear exam		Z2	3.8460	$159.18

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78201	Liver imaging		Z3	3.1620	$130.85
78202	Liver imaging with flow		Z3	3.6600	$151.47
78205	Liver imaging (3d)	CH	Z3	4.1510	$171.78
78206	Liver image (3d) with flow		Z2	4.3810	$181.29
78215	Liver and spleen imaging		Z3	3.3410	$138.26
78216	Liver & spleen image/flow		Z3	2.2660	$93.78
78220	Liver function study		Z3	2.4690	$102.16
78223	Hepatobiliary imaging		Z2	4.3810	$181.29
78230	Salivary gland imaging		Z3	2.8110	$116.34
78231	Serial salivary imaging		Z3	2.2200	$91.85
78232	Salivary gland function exam		Z3	2.3210	$96.04
78258	Esophageal motility study	CH	Z2	3.6980	$153.03
78261	Gastric mucosa imaging		Z2	3.6980	$153.03
78262	Gastroesophageal reflux exam		Z2	3.6980	$153.03
78264	Gastric emptying study		Z2	3.6980	$153.03
78270	Vit b-12 absorption exam		Z3	1.4560	$60.27
78271	Vit b-12 absrp exam, int fac		Z3	1.4640	$60.59
78272	Vit b-12 absorp, combined		Z3	1.6040	$66.39
78278	Acute gi blood loss imaging		Z2	3.6980	$153.03
78282	Gi protein loss exam		Z2	3.6980	$153.03
78290	Meckel's divert exam		Z2	3.6980	$153.03
78291	Leveen/shunt patency exam		Z2	3.6980	$153.03
78299	Gi nuclear procedure		Z2	3.6980	$153.03
78300	Bone imaging, limited area		Z3	2.8660	$118.60
78305	Bone imaging, multiple areas		Z2	3.7230	$154.07
78306	Bone imaging, whole body		Z2	3.7230	$154.07
78315	Bone imaging, 3 phase		Z2	3.7230	$154.07
78320	Bone imaging (3d)		Z2	3.7230	$154.07
78399	Musculoskeletal nuclear exam		Z2	3.7230	$154.07
78414	Non-imaging heart function		Z2	4.7010	$194.53
78428	Cardiac shunt imaging		Z3	3.3020	$136.65
78445	Vascular flow imaging	CH	Z2	2.9600	$122.48
78456	Acute venous thrombus image		Z2	2.9600	$122.48
78457	Venous thrombosis imaging		Z2	2.9600	$122.48
78458	Ven thrombosis images, bilat		Z2	2.9600	$122.48
78459	Heart muscle imaging (pet)		Z2	16.9780	$702.63
78460	Heart muscle blood, single		Z3	3.0450	$126.01
78461	Heart muscle blood, multiple		Z3	3.0610	$126.66
78464	Heart image (3d), single		Z3	4.5320	$187.57
78465	Heart image (3d), multiple		Z3	8.6130	$356.45
78466	Heart infarct image		Z3	3.0290	$125.37

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78468	Heart infarct image (ef)		Z3	3.9100	$161.79
78469	Heart infarct image (3d)	CH	Z3	4.4080	$182.41
78472	Gated heart, planar, single	CH	Z3	4.4000	$182.09
78473	Gated heart, multiple		Z2	4.7010	$194.53
78478	Heart wall motion add-on		N1		
78480	Heart function add-on		N1		
78481	Heart first pass, single		Z3	3.7070	$153.41
78483	Heart first pass, multiple		Z2	4.7010	$194.53
78491	Heart image (pet), single		Z2	16.9780	$702.63
78492	Heart image (pet), multiple		Z2	16.9780	$702.63
78494	Heart image, spect		Z2	4.7010	$194.53
78496	Heart first pass add-on		N1		
78499	Cardiovascular nuclear exam		Z2	4.7010	$194.53
78580	Lung perfusion imaging		Z2	3.1920	$132.11
78584	Lung v/q image single breath		Z3	2.2120	$91.53
78585	Lung v/q imaging		Z2	4.9050	$203.00
78586	Aerosol lung image, single		Z3	2.8970	$119.89
78587	Aerosol lung image, multiple		Z2	3.1920	$132.11
78588	Perfusion lung image		Z2	4.9050	$203.00
78591	Vent image, 1 breath, 1 proj		Z3	2.9360	$121.50
78593	Vent image, 1 proj, gas		Z2	3.1920	$132.11
78594	Vent image, mult proj, gas		Z2	3.1920	$132.11
78596	Lung differential function		Z2	4.9050	$203.00
78599	Respiratory nuclear exam		Z2	3.1920	$132.11
78600	Brain image < 4 views		Z2	2.7710	$114.66
78601	Brain image w/flow < 4 views		Z2	2.7710	$114.66
78605	Brain image 4+ views		Z2	2.7710	$114.66
78606	Brain image w/flow 4 + views		Z3	5.6690	$234.62
78607	Brain imaging (3d)		Z3	6.2300	$257.83
78608	Brain imaging (pet)		Z2	15.7180	$650.47
78610	Brain flow imaging only		Z3	3.3560	$138.90
78630	Cerebrospinal fluid scan		Z3	5.9890	$247.84
78635	Csf ventriculography		Z3	5.5290	$228.82
78645	Csf shunt evaluation		Z2	2.7710	$114.66
78647	Cerebrospinal fluid scan		Z3	6.1210	$253.32
78650	Csf leakage imaging		Z3	5.9260	$245.26
78660	Nuclear exam of tear flow	CH	Z2	2.7710	$114.66
78699	Nervous system nuclear exam		Z2	2.7710	$114.66
78700	Kidney imaging, morphol		Z3	3.1000	$128.27
78701	Kidney imaging with flow		Z3	3.7770	$156.31
78707	K flow/funct image w/o drug		Z3	3.9480	$163.40

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78708	K flow/funct image w/drug		Z3	2.7020	$111.83
78709	K flow/funct image, multiple		Z2	4.9190	$203.56
78710	Kidney imaging (3d)		Z3	4.1660	$172.42
78725	Kidney function study		Z3	1.6820	$69.61
78730	Urinary bladder retention		Z3	1.4020	$58.01
78740	Ureteral reflux study		Z3	3.6910	$152.76
78761	Testicular imaging w/flow		Z3	3.5200	$145.67
78799	Genitourinary nuclear exam		Z2	4.9190	$203.56
78800	Tumor imaging, limited area		Z3	3.1150	$128.91
78801	Tumor imaging, mult areas		Z3	4.2600	$176.29
78802	Tumor imaging, whole body		Z3	5.7790	$239.14
78803	Tumor imaging (3d)		Z3	6.1990	$256.54
78804	Tumor imaging, whole body		Z3	10.8090	$447.33
78805	Abscess imaging, ltd area		Z3	3.0370	$125.69
78806	Abscess imaging, whole body		Z3	6.0740	$251.38
78807	Nuclear localization/abscess		Z3	6.2150	$257.18
78811	Pet image, ltd area		Z2	15.7180	$650.47
78812	Pet image, skull-thigh		Z2	15.7180	$650.47
78813	Pet image, full body		Z2	15.7180	$650.47
78814	Pet image w/ct, lmtd		Z2	15.7180	$650.47
78815	Pet image w/ct, skull-thigh		Z2	15.7180	$650.47
78816	Pet image w/ct, full body		Z2	15.7180	$650.47
78890	Nuclear medicine data proc		N1		
78891	Nuclear med data proc		N1		
78999	Nuclear diagnostic exam		Z2	1.8030	$74.60
79005	Nuclear rx, oral admin		Z3	1.2690	$52.53
79101	Nuclear rx, iv admin		Z3	1.4020	$58.01
79200	Nuclear rx, intracav admin		Z3	1.5110	$62.52
79300	Nuclr rx, interstit colloid		Z2	3.2780	$135.65
79403	Hematopoietic nuclear tx		Z3	2.1490	$88.95
79440	Nuclear rx, intra-articular		Z3	1.2150	$50.28
79445	Nuclear rx, intra-arterial		Z2	3.2780	$135.65
79999	Nuclear medicine therapy		Z2	3.2780	$135.65
90296	Diphtheria antitoxin	CH	K2		$100.02
90371	Hep b ig, im		K2		$117.70
90375	Rabies ig, im/sc		K2		$66.55
90376	Rabies ig, heat treated		K2		$76.60
90385	Rh ig, minidose, im		N1		
90393	Vaccina ig, im		N1		
90396	Varicella-zoster ig, im		K2		$109.89
90476	Adenovirus vaccine, type 4		N1		

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90477	Adenovirus vaccine, type 7		N1		
90581	Anthrax vaccine, sc		N1		
90585	Bcg vaccine, percut		K2		$114.69
90632	Hep a vaccine, adult im		N1		
90633	Hep a vacc, ped/adol, 2 dose		N1		
90634	Hep a vacc, ped/adol, 3 dose		N1		
90636	Hep a/hep b vacc, adult im		N1		
90645	Hib vaccine, hboc, im		N1		
90646	Hib vaccine, prp-d, im		N1		
90647	Hib vaccine, prp-omp, im		N1		
90648	Hib vaccine, prp-t, im		N1		
90655	Flu vaccine no preserv 6-35m	CH	L1		
90656	Flu vaccine no preserv 3 & >	CH	L1		
90657	Flu vaccine, 3 yrs, im	CH	L1		
90658	Flu vaccine, 3 yrs & >, im	CH	L1		
90660	Flu vaccine, nasal	CH	L1		
90665	Lyme disease vaccine, im	CH	K2		$79.91
90669	Pneumococcal vacc, ped <5	CH	L1		
90675	Rabies vaccine, im		K2		$149.67
90676	Rabies vaccine, id		K2		$126.98
90680	Rotovirus vacc 3 dose, oral		N1		
90690	Typhoid vaccine, oral		N1		
90691	Typhoid vaccine, im		N1		
90692	Typhoid vaccine, h-p, sc/id		N1		
90698	Dtap-hib-ip vaccine, im		N1		
90700	Dtap vaccine, < 7 yrs, im		N1		
90701	Dtp vaccine, im		N1		
90702	Dt vaccine < 7, im		N1		
90703	Tetanus vaccine, im		N1		
90704	Mumps vaccine, sc		N1		
90705	Measles vaccine, sc		N1		
90706	Rubella vaccine, sc		N1		
90707	Mmr vaccine, sc		N1		
90708	Measles-rubella vaccine, sc	CH	N1		
90710	Mmrv vaccine, sc		N1		
90712	Oral poliovirus vaccine		N1		
90713	Poliovirus, ipv, sc/im		N1		
90714	Td vaccine no prsrv >/= 7 im		N1		
90715	Tdap vaccine >7 im		N1		
90717	Yellow fever vaccine, sc		N1		
90718	Td vaccine > 7, im		N1		

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90719	Diphtheria vaccine, im		N1		
90720	Dtp/hib vaccine, im		N1		
90721	Dtap/hib vaccine, im		N1		
90725	Cholera vaccine, injectable		N1		
90727	Plague vaccine, im		N1		
90732	Pneumococcal vaccine	CH	L1		
90733	Meningococcal vaccine, sc		K2		$92.10
90734	Meningococcal vaccine, im		K2		$80.45
90735	Encephalitis vaccine, sc		K2		$100.15
90749	Vaccine toxoid		N1		
A4218	Sterile saline or water		N1		
A4220	Infusion pump refill kit		N1		
A4248	Chlorhexidine antisept		N1		
A4262	Temporary tear duct plug		N1		
A4263	Permanent tear duct plug		N1		
A4270	Disposable endoscope sheath		N1		
A4300	Cath impl vasc access portal		N1		
A4301	Implantable access syst perc		N1		
A4305	Drug delivery system >=50 ML		N1		
A4306	Drug delivery system <=50 ml		N1		
A4641	Radiopharm dx agent noc		N1		
A4642	In111 satumomab		N1		
A4648	Implantable tissue marker		N1		
A4650	Implant radiation dosimeter		N1		
A9500	Tc99m sestamibi		N1		
A9501	Technetium TC-99m teboroxime		N1		
A9502	Tc99m tetrofosmin		N1		
A9503	Tc99m medronate		N1		
A9504	Tc99m apcitide		N1		
A9505	TL201 thallium		N1		
A9507	In111 capromab		N1		
A9508	I131 iodobenguate, dx		N1		
A9509	Iodine I-123 sod iodide mil		N1		
A9510	Tc99m disofenin		N1		
A9512	Tc99m pertechnetate		N1		
A9516	Iodine I-123 sod iodide mic		N1		
A9521	Tc99m exametazime		N1		
A9524	I131 serum albumin, dx		N1		
A9526	Nitrogen N-13 ammonia		N1		
A9527	Iodine I-125 sodium iodide	CH	H2	0.5350	$36.05
A9528	Iodine I-131 iodide cap, dx		N1		

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A9529	I131 iodide sol, dx		N1		
A9531	I131 max 100uCi		N1		
A9532	I125 serum albumin, dx		N1		
A9535	Injection, methylene blue		N1		
A9536	Tc99m depreotide		N1		
A9537	Tc99m mebrofenin		N1		
A9538	Tc99m pyrophosphate		N1		
A9539	Tc99m pentetate		N1		
A9540	Tc99m MAA		N1		
A9541	Tc99m sulfur colloid		N1		
A9542	In111 ibritumomab, dx		N1		
A9544	I131 tositumomab, dx		N1		
A9546	Co57/58		N1		
A9547	In111 oxyquinoline		N1		
A9548	In111 pentetate		N1		
A9550	Tc99m gluceptate		N1		
A9551	Tc99m succimer		N1		
A9552	F18 fdg		N1		
A9553	Cr51 chromate		N1		
A9554	I125 iothalamate, dx		N1		
A9555	Rb82 rubidium		N1		
A9556	Ga67 gallium		N1		
A9557	Tc99m bicisate		N1		
A9558	Xe133 xenon 10mci		N1		
A9559	Co57 cyano		N1		
A9560	Tc99m labeled rbc		N1		
A9561	Tc99m oxidronate		N1		
A9562	Tc99m mertiatide		N1		
A9566	Tc99m fanolesomab		N1		
A9567	Technetium TC-99m aerosol		N1		
A9568	Technetium tc99m arcitumomab		N1		
A9569	Technetium TC-99m auto WBC		N1		
A9570	Indium In-111 auto WBC		N1		
A9571	Indium In-111 auto platelet		N1		
A9572	Indium In-111 pentetreotide		N1		
A9576	Inj prohance multipack		N1		
A9577	Inj multihance		N1		
A9578	Inj multihance multipack		N1		
A9579	Gad-base MR contrast NOS,1ml		N1		
A9698	Non-rad contrast materialNOC		N1		
A9699	Radiopharm rx agent noc		N1		

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C1713	Anchor/screw bn/bn,tis/bn		N1		
C1714	Cath, trans atherectomy, dir		N1		
C1715	Brachytherapy needle		N1		
C1716	Brachytx, non-str, Gold-198	CH	H2	0.5030	$33.90
C1717	Brachytx, non-str,HDR Ir-192	CH	H2	3.1460	$211.88
C1719	Brachytx, NS, Non-HDRIr-192	CH	H2	0.9610	$64.71
C1721	AICD, dual chamber		N1		
C1722	AICD, single chamber		N1		
C1724	Cath, trans atherec,rotation		N1		
C1725	Cath, translumin non-laser		N1		
C1726	Cath, bal dil, non-vascular		N1		
C1727	Cath, bal tis dis, non-vas		N1		
C1728	Cath, brachytx seed adm		N1		
C1729	Cath, drainage		N1		
C1730	Cath, EP, 19 or few elect		N1		
C1731	Cath, EP, 20 or more elec		N1		
C1732	Cath, EP, diag/abl, 3D/vect		N1		
C1733	Cath, EP, othr than cool-tip		N1		
C1750	Cath, hemodialysis,long-term		N1		
C1751	Cath, inf, per/cent/midline		N1		
C1752	Cath,hemodialysis,short-term		N1		
C1753	Cath, intravas ultrasound		N1		
C1754	Catheter, intradiscal		N1		
C1755	Catheter, intraspinal		N1		
C1756	Cath, pacing, transesoph		N1		
C1757	Cath, thrombectomy/embolect		N1		
C1758	Catheter, ureteral		N1		
C1759	Cath, intra echocardiography		N1		
C1760	Closure dev, vasc		N1		
C1762	Conn tiss, human(inc fascia)		N1		
C1763	Conn tiss, non-human		N1		
C1764	Event recorder, cardiac		N1		
C1765	Adhesion barrier		N1		
C1766	Intro/sheath,strble,non-peel		N1		
C1767	Generator, neuro non-recharg		N1		
C1768	Graft, vascular		N1		
C1769	Guide wire		N1		
C1770	Imaging coil, MR, insertable		N1		
C1771	Rep dev, urinary, w/sling		N1		
C1772	Infusion pump, programmable		N1		
C1773	Ret dev, insertable		N1		

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C1776	Joint device (implantable)		N1		
C1777	Lead, AICD, endo single coil		N1		
C1778	Lead, neurostimulator		N1		
C1779	Lead, pmkr, transvenous VDD		N1		
C1780	Lens, intraocular (new tech)		N1		
C1781	Mesh (implantable)		N1		
C1782	Morcellator		N1		
C1783	Ocular imp, aqueous drain de		N1		
C1784	Ocular dev, intraop, det ret		N1		
C1785	Pmkr, dual, rate-resp		N1		
C1786	Pmkr, single, rate-resp		N1		
C1787	Patient progr, neurostim		N1		
C1788	Port, indwelling, imp		N1		
C1789	Prosthesis, breast, imp		N1		
C1813	Prosthesis, penile, inflatab		N1		
C1814	Retinal tamp, silicone oil		N1		
C1815	Pros, urinary sph, imp		N1		
C1816	Receiver/transmitter, neuro		N1		
C1817	Septal defect imp sys		N1		
C1818	Integrated keratoprosthesis		N1		
C1819	Tissue localization-excision		N1		
C1820	Generator neuro rechg bat sy		N1		
C1821	Interspinous implant	CH	N1		
C1874	Stent, coated/cov w/del sys		N1		
C1875	Stent, coated/cov w/o del sy		N1		
C1876	Stent, non-coa/non-cov w/del		N1		
C1877	Stent, non-coat/cov w/o del		N1		
C1878	Matrl for vocal cord		N1		
C1879	Tissue marker, implantable		N1		
C1880	Vena cava filter		N1		
C1881	Dialysis access system		N1		
C1882	AICD, other than sing/dual		N1		
C1883	Adapt/ext, pacing/neuro lead		N1		
C1884	Embolization Protect syst		N1		
C1885	Cath, translumin angio laser		N1		
C1887	Catheter, guiding		N1		
C1888	Endovas non-cardiac abl cath		N1		
C1891	Infusion pump,non-prog, perm		N1		
C1892	Intro/sheath,fixed,peel-away		N1		
C1893	Intro/sheath, fixed,non-peel		N1		
C1894	Intro/sheath, non-laser		N1		

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C1895	Lead, AICD, endo dual coil		N1		
C1896	Lead, AICD, non sing/dual		N1		
C1897	Lead, neurostim test kit		N1		
C1898	Lead, pmkr, other than trans		N1		
C1899	Lead, pmkr/AICD combination		N1		
C1900	Lead, coronary venous		N1		
C2614	Probe, perc lumb disc		N1		
C2615	Sealant, pulmonary, liquid		N1		
C2616	Brachytx, non-str,Yttrium-90	CH	H2	199.7060	$13,449.68
C2617	Stent, non-cor, tem w/o del		N1		
C2618	Probe, cryoablation		N1		
C2619	Pmkr, dual, non rate-resp		N1		
C2620	Pmkr, single, non rate-resp		N1		
C2621	Pmkr, other than sing/dual		N1		
C2622	Prosthesis, penile, non-inf		N1		
C2625	Stent, non-cor, tem w/del sy		N1		
C2626	Infusion pump, non-prog,temp		N1		
C2627	Cath, suprapubic/cystoscopic		N1		
C2628	Catheter, occlusion		N1		
C2629	Intro/sheath, laser		N1		
C2630	Cath, EP, cool-tip		N1		
C2631	Rep dev, urinary, w/o sling		N1		
C2634	Brachytx, non-str, HA, I-125	CH	H2	0.6360	$42.81
C2635	Brachytx, non-str, HA, P-103	CH	H2	0.4000	$26.94
C2636	Brachy linear, non-str,P-103	CH	H2	0.8970	$60.44
C2638	Brachytx, stranded, I-125	CH	H2	0.5990	$40.36
C2639	Brachytx, non-stranded,I-125	CH	H2	0.5420	$36.47
C2640	Brachytx, stranded, P-103	CH	H2	0.9880	$66.54
C2641	Brachytx, non-stranded,P-103	CH	H2	0.9420	$63.44
C2642	Brachytx, stranded, C-131	CH	H2	1.4800	$99.70
C2643	Brachytx, non-stranded,C-131	CH	H2	0.8830	$59.45
C2698	Brachytx, stranded, NOS	CH	H2	0.5990	$40.36
C2699	Brachytx, non-stranded, NOS	CH	H2	0.4000	$26.94
C8900	MRA w/cont, abd		Z2	6.4120	$265.37
C8901	MRA w/o cont, abd		Z2	5.2940	$219.10
C8902	MRA w/o fol w/cont, abd		Z2	8.1120	$335.70
C8903	MRI w/cont, breast, uni		Z2	6.4120	$265.37
C8904	MRI w/o cont, breast, uni		Z2	5.2940	$219.10
C8905	MRI w/o fol w/cont, brst, un		Z2	8.1120	$335.70
C8906	MRI w/cont, breast, bi		Z2	6.4120	$265.37
C8907	MRI w/o cont, breast, bi		Z2	5.2940	$219.10

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C8908	MRI w/o fol w/cont, breast,		Z2	8.1120	$335.70
C8909	MRA w/cont, chest		Z2	6.4120	$265.37
C8910	MRA w/o cont, chest		Z2	5.2940	$219.10
C8911	MRA w/o fol w/cont, chest		Z2	8.1120	$335.70
C8912	MRA w/cont, lwr ext		Z2	6.4120	$265.37
C8913	MRA w/o cont, lwr ext		Z2	5.2940	$219.10
C8914	MRA w/o fol w/cont, lwr ext		Z2	8.1120	$335.70
C8918	MRA w/cont, pelvis		Z2	6.4120	$265.37
C8919	MRA w/o cont, pelvis		Z2	5.2940	$219.10
C8920	MRA w/o fol w/cont, pelvis		Z2	8.1120	$335.70
C9003	Palivizumab, per 50 mg		K2		$802.95
C9113	Inj pantoprazole sodium, via		N1		
C9121	Injection, argatroban		K2		$19.82
C9237	Inj, lanreotide acetate		K2		$23.90
C9238	Inj, levetiracetam		K2		$0.43
C9239	Inj, temsirolimus		K2		$47.78
C9240	Injection, ixabepilone		K2		$65.15
C9241	Injection, doripenem, 10 mg		K2		$0.81
C9352	Neuragen nerve guide, per cm	CH	N1		
C9353	Neurawrap nerve protector,cm	CH	N1		
C9354	Veritas collagen matrix, cm2		K2		$11.77
C9355	Neuromatrix nerve cuff, cm		K2		$208.67
C9399	Unclassified drugs or biolog		K7		
E0616	Cardiac event recorder		N1		
E0749	Elec osteogen stim implanted		N1		
E0782	Non-programble infusion pump		N1		
E0783	Programmable infusion pump		N1		
E0785	Replacement impl pump cathet		N1		
E0786	Implantable pump replacement		N1		
G0130	Single energy x-ray study		Z3	0.4440	$18.37
G0173	Linear acc stereo radsur com		Z2	54.4100	$2,251.68
G0251	Linear acc based stero radio		Z2	14.7790	$611.61
G0288	Recon, CTA for surg plan		N1		
G0339	Robot lin-radsurg com, first		Z2	54.4100	$2,251.68
G0340	Robt lin-radsurg fractx 2-5		Z2	39.4130	$1,631.08
J0120	Tetracyclin injection		N1		
J0128	Abarelix injection		K2		$67.33
J0129	Abatacept injection		K2		$18.34
J0130	Abciximab injection		K2		$415.06
J0132	Acetylcysteine injection	CH	K2		$2.13
J0133	Acyclovir injection		N1		

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J0135	Adalimumab injection		K2		$324.32
J0150	Injection adenosine 6 MG		K2		$12.60
J0152	Adenosine injection		K2		$66.89
J0170	Adrenalin epinephrin inject		N1		
J0180	Agalsidase beta injection		K2		$127.14
J0190	Inj biperiden lactate/5 mg	CH	N1		
J0200	Alatrofloxacin mesylate		N1		
J0205	Alglucerase injection		K2		$38.92
J0207	Amifostine		K2		$501.57
J0210	Methyldopate hcl injection		K2		$14.91
J0215	Alefacept		K2		$26.16
J0220	Aglucosidase alfa injection		K2		$124.80
J0256	Alpha 1 proteinase inhibitor		K2		$3.59
J0278	Amikacin sulfate injection		N1		
J0280	Aminophyllin 250 MG inj		N1		
J0282	Amiodarone HCl		N1		
J0285	Amphotericin B		N1		
J0287	Amphotericin b lipid complex		K2		$10.26
J0288	Ampho b cholesteryl sulfate		K2		$11.77
J0289	Amphotericin b liposome inj		K2		$16.84
J0290	Ampicillin 500 MG inj		N1		
J0295	Ampicillin sodium per 1.5 gm		N1		
J0300	Amobarbital 125 MG inj		N1		
J0330	Succinycholine chloride inj		N1		
J0348	Anadulafungin injection		K2		$1.50
J0350	Injection anistreplase 30 u	CH	N1		
J0360	Hydralazine hcl injection		N1		
J0364	Apomorphine hydrochloride		N1		
J0365	Aprotonin, 10,000 kiu		K2		$2.60
J0380	Inj metaraminol bitartrate		N1		
J0390	Chloroquine injection		N1		
J0395	Arbutamine HCl injection		N1		
J0400	Aripiprazole injection	CH	N1		
J0456	Azithromycin		N1		
J0460	Atropine sulfate injection		N1		
J0470	Dimecaprol injection	CH	K2		$26.17
J0475	Baclofen 10 MG injection		K2		$187.25
J0476	Baclofen intrathecal trial		K2		$68.44
J0480	Basiliximab		K2		$1,471.15
J0500	Dicyclomine injection		N1		
J0515	Inj benztropine mesylate		N1		

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J0520	Bethanechol chloride inject		N1		
J0530	Penicillin g benzathine inj		N1		
J0540	Penicillin g benzathine inj		N1		
J0550	Penicillin g benzathine inj	CH	K2		$32.28
J0560	Penicillin g benzathine inj		N1		
J0570	Penicillin g benzathine inj		N1		
J0580	Penicillin g benzathine inj		N1		
J0583	Bivalirudin		K2		$2.04
J0585	Botulinum toxin a per unit		K2		$5.12
J0587	Botulinum toxin type B		K2		$8.55
J0592	Buprenorphine hydrochloride		N1		
J0594	Busulfan injection		K2		$9.53
J0595	Butorphanol tartrate 1 mg		N1		
J0600	Edetate calcium disodium inj		K2		$49.28
J0610	Calcium gluconate injection		N1		
J0620	Calcium glycer & lact/10 ML		N1		
J0630	Calcitonin salmon injection		N1		
J0636	Inj calcitriol per 0.1 mcg		N1		
J0637	Caspofungin acetate		K2		$17.53
J0640	Leucovorin calcium injection		N1		
J0670	Inj mepivacaine HCL/10 ml		N1		
J0690	Cefazolin sodium injection		N1		
J0692	Cefepime HCl for injection		N1		
J0694	Cefoxitin sodium injection		N1		
J0696	Ceftriaxone sodium injection		N1		
J0697	Sterile cefuroxime injection		N1		
J0698	Cefotaxime sodium injection		N1		
J0702	Betamethasone acet&sod phosp		N1		
J0704	Betamethasone sod phosp/4 MG		N1		
J0706	Caffeine citrate injection		N1		
J0710	Cephapirin sodium injection		N1		
J0713	Inj ceftazidime per 500 mg		N1		
J0715	Ceftizoxime sodium / 500 MG		N1		
J0720	Chloramphenicol sodium injec		N1		
J0725	Chorionic gonadotropin/1000u		N1		
J0735	Clonidine hydrochloride		K2		$54.95
J0740	Cidofovir injection		K2		$748.06
J0743	Cilastatin sodium injection		N1		
J0744	Ciprofloxacin iv		N1		
J0745	Inj codeine phosphate /30 MG		N1		
J0760	Colchicine injection		N1		

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J0770	Colistimethate sodium inj		N1		
J0780	Prochlorperazine injection		N1		
J0795	Corticorelin ovine triflutal		K2		$4.19
J0800	Corticotropin injection		K2		$2,311.08
J0835	Inj cosyntropin per 0.25 MG		K2		$64.36
J0850	Cytomegalovirus imm IV /vial		K2		$862.24
J0878	Daptomycin injection		K2		$0.34
J0881	Darbepoetin alfa, non-esrd		K2		$2.72
J0885	Epoetin alfa, non-esrd		K2		$8.90
J0894	Decitabine injection		K2		$26.60
J0895	Deferoxamine mesylate inj		N1		
J0900	Testosterone enanthate inj		N1		
J0945	Brompheniramine maleate inj		N1		
J0970	Estradiol valerate injection		N1		
J1000	Depo-estradiol cypionate inj		N1		
J1020	Methylprednisolone 20 MG inj		N1		
J1030	Methylprednisolone 40 MG inj		N1		
J1040	Methylprednisolone 80 MG inj		N1		
J1051	Medroxyprogesterone inj		N1		
J1060	Testosterone cypionate 1 ML		N1		
J1070	Testosterone cypionat 100 MG		N1		
J1080	Testosterone cypionat 200 MG		N1		
J1094	Inj dexamethasone acetate		N1		
J1100	Dexamethasone sodium phos		N1		
J1110	Inj dihydroergotamine mesylt		N1		
J1120	Acetazolamid sodium injectio		N1		
J1160	Digoxin injection		N1		
J1162	Digoxin immune fab (ovine)		K2		$479.14
J1165	Phenytoin sodium injection		N1		
J1170	Hydromorphone injection		N1		
J1180	Dyphylline injection		N1		
J1190	Dexrazoxane HCl injection		K2		$177.53
J1200	Diphenhydramine hcl injectio		N1		
J1205	Chlorothiazide sodium inj		K2		$162.00
J1212	Dimethyl sulfoxide 50% 50 ML		N1		
J1230	Methadone injection		N1		
J1240	Dimenhydrinate injection		N1		
J1245	Dipyridamole injection		N1		
J1250	Inj dobutamine HCL/250 mg		N1		
J1260	Dolasetron mesylate		K2		$4.11
J1265	Dopamine injection		N1		

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J1270	Injection, doxercalciferol		N1		
J1300	Eculizumab injection		K2		$173.06
J1320	Amitriptyline injection		N1		
J1324	Enfuvirtide injection	CH	N1		
J1325	Epoprostenol injection		N1		
J1327	Eptifibatide injection		K2		$16.70
J1330	Ergonovine maleate injection		N1		
J1335	Ertapenem injection		N1		
J1364	Erythro lactobionate /500 MG		N1		
J1380	Estradiol valerate 10 MG inj		N1		
J1390	Estradiol valerate 20 MG inj		N1		
J1410	Inj estrogen conjugate 25 MG		K2		$69.91
J1430	Ethanolamine oleate 100 mg		K2		$118.22
J1435	Injection estrone per 1 MG		N1		
J1436	Etidronate disodium inj		K2		$70.06
J1438	Etanercept injection		K2		$163.89
J1440	Filgrastim 300 mcg injection		K2		$195.48
J1441	Filgrastim 480 mcg injection		K2		$300.85
J1450	Fluconazole		N1		
J1451	Fomepizole, 15 mg		K2		$13.85
J1452	Intraocular Fomivirsen na		N1		
J1455	Foscarnet sodium injection	CH	K2		$10.19
J1457	Gallium nitrate injection		K2		$1.59
J1458	Galsulfase injection		K2		$314.00
J1460	Gamma globulin 1 CC inj		K2		$11.34
J1470	Gamma globulin 2 CC inj		K2		$22.67
J1480	Gamma globulin 3 CC inj		K2		$34.00
J1490	Gamma globulin 4 CC inj		K2		$45.34
J1500	Gamma globulin 5 CC inj		K2		$56.68
J1510	Gamma globulin 6 CC inj		K2		$68.02
J1520	Gamma globulin 7 CC inj		K2		$79.31
J1530	Gamma globulin 8 CC inj		K2		$90.68
J1540	Gamma globulin 9 CC inj		K2		$102.05
J1550	Gamma globulin 10 CC inj		K2		$113.35
J1560	Gamma globulin > 10 CC inj		K2		$113.35
J1561	Gamunex injection		K2		$32.82
J1562	Vivaglobin, inj		K2		$6.94
J1565	RSV-ivig		K2		$15.87
J1566	Immune globulin, powder		K2		$27.54
J1568	Octagam injection		K2		$33.43
J1569	Gammagard liquid injection		K2		$31.19

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J1570	Ganciclovir sodium injection		N1		
J1571	Hepagam B IM injection		K2		$47.43
J1572	Flebogamma injection		K2		$31.92
J1573	Hepagam B intravenous, inj		K2		$47.43
J1580	Garamycin gentamicin inj		N1		
J1590	Gatifloxacin injection		N1		
J1595	Injection glatiramer acetate		K2		$54.24
J1600	Gold sodium thiomaleate inj		N1		
J1610	Glucagon hydrochloride/1 MG		K2		$67.37
J1620	Gonadorelin hydroch/ 100 mcg		K2		$176.89
J1626	Granisetron HCl injection		K2		$4.86
J1630	Haloperidol injection		N1		
J1631	Haloperidol decanoate inj		N1		
J1640	Hemin, 1 mg		K2		$7.23
J1642	Inj heparin sodium per 10 u		N1		
J1644	Inj heparin sodium per 1000u		N1		
J1645	Dalteparin sodium		N1		
J1650	Inj enoxaparin sodium		N1		
J1652	Fondaparinux sodium		K2		$5.61
J1655	Tinzaparin sodium injection		N1		
J1670	Tetanus immune globulin inj		K2		$97.86
J1700	Hydrocortisone acetate inj		N1		
J1710	Hydrocortisone sodium ph inj		N1		
J1720	Hydrocortisone sodium succ i		N1		
J1730	Diazoxide injection		K2		$112.16
J1740	Ibandronate sodium injection		K2		$136.35
J1742	Ibutilide fumarate injection		K2		$317.20
J1743	Idursulfase injection		K2		$446.44
J1745	Infliximab injection		K2		$54.00
J1756	Iron sucrose injection		K2		$0.35
J1785	Injection imiglucerase /unit		K2		$3.93
J1790	Droperidol injection		N1		
J1800	Propranolol injection		N1		
J1815	Insulin injection		N1		
J1817	Insulin for insulin pump use		N1		
J1830	Interferon beta-1b / .25 MG		K2		$114.42
J1835	Itraconazole injection		K2		$39.15
J1840	Kanamycin sulfate 500 MG inj		N1		
J1850	Kanamycin sulfate 75 MG inj		N1		
J1885	Ketorolac tromethamine inj		N1		
J1890	Cephalothin sodium injection		N1		

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J1931	Laronidase injection		K2		$23.89
J1940	Furosemide injection		N1		
J1945	Lepirudin		K2		$157.97
J1950	Leuprolide acetate /3.75 MG		K2		$433.32
J1956	Levofloxacin injection		N1		
J1960	Levorphanol tartrate inj		N1		
J1980	Hyoscyamine sulfate inj		N1		
J1990	Chlordiazepoxide injection		N1		
J2001	Lidocaine injection		N1		
J2010	Lincomycin injection		N1		
J2020	Linezolid injection		K2		$27.56
J2060	Lorazepam injection		N1		
J2150	Mannitol injection		N1		
J2170	Mecasermin injection	CH	N1		
J2175	Meperidine hydrochl /100 MG		N1		
J2180	Meperidine/promethazine inj		N1		
J2185	Meropenem		N1		
J2210	Methylergonovin maleate inj		N1		
J2248	Micafungin sodium injection		K2		$1.32
J2250	Inj midazolam hydrochloride		N1		
J2260	Inj milrinone lactate / 5 MG		N1		
J2270	Morphine sulfate injection		N1		
J2271	Morphine so4 injection 100mg		N1		
J2275	Morphine sulfate injection		N1		
J2278	Ziconotide injection		K2		$6.39
J2280	Inj, moxifloxacin 100 mg		N1		
J2300	Inj nalbuphine hydrochloride		N1		
J2310	Inj naloxone hydrochloride		N1		
J2315	Naltrexone, depot form		K2		$1.85
J2320	Nandrolone decanoate 50 MG		N1		
J2321	Nandrolone decanoate 100 MG		N1		
J2322	Nandrolone decanoate 200 MG		N1		
J2323	Natalizumab injection		K2		$7.39
J2325	Nesiritide injection		K2		$32.86
J2353	Octreotide injection, depot		K2		$99.84
J2354	Octreotide inj, non-depot		N1		
J2355	Oprelvekin injection		K2		$242.32
J2357	Omalizumab injection		K2		$17.48
J2360	Orphenadrine injection		N1		
J2370	Phenylephrine hcl injection		N1		
J2400	Chloroprocaine hcl injection		N1		

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J2405	Ondansetron hcl injection		K2		$0.22
J2410	Oxymorphone hcl injection		N1		
J2425	Palifermin injection		K2		$11.15
J2430	Pamidronate disodium /30 MG		K2		$27.79
J2440	Papaverin hcl injection		N1		
J2460	Oxytetracycline injection	CH	K2		$169.00
J2469	Palonosetron HCl		K2		$16.89
J2501	Paricalcitol		N1		
J2503	Pegaptanib sodium injection		K2		$1,011.57
J2504	Pegademase bovine, 25 iu		K2		$195.62
J2505	Injection, pegfilgrastim 6mg		K2		$2,158.59
J2510	Penicillin g procaine inj		N1		
J2513	Pentastarch 10% solution	CH	N1		
J2515	Pentobarbital sodium inj		N1		
J2540	Penicillin g potassium inj		N1		
J2543	Piperacillin/tazobactam		N1		
J2550	Promethazine hcl injection		N1		
J2560	Phenobarbital sodium inj		N1		
J2590	Oxytocin injection		N1		
J2597	Inj desmopressin acetate		N1		
J2650	Prednisolone acetate inj		N1		
J2670	Totazoline hcl injection		N1		
J2675	Inj progesterone per 50 MG		N1		
J2680	Fluphenazine decanoate 25 MG		N1		
J2690	Procainamide hcl injection		N1		
J2700	Oxacillin sodium injeciton		N1		
J2710	Neostigmine methylslfte inj		N1		
J2720	Inj protamine sulfate/10 MG		N1		
J2724	Protein C concentrate		K2		$11.96
J2725	Inj protirelin per 250 mcg		N1		
J2730	Pralidoxime chloride inj		K2		$86.41
J2760	Phentolaine mesylate inj		N1		
J2765	Metoclopramide hcl injection		N1		
J2770	Quinupristin/dalfopristin		K2		$125.56
J2778	Ranibizumab injection		K2		$397.53
J2780	Ranitidine hydrochloride inj		N1		
J2783	Rasburicase		K2		$147.46
J2788	Rho d immune globulin 50 mcg		K2		$27.89
J2790	Rho d immune globulin inj		K2		$88.01
J2791	Rhophylac injection		K2		$5.22
J2792	Rho(D) immune globulin h, sd		K2		$15.32

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J2794	Risperidone, long acting		K2		$4.84
J2795	Ropivacaine HCl injection		N1		
J2800	Methocarbamol injection		N1		
J2805	Sincalide injection		N1		
J2810	Inj theophylline per 40 MG		N1		
J2820	Sargramostim injection		K2		$24.63
J2850	Inj secretin synthetic human		K2		$19.93
J2910	Aurothioglucose injeciton		N1		
J2916	Na ferric gluconate complex		N1		
J2920	Methylprednisolone injection		N1		
J2930	Methylprednisolone injection		N1		
J2940	Somatrem injection	CH	N1		
J2941	Somatropin injection		K2		$47.18
J2950	Promazine hcl injection		N1		
J2993	Reteplase injection		K2		$818.01
J2995	Inj streptokinase /250000 IU	CH	N1		
J2997	Alteplase recombinant		K2		$31.57
J3000	Streptomycin injection		N1		
J3010	Fentanyl citrate injeciton		N1		
J3030	Sumatriptan succinate / 6 MG		K2		$65.35
J3070	Pentazocine injection		N1		
J3100	Tenecteplase injection		K2		$2,007.72
J3105	Terbutaline sulfate inj		N1		
J3120	Testosterone enanthate inj		N1		
J3130	Testosterone enanthate inj		N1		
J3140	Testosterone suspension inj		N1		
J3150	Testosteron propionate inj		N1		
J3230	Chlorpromazine hcl injection		N1		
J3240	Thyrotropin injection		K2		$823.13
J3243	Tigecycline injection		K2		$1.00
J3246	Tirofiban HCl		K2		$7.28
J3250	Trimethobenzamide hcl inj		N1		
J3260	Tobramycin sulfate injection		N1		
J3265	Injection torsemide 10 mg/ml		N1		
J3280	Thiethylperazine maleate inj		N1		
J3285	Treprostinil injection		K2		$54.83
J3301	Triamcinolone acetonide inj		N1		
J3302	Triamcinolone diacetate inj		N1		
J3303	Triamcinolone hexacetonl inj		N1		
J3305	Inj trimetrexate glucoronate		K2		$146.89
J3310	Perphenazine injeciton		N1		

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J3315	Triptorelin pamoate		K2		$146.35
J3320	Spectinomycn di-hcl inj		N1		
J3350	Urea injection	CH	N1		
J3355	Urofollitropin, 75 iu		K2		$48.25
J3360	Diazepam injection		N1		
J3364	Urokinase 5000 IU injection		N1		
J3365	Urokinase 250,000 IU inj		K2		$449.09
J3370	Vancomycin hcl injection		N1		
J3396	Verteporfin injection		K2		$8.98
J3400	Triflupromazine hcl inj	CH	K2		$20.14
J3410	Hydroxyzine hcl injection		N1		
J3411	Thiamine hcl 100 mg		N1		
J3415	Pyridoxine hcl 100 mg		N1		
J3420	Vitamin b12 injection		N1		
J3430	Vitamin k phytonadione inj		N1		
J3465	Injection, voriconazole		K2		$5.14
J3470	Hyaluronidase injection		N1		
J3471	Ovine, up to 999 USP units		N1		
J3472	Ovine, 1000 USP units		K2		$132.50
J3473	Hyaluronidase recombinant	CH	N1		
J3475	Inj magnesium sulfate		N1		
J3480	Inj potassium chloride		N1		
J3485	Zidovudine		N1		
J3486	Ziprasidone mesylate		N1		
J3487	Zoledronic acid		K2		$206.68
J3488	Reclast injection		K2		$212.50
J3490	Drugs unclassified injection		N1		
J3530	Nasal vaccine inhalation		N1		
J3590	Unclassified biologics		N1		
J7030	Normal saline solution infus		N1		
J7040	Normal saline solution infus		N1		
J7042	5% dextrose/normal saline		N1		
J7050	Normal saline solution infus		N1		
J7060	5% dextrose/water		N1		
J7070	D5w infusion		N1		
J7100	Dextran 40 infusion		N1		
J7110	Dextran 75 infusion		N1		
J7120	Ringers lactate infusion		N1		
J7130	Hypertonic saline solution		N1		
J7187	Humate-P, inj		K2		$0.88
J7189	Factor viia		K2		$1.17

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J7190	Factor viii		K2		$0.74
J7191	Factor VIII (porcine)	CH	K2		$1.17
J7192	Factor viii recombinant		K2		$1.06
J7193	Factor IX non-recombinant		K2		$0.88
J7194	Factor ix complex		K2		$0.79
J7195	Factor IX recombinant		K2		$1.05
J7197	Antithrombin iii injection	CH	N1		
J7198	Anti-inhibitor		K2		$1.41
J7308	Aminolevulinic acid hcl top		K2		$107.67
J7310	Ganciclovir long act implant		K2		$4,680.00
J7311	Fluocinolone acetonide implt		K2		$18,980.00
J7321	Hyalgan/supartz inj per dose		K2		$99.33
J7322	Synvisc inj per dose		K2		$176.66
J7323	Euflexxa inj per dose		K2		$107.97
J7324	Orthovisc inj per dose		K2		$174.32
J7340	Metabolic active D/E tissue		K2		$29.60
J7341	Non-human, metabolic tissue		N1		
J7342	Metabolically active tissue		K2		$36.02
J7343	Nonmetabolic act d/e tissue		K2		$10.61
J7344	Nonmetabolic active tissue		K2		$84.67
J7346	Injectable human tissue		K2		$764.93
J7347	Integra matrix tissue		K2		$18.94
J7348	Tissuemend tissue	CH	N1		
J7349	Primatrix tissue		K2		$37.74
J7500	Azathioprine oral 50mg		N1		
J7501	Azathioprine parenteral		K2		$49.10
J7502	Cyclosporine oral 100 mg		K2		$3.59
J7504	Lymphocyte immune globulin		K2		$376.55
J7505	Monoclonal antibodies		K2		$968.26
J7506	Prednisone oral		N1		
J7507	Tacrolimus oral per 1 MG		K2		$3.84
J7509	Methylprednisolone oral		N1		
J7510	Prednisolone oral per 5 mg		N1		
J7511	Antithymocyte globuln rabbit		K2		$338.22
J7513	Daclizumab, parenteral		K2		$309.72
J7515	Cyclosporine oral 25 mg		N1		
J7516	Cyclosporin parenteral 250mg	CH	K2		$19.44
J7517	Mycophenolate mofetil oral		K2		$2.85
J7518	Mycophenolic acid		K2		$2.41
J7520	Sirolimus, oral		K2		$7.78
J7525	Tacrolimus injection		K2		$137.38

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J7599	Immunosuppressive drug noc		N1		
J7674	Methacholine chloride, neb		N1		
J7799	Non-inhalation drug for DME		N1		
J8501	Oral aprepitant		K2		$5.17
J8510	Oral busulfan		K2		$2.45
J8520	Capecitabine, oral, 150 mg		K2		$4.52
J8521	Capecitabine, oral, 500 mg		K2		$15.00
J8530	Cyclophosphamide oral 25 MG		N1		
J8540	Oral dexamethasone		N1		
J8560	Etoposide oral 50 MG		K2		$28.99
J8597	Antiemetic drug oral NOS		N1		
J8600	Melphalan oral 2 MG	CH	N1		
J8610	Methotrexate oral 2.5 MG		N1		
J8650	Nabilone oral	CH	N1		
J8700	Temozolomide		K2		$7.52
J9000	Doxorubic hcl 10 MG vl chemo		N1		
J9001	Doxorubicin hcl liposome inj		K2		$405.69
J9010	Alemtuzumab injection		K2		$540.67
J9015	Aldesleukin/single use vial		K2		$752.92
J9017	Arsenic trioxide		K2		$33.83
J9020	Asparaginase injection		K2		$55.94
J9025	Azacitidine injection		K2		$4.39
J9027	Clofarabine injection		K2		$113.00
J9031	Bcg live intravesical vac		K2		$111.60
J9035	Bevacizumab injection		K2		$56.35
J9040	Bleomycin sulfate injection	CH	N1		
J9041	Bortezomib injection		K2		$33.78
J9045	Carboplatin injection	CH	N1		
J9050	Carmus bischl nitro inj		K2		$153.87
J9055	Cetuximab injection		K2		$48.87
J9060	Cisplatin 10 MG injection		N1		
J9062	Cisplatin 50 MG injection		N1		
J9065	Inj cladribine per 1 MG		K2		$30.05
J9070	Cyclophosphamide 100 MG inj		N1		
J9080	Cyclophosphamide 200 MG inj		N1		
J9090	Cyclophosphamide 500 MG inj		N1		
J9091	Cyclophosphamide 1.0 grm inj		N1		
J9092	Cyclophosphamide 2.0 grm inj		N1		
J9093	Cyclophosphamide lyophilized		N1		
J9094	Cyclophosphamide lyophilized		N1		
J9095	Cyclophosphamide lyophilized		N1		

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J9096	Cyclophosphamide lyophilized		N1		
J9097	Cyclophosphamide lyophilized		N1		
J9098	Cytarabine liposome		K2		$407.12
J9100	Cytarabine hcl 100 MG inj		N1		
J9110	Cytarabine hcl 500 MG inj		N1		
J9120	Dactinomycin actinomycin d		K2		$484.12
J9130	Dacarbazine 100 mg inj		N1		
J9140	Dacarbazine 200 MG inj		N1		
J9150	Daunorubicin		K2		$16.82
J9151	Daunorubicin citrate liposom		K2		$55.01
J9160	Denileukin diftitox, 300 mcg		K2		$1,383.43
J9165	Diethylstilbestrol injection	CH	K2		$85.15
J9170	Docetaxel		K2		$319.70
J9175	Elliotts b solution per ml		N1		
J9178	Inj, epirubicin hcl, 2 mg		K2		$6.12
J9181	Etoposide 10 MG inj		N1		
J9182	Etoposide 100 MG inj		N1		
J9185	Fludarabine phosphate inj		K2		$196.97
J9190	Fluorouracil injection		N1		
J9200	Floxuridine injection		K2		$50.16
J9201	Gemcitabine HCl		K2		$129.29
J9202	Goserelin acetate implant		K2		$186.15
J9206	Irinotecan injection		K2		$123.85
J9208	Ifosfomide injection		K2		$37.21
J9209	Mesna injection		K2		$7.72
J9211	Idarubicin hcl injection		K2		$270.86
J9212	Interferon alfacon-1	CH	N1		
J9213	Interferon alfa-2a inj		K2		$40.15
J9214	Interferon alfa-2b inj		K2		$13.89
J9215	Interferon alfa-n3 inj		K2		$8.95
J9216	Interferon gamma 1-b inj		K2		$303.74
J9217	Leuprolide acetate suspnsion		K2		$216.69
J9218	Leuprolide acetate injeciton		K2		$7.32
J9219	Leuprolide acetate implant		K2		$1,577.83
J9225	Vantas implant		K2		$1,479.64
J9226	Supprelin LA implant		K2		$14,379.26
J9230	Mechlorethamine hcl inj		K2		$141.72
J9245	Inj melphalan hydrochl 50 MG		K2		$1,534.12
J9250	Methotrexate sodium inj		N1		
J9260	Methotrexate sodium inj		N1		
J9261	Nelarabine injection		K2		$89.95

Note: the Medicare program payment is 80 percent of the total payment amount and beneficiary coinsurance is 20 percent of the total payment amount, except for screening flexible sigmoidoscopies and screening colonoscopies for which the program payment is 75 percent and the beneficiary coinsurance is 25 percent.

HCPCS Code	Short Descriptor	Comment Indicator	Payment Indicator	CY 2009 Second Year Transition Payment Weight	CY 2009 Second Year Transition Payment
J9263	Oxaliplatin		K2		$9.31
J9264	Paclitaxel protein bound		K2		$8.69
J9265	Paclitaxel injection		K2		$11.72
J9266	Pegaspargase/singl dose vial		K2		$2,054.11
J9268	Pentostatin injection		K2		$1,794.41
J9270	Plicamycin (mithramycin) inj	CH	N1		
J9280	Mitomycin 5 MG inj	CH	N1		
J9290	Mitomycin 20 MG inj	CH	N1		
J9291	Mitomycin 40 MG inj	CH	N1		
J9293	Mitoxantrone hydrochl / 5 MG		K2		$87.02
J9300	Gemtuzumab ozogamicin		K2		$2,383.14
J9303	Panitumumab injection		K2		$80.70
J9305	Pemetrexed injection		K2		$45.33
J9310	Rituximab cancer treatment		K2		$510.74
J9320	Streptozocin injection		K2		$187.04
J9340	Thiotepa injection		K2		$39.63
J9350	Topotecan		K2		$881.59
J9355	Trastuzumab		K2		$58.95
J9357	Valrubicin, 200 mg	CH	N1		
J9360	Vinblastine sulfate inj		N1		
J9370	Vincristine sulfate 1 MG inj		N1		
J9375	Vincristine sulfate 2 MG inj		N1		
J9380	Vincristine sulfate 5 MG inj		N1		
J9390	Vinorelbine tartrate/10 mg		K2		$15.91
J9395	Injection, Fulvestrant		K2		$79.83
J9600	Porfimer sodium		K2		$2,456.31
J9999	Chemotherapy drug		N1		
L8600	Implant breast silicone/eq		N1		
L8603	Collagen imp urinary 2.5 ml		N1		
L8606	Synthetic implnt urinary 1ml		N1		
L8609	Artificial cornea		N1		
L8610	Ocular implant		N1		
L8612	Aqueous shunt prosthesis		N1		
L8613	Ossicular implant		N1		
L8614	Cochlear device		N1		
L8630	Metacarpophalangeal implant		N1		
L8631	MCP joint repl 2 pc or more		N1		
L8641	Metatarsal joint implant		N1		
L8642	Hallux implant		N1		
L8658	Interphalangeal joint spacer		N1		
L8659	Interphalangeal joint repl		N1		

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HCPCS Code	Short Descriptor	Comment Indicator	Payment Indicator	CY 2009 Second Year Transition Payment Weight	CY 2009 Second Year Transition Payment
L8670	Vascular graft, synthetic		N1		
L8682	Implt neurostim radiofq rec		N1		
L8690	Aud osseo dev, int/ext comp	CH	N1		
L8699	Prosthetic implant NOS		N1		
P9041	Albumin (human),5%, 50ml		K2		$20.32
P9045	Albumin (human), 5%, 250 ml		K2		$72.68
P9046	Albumin (human), 25%, 20 ml		K2		$24.81
P9047	Albumin (human), 25%, 50ml		K2		$71.52
Q0163	Diphenhydramine HCl 50mg		N1		
Q0164	Prochlorperazine maleate 5mg		N1		
Q0166	Granisetron HCl 1 mg oral		K2		$46.07
Q0167	Dronabinol 2.5mg oral		N1		
Q0169	Promethazine HCl 12.5mg oral		N1		
Q0171	Chlorpromazine HCl 10mg oral		N1		
Q0173	Trimethobenzamide HCl 250mg		N1		
Q0174	Thiethylperazine maleate10mg		N1		
Q0175	Perphenazine 4mg oral		N1		
Q0177	Hydroxyzine pamoate 25mg		N1		
Q0179	Ondansetron HCl 8mg oral		K2		$4.52
Q0180	Dolasetron mesylate oral		K2		$48.24
Q0515	Sermorelin acetate injection		K2		$1.72
Q1003	Ntiol category 3		L6		$50.00
Q2004	Bladder calculi irrig sol		N1		
Q2009	Fosphenytoin, 50 mg	CH	N1		
Q2017	Teniposide, 50 mg		K2		$281.98
Q3025	IM inj interferon beta 1-a		K2		$129.80
Q4096	VWF complex, not Humate-P		K2		$0.64
Q4097	Inj IVIG Privigen 500 mg		K2		$33.54
Q4098	Inj iron dextran		K2		$11.38
Q9951	LOCM >= 400 mg/ml iodine,1ml		N1		
Q9953	Inj Fe-based MR contrast,1ml		N1		
Q9954	Oral MR contrast, 100 ml		N1		
Q9955	Inj perflexane lip micros,ml		N1		
Q9956	Inj octafluoropropane mic,ml		N1		
Q9957	Inj perflutren lip micros,ml		N1		
Q9958	HOCM <=149 mg/ml iodine, 1ml		N1		
Q9959	HOCM 150-199mg/ml iodine,1ml		N1		
Q9960	HOCM 200-249mg/ml iodine,1ml		N1		
Q9961	HOCM 250-299mg/ml iodine,1ml		N1		
Q9962	HOCM 300-349mg/ml iodine,1ml		N1		
Q9963	HOCM 350-399mg/ml iodine,1ml		N1		

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HCPCS Code	Short Descriptor	Comment Indicator	Payment Indicator	CY 2009 Second Year Transition Payment Weight	CY 2009 Second Year Transition Payment
Q9964	HOCM>= 400mg/ml iodine, 1ml		N1		
Q9965	LOCM 100-199mg/ml iodine,1ml		N1		
Q9966	LOCM 200-299mg/ml iodine,1ml		N1		
Q9967	LOCM 300-399mg/ml iodine,1ml		N1		
V2630	Anter chamber intraocul lens		N1		
V2631	Iris support intraoclr lens		N1		
V2632	Post chmbr intraocular lens		N1		
V2785	Corneal tissue processing		F4		
V2790	Amniotic membrane		N1		

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ADDENDUM D1.—PROPOSED OPPS PAYMENT STATUS INDICATORS

Indicator	Item/Code/Service	OPPS Payment Status
A	Services furnished to a hospital outpatient that are paid under a fee schedule or payment system other than OPPS, for example: • Ambulance Services • Clinical Diagnostic Laboratory Services • Non-Implantable Prosthetic and Orthotic Devices • EPO for ESRD Patients • Physical, Occupational, and Speech Therapy • Routine Dialysis Services for ESRD Patients Provided in a Certified Dialysis Unit of a Hospital • Diagnostic Mammography • Screening Mammography	Not paid under OPPS. Paid by fiscal intermediaries/MACs under a fee schedule or payment system other than OPPS. Not subject to deductible or coinsurance. Not subject to deductible.
B	Codes that are not recognized by OPPS when submitted on an outpatient hospital Part B bill type (12x and 13x).	Not paid under OPPS. • May be paid by fiscal intermediaries/MACs when submitted on a different bill type, for example, 75x (CORF), but not paid under OPPS. • An alternate code that is recognized by OPPS when submitted on an outpatient hospital Part B bill type (12x and 13x) may be available.
C	Inpatient Procedures	Not paid under OPPS. Admit patient. Bill as inpatient.
D	Discontinued Codes	Not paid under OPPS or any other Medicare payment system.
E	Items, Codes, and Services: • That are not covered by Medicare based on statutory exclusion. • That are not covered by Medicare for reasons other than statutory exclusion. • That are not recognized by Medicare but for which an alternate code for the same item or service may be available. • For which separate payment is not provided by Medicare.	Not paid under OPPS or any other Medicare payment system.

Indicator	Item/Code/Service	OPPS Payment Status
F	Corneal Tissue Acquisition; Certain CRNA Services and Hepatitis B Vaccines	Not paid under OPPS. Paid at reasonable cost.
G	Pass-Through Drugs and Biologicals	Paid under OPPS; separate APC payment includes pass-through amount.
H	**Pass-Through Device Categories**	Separate cost-based pass-through payment; not subject to copayment.
K	(1) Nonpass-Through Drugs and Biologicals (2) Therapeutic Radiopharmaceuticals	(1) Paid under OPPS; separate APC payment. (2) Paid under OPPS; separate APC payment.
L	Influenza Vaccine; Pneumococcal Pneumonia Vaccine	Not paid under OPPS. Paid at reasonable cost; not subject to deductible or coinsurance.
M	Items and Services Not Billable to the Fiscal Intermediary/MAC	Not paid under OPPS.
N	Items and Services Packaged into APC Rates	Paid under OPPS; payment is packaged into payment for other services, including outliers. Therefore, there is no separate APC payment.
P	Partial Hospitalization	Paid under OPPS; per diem APC payment.
Q1	STVX-Packaged Codes	Paid under OPPS; Addendum B displays APC assignments when services are separately payable. (1) Packaged APC payment if billed on the same date of service as a HCPCS code assigned status indicator "S," "T," "V," or "X." (2) In all other circumstances, payment is made through a separate APC payment.
Q2	T-Packaged Codes	Paid under OPPS; Addendum B displays APC assignments when services are separately payable. (1) Packaged APC payment if billed on the same date of service as a HCPCS code assigned status indicator "T." (2) In all other circumstances, payment is made through a separate APC payment.

Indicator	Item/Code/Service	OPPS Payment Status
Q3	Codes That May Be Paid Through a Composite APC	Paid under OPPS; Addendum B displays APC assignments when services are separately payable. Addendum M displays composite APC assignments when codes are paid through a composite APC. (1) Composite APC payment based on OPPS composite-specific payment criteria. Payment is packaged into a single payment for specific combinations of service. (2) In all other circumstances, payment is made through a separate APC payment or packaged into payment for other services.
R	Blood and Blood Products	Paid under OPPS; separate APC payment.
S	Significant Procedure, Not Discounted when Multiple	Paid under OPPS; separate APC payment.
T	Significant Procedure, Multiple Reduction Applies	Paid under OPPS; separate APC payment.
U	Brachytherapy Sources	Paid under OPPS; separate APC payment.
V	Clinic or Emergency Department Visit	Paid under OPPS; separate APC payment.
X	Ancillary Services	Paid under OPPS; separate APC payment.
Y	Non-Implantable Durable Medical Equipment	Not paid under OPPS. All institutional providers other than home health agencies bill to DMERC.

ADDENDUM DD1.--PROPOSED ASC PAYMENT INDICATORS

Indicator	Payment Indicator Definition
A2	Surgical procedure on ASC list in CY 2007; payment based on OPPS relative payment weight.
D5	Deleted/discontinued code; no payment made.
F4	Corneal tissue acquisition, hepatitis B vaccine; paid at reasonable cost.
G2	Non office-based surgical procedure added in CY 2008 or later; payment based on OPPS relative payment weight.
H2	Brachytherapy source paid separately when provided integral to a surgical procedure on ASC list; payment based on OPPS rate.
H8	Device-intensive procedure on ASC list in CY 2007; paid at adjusted rate.
J7	OPPS pass-through device paid separately when provided integral to a surgical procedure on ASC list; payment contractor-priced.
J8	Device-intensive procedure added to ASC list in CY 2008 or later; paid at adjusted rate.
K2	Drugs and biologicals paid separately when provided integral to a surgical procedure on ASC list; payment based on OPPS rate.
K7	Unclassified drugs and biologicals; payment contractor-priced.
L1	Influenza vaccine; pneumococcal vaccine. Packaged item/service; no separate payment made.
L6	New Technology Intraocular Lens (NTIOL); special payment.
N1	Packaged service/item; no separate payment made.
P2	Office-based surgical procedure added to ASC list in CY 2008 or later with MPFS nonfacility PE RVUs; payment based on OPPS relative payment weight.
P3	Office-based surgical procedure added to ASC list in CY 2008 or later with MPFS nonfacility PE RVUs; payment based on MPFS nonfacility PE RVUs.
R2	Office-based surgical procedure added to ASC list in CY 2008 or later without MPFS nonfacility PE RVUs; payment based on OPPS relative payment weight.
Z2	Radiology service paid separately when provided integral to a surgical procedure on ASC list; payment based on OPPS relative payment weight.
Z3	Radiology service paid separately when provided integral to a surgical procedure on ASC list; payment based on MPFS nonfacility PE RVUs.

ADDENDUM D2.--PROPOSED OPPS COMMENT INDICATORS

Comment Indicator	Descriptor
NI	New code, interim APC assignment; comments will be accepted on the interim APC assignment for the new code.
CH	Active HCPCS code in current year and next calendar year, status indicator and/or APC assignment has changed; or active HCPCS code that will be discontinued at the end of the current calendar year.

ADDENDUM DD2.--PROPOSED ASC COMMENT INDICATORS

Comment Indicator	Comment Indicator Meanings
CH	Active HCPCS code in current year and next calendar year, payment indicator assignment has changed; or active HCPCS code that is newly recognized as payable in ASC; or active HCPCS code that will be discontinued at the end of the current calendar year.
NI	New code, interim payment indicator assignment; comments will be accepted on the interim payment assignment for the new code.

ADDENDUM E.--PROPOSED HCPCS CODES THAT WOULD BE PAID ONLY AS INPATIENT PROCEDURES FOR CY 2009

HCPCS Code	Short Descriptor	SI
00176	Anesth, pharyngeal surgery	C
00192	Anesth, facial bone surgery	C
00214	Anesth, skull drainage	C
00215	Anesth, skull repair/fract	C
00452	Anesth, surgery of shoulder	C
00474	Anesth, surgery of rib(s)	C
00524	Anesth, chest drainage	C
00540	Anesth, chest surgery	C
00542	Anesth, release of lung	C
00546	Anesth, lung,chest wall surg	C
00560	Anesth, heart surg w/o pump	C
00561	Anesth, heart surg < age 1	C
00562	Anesth, heart surg w/pump	C
00580	Anesth, heart/lung transplnt	C
00604	Anesth, sitting procedure	C
00622	Anesth, removal of nerves	C
00632	Anesth, removal of nerves	C
00670	Anesth, spine, cord surgery	C
00792	Anesth, hemorr/excise liver	C
00794	Anesth, pancreas removal	C
00796	Anesth, for liver transplant	C
00802	Anesth, fat layer removal	C
00844	Anesth, pelvis surgery	C
00846	Anesth, hysterectomy	C
00848	Anesth, pelvic organ surg	C
00864	Anesth, removal of bladder	C
00865	Anesth, removal of prostate	C
00866	Anesth, removal of adrenal	C
00868	Anesth, kidney transplant	C
00882	Anesth, major vein ligation	C
00904	Anesth, perineal surgery	C
00908	Anesth, removal of prostate	C

HCPCS Code	Short Descriptor	SI
00932	Anesth, amputation of penis	C
00934	Anesth, penis, nodes removal	C
00936	Anesth, penis, nodes removal	C
00944	Anesth, vaginal hysterectomy	C
01140	Anesth, amputation at pelvis	C
01150	Anesth, pelvic tumor surgery	C
01212	Anesth, hip disarticulation	C
01214	Anesth, hip arthroplasty	C
01232	Anesth, amputation of femur	C
01234	Anesth, radical femur surg	C
01272	Anesth, femoral artery surg	C
01274	Anesth, femoral embolectomy	C
01402	Anesth, knee arthroplasty	C
01404	Anesth, amputation at knee	C
01442	Anesth, knee artery surg	C
01444	Anesth, knee artery repair	C
01486	Anesth, ankle replacement	C
01502	Anesth, lwr leg embolectomy	C
01632	Anesth, surgery of shoulder	C
01634	Anesth, shoulder joint amput	C
01636	Anesth, forequarter amput	C
01638	Anesth, shoulder replacement	C
01652	Anesth, shoulder vessel surg	C
01654	Anesth, shoulder vessel surg	C
01656	Anesth, arm-leg vessel surg	C
01756	Anesth, radical humerus surg	C
01990	Support for organ donor	C
11004	Debride genitalia & perineum	C
11005	Debride abdom wall	C
11006	Debride genit/per/abdom wall	C
11008	Remove mesh from abd wall	C
15756	Free myo/skin flap microvasc	C
15757	Free skin flap, microvasc	C
15758	Free fascial flap, microvasc	C
16036	Escharotomy; add'l incision	C
19271	Revision of chest wall	C
19272	Extensive chest wall surgery	C
19305	Mast, radical	C
19306	Mast, rad, urban type	C
19361	Breast reconstr w/lat flap	C
19364	Breast reconstruction	C
19367	Breast reconstruction	C
19368	Breast reconstruction	C
19369	Breast reconstruction	C
20661	Application of head brace	C
20664	Halo brace application	C

HCPCS Code	Short Descriptor	SI
20802	Replantation, arm, complete	C
20805	Replant forearm, complete	C
20808	Replantation hand, complete	C
20816	Replantation digit, complete	C
20824	Replantation thumb, complete	C
20827	Replantation thumb, complete	C
20838	Replantation foot, complete	C
20930	Sp bone algrft morsel add-on	C
20931	Sp bone algrft struct add-on	C
20936	Sp bone agrft local add-on	C
20937	Sp bone agrft morsel add-on	C
20938	Sp bone agrft struct add-on	C
20955	Fibula bone graft, microvasc	C
20956	Iliac bone graft, microvasc	C
20957	Mt bone graft, microvasc	C
20962	Other bone graft, microvasc	C
20969	Bone/skin graft, microvasc	C
20970	Bone/skin graft, iliac crest	C
21045	Extensive jaw surgery	C
21141	Reconstruct midface, lefort	C
21142	Reconstruct midface, lefort	C
21143	Reconstruct midface, lefort	C
21145	Reconstruct midface, lefort	C
21146	Reconstruct midface, lefort	C
21147	Reconstruct midface, lefort	C
21151	Reconstruct midface, lefort	C
21154	Reconstruct midface, lefort	C
21155	Reconstruct midface, lefort	C
21159	Reconstruct midface, lefort	C
21160	Reconstruct midface, lefort	C
21179	Reconstruct entire forehead	C
21180	Reconstruct entire forehead	C
21182	Reconstruct cranial bone	C
21183	Reconstruct cranial bone	C
21184	Reconstruct cranial bone	C
21188	Reconstruction of midface	C
21193	Reconst lwr jaw w/o graft	C
21194	Reconst lwr jaw w/graft	C
21196	Reconst lwr jaw w/fixation	C
21247	Reconstruct lower jaw bone	C
21255	Reconstruct lower jaw bone	C
21256	Reconstruction of orbit	C
21268	Revise eye sockets	C
21343	Treatment of sinus fracture	C
21344	Treatment of sinus fracture	C
21346	Treat nose/jaw fracture	C

HCPCS Code	Short Descriptor	SI
21347	Treat nose/jaw fracture	C
21348	Treat nose/jaw fracture	C
21366	Treat cheek bone fracture	C
21395	Treat eye socket fracture	C
21422	Treat mouth roof fracture	C
21423	Treat mouth roof fracture	C
21431	Treat craniofacial fracture	C
21432	Treat craniofacial fracture	C
21433	Treat craniofacial fracture	C
21435	Treat craniofacial fracture	C
21436	Treat craniofacial fracture	C
21510	Drainage of bone lesion	C
21615	Removal of rib	C
21616	Removal of rib and nerves	C
21620	Partial removal of sternum	C
21627	Sternal debridement	C
21630	Extensive sternum surgery	C
21632	Extensive sternum surgery	C
21705	Revision of neck muscle/rib	C
21740	Reconstruction of sternum	C
21750	Repair of sternum separation	C
21810	Treatment of rib fracture(s)	C
21825	Treat sternum fracture	C
22010	I&d, p-spine, c/t/cerv-thor	C
22015	I&d, p-spine, l/s/ls	C
22110	Remove part of neck vertebra	C
22112	Remove part, thorax vertebra	C
22114	Remove part, lumbar vertebra	C
22116	Remove extra spine segment	C
22206	Cut spine 3 col, thor	C
22207	Cut spine 3 col, lumb	C
22208	Cut spine 3 col, addl seg	C
22210	Revision of neck spine	C
22212	Revision of thorax spine	C
22214	Revision of lumbar spine	C
22216	Revise, extra spine segment	C
22220	Revision of neck spine	C
22224	Revision of lumbar spine	C
22226	Revise, extra spine segment	C
22318	Treat odontoid fx w/o graft	C
22319	Treat odontoid fx w/graft	C
22325	Treat spine fracture	C
22326	Treat neck spine fracture	C
22327	Treat thorax spine fracture	C
22328	Treat each add spine fx	C
22532	Lat thorax spine fusion	C

HCPCS Code	Short Descriptor	SI
22533	Lat lumbar spine fusion	C
22534	Lat thor/lumb, add'l seg	C
22548	Neck spine fusion	C
22554	Neck spine fusion	C
22556	Thorax spine fusion	C
22558	Lumbar spine fusion	C
22585	Additional spinal fusion	C
22590	Spine & skull spinal fusion	C
22595	Neck spinal fusion	C
22600	Neck spine fusion	C
22610	Thorax spine fusion	C
22630	Lumbar spine fusion	C
22632	Spine fusion, extra segment	C
22800	Fusion of spine	C
22802	Fusion of spine	C
22804	Fusion of spine	C
22808	Fusion of spine	C
22810	Fusion of spine	C
22812	Fusion of spine	C
22818	Kyphectomy, 1-2 segments	C
22819	Kyphectomy, 3 or more	C
22830	Exploration of spinal fusion	C
22840	Insert spine fixation device	C
22841	Insert spine fixation device	C
22842	Insert spine fixation device	C
22843	Insert spine fixation device	C
22844	Insert spine fixation device	C
22845	Insert spine fixation device	C
22846	Insert spine fixation device	C
22847	Insert spine fixation device	C
22848	Insert pelv fixation device	C
22849	Reinsert spinal fixation	C
22850	Remove spine fixation device	C
22852	Remove spine fixation device	C
22855	Remove spine fixation device	C
22857	Lumbar artif diskectomy	C
22862	Revise lumbar artif disc	C
22865	Remove lumb artif disc	C
23200	Removal of collar bone	C
23210	Removal of shoulder blade	C
23220	Partial removal of humerus	C
23221	Partial removal of humerus	C
23222	Partial removal of humerus	C
23332	Remove shoulder foreign body	C
23472	Reconstruct shoulder joint	C
23900	Amputation of arm & girdle	C

HCPCS Code	Short Descriptor	SI
23920	Amputation at shoulder joint	C
24900	Amputation of upper arm	C
24920	Amputation of upper arm	C
24930	Amputation follow-up surgery	C
24931	Amputate upper arm & implant	C
24940	Revision of upper arm	C
25900	Amputation of forearm	C
25905	Amputation of forearm	C
25909	Amputation follow-up surgery	C
25915	Amputation of forearm	C
25920	Amputate hand at wrist	C
25924	Amputation follow-up surgery	C
25927	Amputation of hand	C
26551	Great toe-hand transfer	C
26553	Single transfer, toe-hand	C
26554	Double transfer, toe-hand	C
26556	Toe joint transfer	C
26992	Drainage of bone lesion	C
27005	Incision of hip tendon	C
27025	Incision of hip/thigh fascia	C
27030	Drainage of hip joint	C
27036	Excision of hip joint/muscle	C
27054	Removal of hip joint lining	C
27070	Partial removal of hip bone	C
27071	Partial removal of hip bone	C
27075	Extensive hip surgery	C
27076	Extensive hip surgery	C
27077	Extensive hip surgery	C
27078	Extensive hip surgery	C
27079	Extensive hip surgery	C
27090	Removal of hip prosthesis	C
27091	Removal of hip prosthesis	C
27120	Reconstruction of hip socket	C
27122	Reconstruction of hip socket	C
27125	Partial hip replacement	C
27130	Total hip arthroplasty	C
27132	Total hip arthroplasty	C
27134	Revise hip joint replacement	C
27137	Revise hip joint replacement	C
27138	Revise hip joint replacement	C
27140	Transplant femur ridge	C
27146	Incision of hip bone	C
27147	Revision of hip bone	C
27151	Incision of hip bones	C
27156	Revision of hip bones	C
27158	Revision of pelvis	C

HCPCS Code	Short Descriptor	SI
27161	Incision of neck of femur	C
27165	Incision/fixation of femur	C
27170	Repair/graft femur head/neck	C
27175	Treat slipped epiphysis	C
27176	Treat slipped epiphysis	C
27177	Treat slipped epiphysis	C
27178	Treat slipped epiphysis	C
27179	Revise head/neck of femur	C
27181	Treat slipped epiphysis	C
27185	Revision of femur epiphysis	C
27187	Reinforce hip bones	C
27215	Treat pelvic fracture(s)	C
27217	Treat pelvic ring fracture	C
27218	Treat pelvic ring fracture	C
27222	Treat hip socket fracture	C
27226	Treat hip wall fracture	C
27227	Treat hip fracture(s)	C
27228	Treat hip fracture(s)	C
27232	Treat thigh fracture	C
27236	Treat thigh fracture	C
27240	Treat thigh fracture	C
27244	Treat thigh fracture	C
27245	Treat thigh fracture	C
27248	Treat thigh fracture	C
27253	Treat hip dislocation	C
27254	Treat hip dislocation	C
27258	Treat hip dislocation	C
27259	Treat hip dislocation	C
27268	Cltx thigh fx w/mnpj	C
27269	Optx thigh fx	C
27280	Fusion of sacroiliac joint	C
27282	Fusion of pubic bones	C
27284	Fusion of hip joint	C
27286	Fusion of hip joint	C
27290	Amputation of leg at hip	C
27295	Amputation of leg at hip	C
27303	Drainage of bone lesion	C
27365	Extensive leg surgery	C
27445	Revision of knee joint	C
27447	Total knee arthroplasty	C
27448	Incision of thigh	C
27450	Incision of thigh	C
27454	Realignment of thigh bone	C
27455	Realignment of knee	C
27457	Realignment of knee	C
27465	Shortening of thigh bone	C

HCPCS Code	Short Descriptor	SI
27466	Lengthening of thigh bone	C
27468	Shorten/lengthen thighs	C
27470	Repair of thigh	C
27472	Repair/graft of thigh	C
27477	Surgery to stop leg growth	C
27485	Surgery to stop leg growth	C
27486	Revise/replace knee joint	C
27487	Revise/replace knee joint	C
27488	Removal of knee prosthesis	C
27495	Reinforce thigh	C
27506	Treatment of thigh fracture	C
27507	Treatment of thigh fracture	C
27511	Treatment of thigh fracture	C
27513	Treatment of thigh fracture	C
27514	Treatment of thigh fracture	C
27519	Treat thigh fx growth plate	C
27535	Treat knee fracture	C
27536	Treat knee fracture	C
27540	Treat knee fracture	C
27556	Treat knee dislocation	C
27557	Treat knee dislocation	C
27558	Treat knee dislocation	C
27580	Fusion of knee	C
27590	Amputate leg at thigh	C
27591	Amputate leg at thigh	C
27592	Amputate leg at thigh	C
27596	Amputation follow-up surgery	C
27598	Amputate lower leg at knee	C
27645	Extensive lower leg surgery	C
27646	Extensive lower leg surgery	C
27702	Reconstruct ankle joint	C
27703	Reconstruction, ankle joint	C
27712	Realignment of lower leg	C
27715	Revision of lower leg	C
27724	Repair/graft of tibia	C
27725	Repair of lower leg	C
27727	Repair of lower leg	C
27880	Amputation of lower leg	C
27881	Amputation of lower leg	C
27882	Amputation of lower leg	C
27888	Amputation of foot at ankle	C
28800	Amputation of midfoot	C
28805	Amputation thru metatarsal	C
31225	Removal of upper jaw	C
31230	Removal of upper jaw	C
31290	Nasal/sinus endoscopy, surg	C

HCPCS Code	Short Descriptor	SI
31291	Nasal/sinus endoscopy, surg	C
31360	Removal of larynx	C
31365	Removal of larynx	C
31367	Partial removal of larynx	C
31368	Partial removal of larynx	C
31370	Partial removal of larynx	C
31375	Partial removal of larynx	C
31380	Partial removal of larynx	C
31382	Partial removal of larynx	C
31390	Removal of larynx & pharynx	C
31395	Reconstruct larynx & pharynx	C
31584	Treat larynx fracture	C
31587	Revision of larynx	C
31725	Clearance of airways	C
31760	Repair of windpipe	C
31766	Reconstruction of windpipe	C
31770	Repair/graft of bronchus	C
31775	Reconstruct bronchus	C
31780	Reconstruct windpipe	C
31781	Reconstruct windpipe	C
31786	Remove windpipe lesion	C
31800	Repair of windpipe injury	C
31805	Repair of windpipe injury	C
32035	Exploration of chest	C
32036	Exploration of chest	C
32095	Biopsy through chest wall	C
32100	Exploration/biopsy of chest	C
32110	Explore/repair chest	C
32120	Re-exploration of chest	C
32124	Explore chest free adhesions	C
32140	Removal of lung lesion(s)	C
32141	Remove/treat lung lesions	C
32150	Removal of lung lesion(s)	C
32151	Remove lung foreign body	C
32160	Open chest heart massage	C
32200	Drain, open, lung lesion	C
32215	Treat chest lining	C
32220	Release of lung	C
32225	Partial release of lung	C
32310	Removal of chest lining	C
32320	Free/remove chest lining	C
32402	Open biopsy chest lining	C
32440	Removal of lung	C
32442	Sleeve pneumonectomy	C
32445	Removal of lung	C
32480	Partial removal of lung	C

HCPCS Code	Short Descriptor	SI
32482	Bilobectomy	C
32484	Segmentectomy	C
32486	Sleeve lobectomy	C
32488	Completion pneumonectomy	C
32491	Lung volume reduction	C
32500	Partial removal of lung	C
32501	Repair bronchus add-on	C
32503	Resect apical lung tumor	C
32504	Resect apical lung tum/chest	C
32540	Removal of lung lesion	C
32650	Thoracoscopy, surgical	C
32651	Thoracoscopy, surgical	C
32652	Thoracoscopy, surgical	C
32653	Thoracoscopy, surgical	C
32654	Thoracoscopy, surgical	C
32655	Thoracoscopy, surgical	C
32656	Thoracoscopy, surgical	C
32657	Thoracoscopy, surgical	C
32658	Thoracoscopy, surgical	C
32659	Thoracoscopy, surgical	C
32660	Thoracoscopy, surgical	C
32661	Thoracoscopy, surgical	C
32662	Thoracoscopy, surgical	C
32663	Thoracoscopy, surgical	C
32664	Thoracoscopy, surgical	C
32665	Thoracoscopy, surgical	C
32800	Repair lung hernia	C
32810	Close chest after drainage	C
32815	Close bronchial fistula	C
32820	Reconstruct injured chest	C
32850	Donor pneumonectomy	C
32851	Lung transplant, single	C
32852	Lung transplant with bypass	C
32853	Lung transplant, double	C
32854	Lung transplant with bypass	C
32855	Prepare donor lung, single	C
32856	Prepare donor lung, double	C
32900	Removal of rib(s)	C
32905	Revise & repair chest wall	C
32906	Revise & repair chest wall	C
32940	Revision of lung	C
32997	Total lung lavage	C
33015	Incision of heart sac	C
33020	Incision of heart sac	C
33025	Incision of heart sac	C
33030	Partial removal of heart sac	C

HCPCS Code	Short Descriptor	SI
33031	Partial removal of heart sac	C
33050	Removal of heart sac lesion	C
33120	Removal of heart lesion	C
33130	Removal of heart lesion	C
33140	Heart revascularize (tmr)	C
33141	Heart tmr w/other procedure	C
33202	Insert epicard eltrd, open	C
33203	Insert epicard eltrd, endo	C
33236	Remove electrode/thoracotomy	C
33237	Remove electrode/thoracotomy	C
33238	Remove electrode/thoracotomy	C
33243	Remove eltrd/thoracotomy	C
33250	Ablate heart dysrhythm focus	C
33251	Ablate heart dysrhythm focus	C
33254	Ablate atria, lmtd	C
33255	Ablate atria w/o bypass, ext	C
33256	Ablate atria w/bypass, exten	C
33257	Ablate atria, lmtd, add-on	C
33258	Ablate atria, x10sv, add-on	C
33259	Ablate atria w/bypass add-on	C
33261	Ablate heart dysrhythm focus	C
33265	Ablate atria, lmtd, endo	C
33266	Ablate atria, x10sv, endo	C
33300	Repair of heart wound	C
33305	Repair of heart wound	C
33310	Exploratory heart surgery	C
33315	Exploratory heart surgery	C
33320	Repair major blood vessel(s)	C
33321	Repair major vessel	C
33322	Repair major blood vessel(s)	C
33330	Insert major vessel graft	C
33332	Insert major vessel graft	C
33335	Insert major vessel graft	C
33400	Repair of aortic valve	C
33401	Valvuloplasty, open	C
33403	Valvuloplasty, w/cp bypass	C
33404	Prepare heart-aorta conduit	C
33405	Replacement of aortic valve	C
33406	Replacement of aortic valve	C
33410	Replacement of aortic valve	C
33411	Replacement of aortic valve	C
33412	Replacement of aortic valve	C
33413	Replacement of aortic valve	C
33414	Repair of aortic valve	C
33415	Revision, subvalvular tissue	C
33416	Revise ventricle muscle	C

HCPCS Code	Short Descriptor	SI
33417	Repair of aortic valve	C
33420	Revision of mitral valve	C
33422	Revision of mitral valve	C
33425	Repair of mitral valve	C
33426	Repair of mitral valve	C
33427	Repair of mitral valve	C
33430	Replacement of mitral valve	C
33460	Revision of tricuspid valve	C
33463	Valvuloplasty, tricuspid	C
33464	Valvuloplasty, tricuspid	C
33465	Replace tricuspid valve	C
33468	Revision of tricuspid valve	C
33470	Revision of pulmonary valve	C
33471	Valvotomy, pulmonary valve	C
33472	Revision of pulmonary valve	C
33474	Revision of pulmonary valve	C
33475	Replacement, pulmonary valve	C
33476	Revision of heart chamber	C
33478	Revision of heart chamber	C
33496	Repair, prosth valve clot	C
33500	Repair heart vessel fistula	C
33501	Repair heart vessel fistula	C
33502	Coronary artery correction	C
33503	Coronary artery graft	C
33504	Coronary artery graft	C
33505	Repair artery w/tunnel	C
33506	Repair artery, translocation	C
33507	Repair art, intramural	C
33510	CABG, vein, single	C
33511	CABG, vein, two	C
33512	CABG, vein, three	C
33513	CABG, vein, four	C
33514	CABG, vein, five	C
33516	Cabg, vein, six or more	C
33517	CABG, artery-vein, single	C
33518	CABG, artery-vein, two	C
33519	CABG, artery-vein, three	C
33521	CABG, artery-vein, four	C
33522	CABG, artery-vein, five	C
33523	Cabg, art-vein, six or more	C
33530	Coronary artery, bypass/reop	C
33533	CABG, arterial, single	C
33534	CABG, arterial, two	C
33535	CABG, arterial, three	C
33536	Cabg, arterial, four or more	C
33542	Removal of heart lesion	C

HCPCS Code	Short Descriptor	SI
33545	Repair of heart damage	C
33548	Restore/remodel, ventricle	C
33572	Open coronary endarterectomy	C
33600	Closure of valve	C
33602	Closure of valve	C
33606	Anastomosis/artery-aorta	C
33608	Repair anomaly w/conduit	C
33610	Repair by enlargement	C
33611	Repair double ventricle	C
33612	Repair double ventricle	C
33615	Repair, modified fontan	C
33617	Repair single ventricle	C
33619	Repair single ventricle	C
33641	Repair heart septum defect	C
33645	Revision of heart veins	C
33647	Repair heart septum defects	C
33660	Repair of heart defects	C
33665	Repair of heart defects	C
33670	Repair of heart chambers	C
33675	Close mult vsd	C
33676	Close mult vsd w/resection	C
33677	Cl mult vsd w/rem pul band	C
33681	Repair heart septum defect	C
33684	Repair heart septum defect	C
33688	Repair heart septum defect	C
33690	Reinforce pulmonary artery	C
33692	Repair of heart defects	C
33694	Repair of heart defects	C
33697	Repair of heart defects	C
33702	Repair of heart defects	C
33710	Repair of heart defects	C
33720	Repair of heart defect	C
33722	Repair of heart defect	C
33724	Repair venous anomaly	C
33726	Repair pul venous stenosis	C
33730	Repair heart-vein defect(s)	C
33732	Repair heart-vein defect	C
33735	Revision of heart chamber	C
33736	Revision of heart chamber	C
33737	Revision of heart chamber	C
33750	Major vessel shunt	C
33755	Major vessel shunt	C
33762	Major vessel shunt	C
33764	Major vessel shunt & graft	C
33766	Major vessel shunt	C
33767	Major vessel shunt	C

HCPCS Code	Short Descriptor	SI
33768	Cavopulmonary shunting	C
33770	Repair great vessels defect	C
33771	Repair great vessels defect	C
33774	Repair great vessels defect	C
33775	Repair great vessels defect	C
33776	Repair great vessels defect	C
33777	Repair great vessels defect	C
33778	Repair great vessels defect	C
33779	Repair great vessels defect	C
33780	Repair great vessels defect	C
33781	Repair great vessels defect	C
33786	Repair arterial trunk	C
33788	Revision of pulmonary artery	C
33800	Aortic suspension	C
33802	Repair vessel defect	C
33803	Repair vessel defect	C
33813	Repair septal defect	C
33814	Repair septal defect	C
33820	Revise major vessel	C
33822	Revise major vessel	C
33824	Revise major vessel	C
33840	Remove aorta constriction	C
33845	Remove aorta constriction	C
33851	Remove aorta constriction	C
33852	Repair septal defect	C
33853	Repair septal defect	C
33860	Ascending aortic graft	C
33861	Ascending aortic graft	C
33863	Ascending aortic graft	C
33864	Ascending aortic graft	C
33870	Transverse aortic arch graft	C
33875	Thoracic aortic graft	C
33877	Thoracoabdominal graft	C
33880	Endovasc taa repr incl subcl	C
33881	Endovasc taa repr w/o subcl	C
33883	Insert endovasc prosth, taa	C
33884	Endovasc prosth, taa, add-on	C
33886	Endovasc prosth, delayed	C
33889	Artery transpose/endovas taa	C
33891	Car-car bp grft/endovas taa	C
33910	Remove lung artery emboli	C
33915	Remove lung artery emboli	C
33916	Surgery of great vessel	C
33917	Repair pulmonary artery	C
33920	Repair pulmonary atresia	C
33922	Transect pulmonary artery	C

HCPCS Code	Short Descriptor	SI
33924	Remove pulmonary shunt	C
33925	Rpr pul art unifocal w/o cpb	C
33926	Repr pul art, unifocal w/cpb	C
33930	Removal of donor heart/lung	C
33933	Prepare donor heart/lung	C
33935	Transplantation, heart/lung	C
33940	Removal of donor heart	C
33944	Prepare donor heart	C
33945	Transplantation of heart	C
33960	External circulation assist	C
33961	External circulation assist	C
33967	Insert ia percut device	C
33968	Remove aortic assist device	C
33970	Aortic circulation assist	C
33971	Aortic circulation assist	C
33973	Insert balloon device	C
33974	Remove intra-aortic balloon	C
33975	Implant ventricular device	C
33976	Implant ventricular device	C
33977	Remove ventricular device	C
33978	Remove ventricular device	C
33979	Insert intracorporeal device	C
33980	Remove intracorporeal device	C
34001	Removal of artery clot	C
34051	Removal of artery clot	C
34151	Removal of artery clot	C
34401	Removal of vein clot	C
34451	Removal of vein clot	C
34502	Reconstruct vena cava	C
34800	Endovas aaa repr w/sm tube	C
34802	Endovas aaa repr w/2-p part	C
34803	Endovas aaa repr w/3-p part	C
34804	Endovas aaa repr w/1-p part	C
34805	Endovas aaa repr w/long tube	C
34806	Aneurysm press sensor add-on	C
34808	Endovas iliac a device addon	C
34812	Xpose for endoprosth, femorl	C
34813	Femoral endovas graft add-on	C
34820	Xpose for endoprosth, iliac	C
34825	Endovasc extend prosth, init	C
34826	Endovasc exten prosth, add'l	C
34830	Open aortic tube prosth repr	C
34831	Open aortoiliac prosth repr	C
34832	Open aortofemor prosth repr	C
34833	Xpose for endoprosth, iliac	C
34834	Xpose, endoprosth, brachial	C

HCPCS Code	Short Descriptor	SI
34900	Endovasc iliac repr w/graft	C
35001	Repair defect of artery	C
35002	Repair artery rupture, neck	C
35005	Repair defect of artery	C
35013	Repair artery rupture, arm	C
35021	Repair defect of artery	C
35022	Repair artery rupture, chest	C
35045	Repair defect of arm artery	C
35081	Repair defect of artery	C
35082	Repair artery rupture, aorta	C
35091	Repair defect of artery	C
35092	Repair artery rupture, aorta	C
35102	Repair defect of artery	C
35103	Repair artery rupture, groin	C
35111	Repair defect of artery	C
35112	Repair artery rupture,spleen	C
35121	Repair defect of artery	C
35122	Repair artery rupture, belly	C
35131	Repair defect of artery	C
35132	Repair artery rupture, groin	C
35141	Repair defect of artery	C
35142	Repair artery rupture, thigh	C
35151	Repair defect of artery	C
35152	Repair artery rupture, knee	C
35182	Repair blood vessel lesion	C
35189	Repair blood vessel lesion	C
35211	Repair blood vessel lesion	C
35216	Repair blood vessel lesion	C
35221	Repair blood vessel lesion	C
35241	Repair blood vessel lesion	C
35246	Repair blood vessel lesion	C
35251	Repair blood vessel lesion	C
35271	Repair blood vessel lesion	C
35276	Repair blood vessel lesion	C
35281	Repair blood vessel lesion	C
35301	Rechanneling of artery	C
35302	Rechanneling of artery	C
35303	Rechanneling of artery	C
35304	Rechanneling of artery	C
35305	Rechanneling of artery	C
35306	Rechanneling of artery	C
35311	Rechanneling of artery	C
35331	Rechanneling of artery	C
35341	Rechanneling of artery	C
35351	Rechanneling of artery	C
35355	Rechanneling of artery	C

HCPCS Code	Short Descriptor	SI
35361	Rechanneling of artery	C
35363	Rechanneling of artery	C
35371	Rechanneling of artery	C
35372	Rechanneling of artery	C
35390	Reoperation, carotid add-on	C
35400	Angioscopy	C
35450	Repair arterial blockage	C
35452	Repair arterial blockage	C
35454	Repair arterial blockage	C
35456	Repair arterial blockage	C
35480	Atherectomy, open	C
35481	Atherectomy, open	C
35482	Atherectomy, open	C
35483	Atherectomy, open	C
35501	Artery bypass graft	C
35506	Artery bypass graft	C
35508	Artery bypass graft	C
35509	Artery bypass graft	C
35510	Artery bypass graft	C
35511	Artery bypass graft	C
35512	Artery bypass graft	C
35515	Artery bypass graft	C
35516	Artery bypass graft	C
35518	Artery bypass graft	C
35521	Artery bypass graft	C
35522	Artery bypass graft	C
35523	Artery bypass graft	C
35525	Artery bypass graft	C
35526	Artery bypass graft	C
35531	Artery bypass graft	C
35533	Artery bypass graft	C
35536	Artery bypass graft	C
35537	Artery bypass graft	C
35538	Artery bypass graft	C
35539	Artery bypass graft	C
35540	Artery bypass graft	C
35548	Artery bypass graft	C
35549	Artery bypass graft	C
35551	Artery bypass graft	C
35556	Artery bypass graft	C
35558	Artery bypass graft	C
35560	Artery bypass graft	C
35563	Artery bypass graft	C
35565	Artery bypass graft	C
35566	Artery bypass graft	C
35571	Artery bypass graft	C

HCPCS Code	Short Descriptor	SI
35583	Vein bypass graft	C
35585	Vein bypass graft	C
35587	Vein bypass graft	C
35600	Harvest art for cabg add-on	C
35601	Artery bypass graft	C
35606	Artery bypass graft	C
35612	Artery bypass graft	C
35616	Artery bypass graft	C
35621	Artery bypass graft	C
35623	Bypass graft, not vein	C
35626	Artery bypass graft	C
35631	Artery bypass graft	C
35636	Artery bypass graft	C
35637	Artery bypass graft	C
35638	Artery bypass graft	C
35642	Artery bypass graft	C
35645	Artery bypass graft	C
35646	Artery bypass graft	C
35647	Artery bypass graft	C
35650	Artery bypass graft	C
35651	Artery bypass graft	C
35654	Artery bypass graft	C
35656	Artery bypass graft	C
35661	Artery bypass graft	C
35663	Artery bypass graft	C
35665	Artery bypass graft	C
35666	Artery bypass graft	C
35671	Artery bypass graft	C
35681	Composite bypass graft	C
35682	Composite bypass graft	C
35683	Composite bypass graft	C
35691	Arterial transposition	C
35693	Arterial transposition	C
35694	Arterial transposition	C
35695	Arterial transposition	C
35697	Reimplant artery each	C
35700	Reoperation, bypass graft	C
35701	Exploration, carotid artery	C
35721	Exploration, femoral artery	C
35741	Exploration popliteal artery	C
35800	Explore neck vessels	C
35820	Explore chest vessels	C
35840	Explore abdominal vessels	C
35870	Repair vessel graft defect	C
35901	Excision, graft, neck	C
35905	Excision, graft, thorax	C

HCPCS Code	Short Descriptor	SI
35907	Excision, graft, abdomen	C
36660	Insertion catheter, artery	C
36822	Insertion of cannula(s)	C
36823	Insertion of cannula(s)	C
37140	Revision of circulation	C
37145	Revision of circulation	C
37160	Revision of circulation	C
37180	Revision of circulation	C
37181	Splice spleen/kidney veins	C
37182	Insert hepatic shunt (tips)	C
37215	Transcath stent, cca w/eps	C
37616	Ligation of chest artery	C
37617	Ligation of abdomen artery	C
37618	Ligation of extremity artery	C
37660	Revision of major vein	C
37788	Revascularization, penis	C
38100	Removal of spleen, total	C
38101	Removal of spleen, partial	C
38102	Removal of spleen, total	C
38115	Repair of ruptured spleen	C
38380	Thoracic duct procedure	C
38381	Thoracic duct procedure	C
38382	Thoracic duct procedure	C
38562	Removal, pelvic lymph nodes	C
38564	Removal, abdomen lymph nodes	C
38724	Removal of lymph nodes, neck	C
38746	Remove thoracic lymph nodes	C
38747	Remove abdominal lymph nodes	C
38765	Remove groin lymph nodes	C
38770	Remove pelvis lymph nodes	C
38780	Remove abdomen lymph nodes	C
39000	Exploration of chest	C
39010	Exploration of chest	C
39200	Removal chest lesion	C
39220	Removal chest lesion	C
39499	Chest procedure	C
39501	Repair diaphragm laceration	C
39502	Repair paraesophageal hernia	C
39503	Repair of diaphragm hernia	C
39520	Repair of diaphragm hernia	C
39530	Repair of diaphragm hernia	C
39531	Repair of diaphragm hernia	C
39540	Repair of diaphragm hernia	C
39541	Repair of diaphragm hernia	C
39545	Revision of diaphragm	C
39560	Resect diaphragm, simple	C

HCPCS Code	Short Descriptor	SI
39561	Resect diaphragm, complex	C
39599	Diaphragm surgery procedure	C
41130	Partial removal of tongue	C
41135	Tongue and neck surgery	C
41140	Removal of tongue	C
41145	Tongue removal, neck surgery	C
41150	Tongue, mouth, jaw surgery	C
41153	Tongue, mouth, neck surgery	C
41155	Tongue, jaw, & neck surgery	C
42426	Excise parotid gland/lesion	C
42845	Extensive surgery of throat	C
42894	Revision of pharyngeal walls	C
42953	Repair throat, esophagus	C
42961	Control throat bleeding	C
42971	Control nose/throat bleeding	C
43045	Incision of esophagus	C
43100	Excision of esophagus lesion	C
43101	Excision of esophagus lesion	C
43107	Removal of esophagus	C
43108	Removal of esophagus	C
43112	Removal of esophagus	C
43113	Removal of esophagus	C
43116	Partial removal of esophagus	C
43117	Partial removal of esophagus	C
43118	Partial removal of esophagus	C
43121	Partial removal of esophagus	C
43122	Partial removal of esophagus	C
43123	Partial removal of esophagus	C
43124	Removal of esophagus	C
43135	Removal of esophagus pouch	C
43300	Repair of esophagus	C
43305	Repair esophagus and fistula	C
43310	Repair of esophagus	C
43312	Repair esophagus and fistula	C
43313	Esophagoplasty congenital	C
43314	Tracheo-esophagoplasty cong	C
43320	Fuse esophagus & stomach	C
43324	Revise esophagus & stomach	C
43325	Revise esophagus & stomach	C
43326	Revise esophagus & stomach	C
43330	Repair of esophagus	C
43331	Repair of esophagus	C
43340	Fuse esophagus & intestine	C
43341	Fuse esophagus & intestine	C
43350	Surgical opening, esophagus	C
43351	Surgical opening, esophagus	C

HCPCS Code	Short Descriptor	SI
43352	Surgical opening, esophagus	C
43360	Gastrointestinal repair	C
43361	Gastrointestinal repair	C
43400	Ligate esophagus veins	C
43401	Esophagus surgery for veins	C
43405	Ligate/staple esophagus	C
43410	Repair esophagus wound	C
43415	Repair esophagus wound	C
43425	Repair esophagus opening	C
43460	Pressure treatment esophagus	C
43496	Free jejunum flap, microvasc	C
43500	Surgical opening of stomach	C
43501	Surgical repair of stomach	C
43502	Surgical repair of stomach	C
43520	Incision of pyloric muscle	C
43605	Biopsy of stomach	C
43610	Excision of stomach lesion	C
43611	Excision of stomach lesion	C
43620	Removal of stomach	C
43621	Removal of stomach	C
43622	Removal of stomach	C
43631	Removal of stomach, partial	C
43632	Removal of stomach, partial	C
43633	Removal of stomach, partial	C
43634	Removal of stomach, partial	C
43635	Removal of stomach, partial	C
43640	Vagotomy & pylorus repair	C
43641	Vagotomy & pylorus repair	C
43644	Lap gastric bypass/roux-en-y	C
43645	Lap gastr bypass incl smll i	C
43770	Lap place gastr adj device	C
43771	Lap revise gastr adj device	C
43772	Lap rmvl gastr adj device	C
43773	Lap replace gastr adj device	C
43774	Lap rmvl gastr adj all parts	C
43800	Reconstruction of pylorus	C
43810	Fusion of stomach and bowel	C
43820	Fusion of stomach and bowel	C
43825	Fusion of stomach and bowel	C
43832	Place gastrostomy tube	C
43840	Repair of stomach lesion	C
43843	Gastroplasty w/o v-band	C
43845	Gastroplasty duodenal switch	C
43846	Gastric bypass for obesity	C
43847	Gastric bypass incl small i	C
43848	Revision gastroplasty	C

HCPCS Code	Short Descriptor	SI
43850	Revise stomach-bowel fusion	C
43855	Revise stomach-bowel fusion	C
43860	Revise stomach-bowel fusion	C
43865	Revise stomach-bowel fusion	C
43880	Repair stomach-bowel fistula	C
43881	Impl/redo electrd, antrum	C
43882	Revise/remove electrd antrum	C
44005	Freeing of bowel adhesion	C
44010	Incision of small bowel	C
44015	Insert needle cath bowel	C
44020	Explore small intestine	C
44021	Decompress small bowel	C
44025	Incision of large bowel	C
44050	Reduce bowel obstruction	C
44055	Correct malrotation of bowel	C
44110	Excise intestine lesion(s)	C
44111	Excision of bowel lesion(s)	C
44120	Removal of small intestine	C
44121	Removal of small intestine	C
44125	Removal of small intestine	C
44126	Enterectomy w/o taper, cong	C
44127	Enterectomy w/taper, cong	C
44128	Enterectomy cong, add-on	C
44130	Bowel to bowel fusion	C
44132	Enterectomy, cadaver donor	C
44133	Enterectomy, live donor	C
44135	Intestine transplnt, cadaver	C
44136	Intestine transplant, live	C
44137	Remove intestinal allograft	C
44139	Mobilization of colon	C
44140	Partial removal of colon	C
44141	Partial removal of colon	C
44143	Partial removal of colon	C
44144	Partial removal of colon	C
44145	Partial removal of colon	C
44146	Partial removal of colon	C
44147	Partial removal of colon	C
44150	Removal of colon	C
44151	Removal of colon/ileostomy	C
44155	Removal of colon/ileostomy	C
44156	Removal of colon/ileostomy	C
44157	Colectomy w/ileoanal anast	C
44158	Colectomy w/neo-rectum pouch	C
44160	Removal of colon	C
44187	Lap, ileo/jejuno-stomy	C
44188	Lap, colostomy	C

HCPCS Code	Short Descriptor	SI
44202	Lap, enterectomy	C
44203	Lap resect s/intestine, addl	C
44204	Laparo partial colectomy	C
44205	Lap colectomy part w/ileum	C
44210	Laparo total proctocolectomy	C
44211	Lap colectomy w/proctectomy	C
44212	Laparo total proctocolectomy	C
44227	Lap, close enterostomy	C
44300	Open bowel to skin	C
44310	Ileostomy/jejunostomy	C
44314	Revision of ileostomy	C
44316	Devise bowel pouch	C
44320	Colostomy	C
44322	Colostomy with biopsies	C
44345	Revision of colostomy	C
44346	Revision of colostomy	C
44602	Suture, small intestine	C
44603	Suture, small intestine	C
44604	Suture, large intestine	C
44605	Repair of bowel lesion	C
44615	Intestinal stricturoplasty	C
44620	Repair bowel opening	C
44625	Repair bowel opening	C
44626	Repair bowel opening	C
44640	Repair bowel-skin fistula	C
44650	Repair bowel fistula	C
44660	Repair bowel-bladder fistula	C
44661	Repair bowel-bladder fistula	C
44680	Surgical revision, intestine	C
44700	Suspend bowel w/prosthesis	C
44715	Prepare donor intestine	C
44720	Prep donor intestine/venous	C
44721	Prep donor intestine/artery	C
44800	Excision of bowel pouch	C
44820	Excision of mesentery lesion	C
44850	Repair of mesentery	C
44899	Bowel surgery procedure	C
44900	Drain app abscess, open	C
44950	Appendectomy	C
44955	Appendectomy add-on	C
44960	Appendectomy	C
45110	Removal of rectum	C
45111	Partial removal of rectum	C
45112	Removal of rectum	C
45113	Partial proctectomy	C
45114	Partial removal of rectum	C

HCPCS Code	Short Descriptor	SI
45116	Partial removal of rectum	C
45119	Remove rectum w/reservoir	C
45120	Removal of rectum	C
45121	Removal of rectum and colon	C
45123	Partial proctectomy	C
45126	Pelvic exenteration	C
45130	Excision of rectal prolapse	C
45135	Excision of rectal prolapse	C
45136	Excise ileoanal reservior	C
45395	Lap, removal of rectum	C
45397	Lap, remove rectum w/pouch	C
45400	Laparoscopic proc	C
45402	Lap proctopexy w/sig resect	C
45540	Correct rectal prolapse	C
45550	Repair rectum/remove sigmoid	C
45562	Exploration/repair of rectum	C
45563	Exploration/repair of rectum	C
45800	Repair rect/bladder fistula	C
45805	Repair fistula w/colostomy	C
45820	Repair rectourethral fistula	C
45825	Repair fistula w/colostomy	C
46705	Repair of anal stricture	C
46710	Repr per/vag pouch sngl proc	C
46712	Repr per/vag pouch dbl proc	C
46715	Rep perf anoper fistu	C
46716	Rep perf anoper/vestib fistu	C
46730	Construction of absent anus	C
46735	Construction of absent anus	C
46740	Construction of absent anus	C
46742	Repair of imperforated anus	C
46744	Repair of cloacal anomaly	C
46746	Repair of cloacal anomaly	C
46748	Repair of cloacal anomaly	C
46751	Repair of anal sphincter	C
47010	Open drainage, liver lesion	C
47015	Inject/aspirate liver cyst	C
47100	Wedge biopsy of liver	C
47120	Partial removal of liver	C
47122	Extensive removal of liver	C
47125	Partial removal of liver	C
47130	Partial removal of liver	C
47133	Removal of donor liver	C
47135	Transplantation of liver	C
47136	Transplantation of liver	C
47140	Partial removal, donor liver	C
47141	Partial removal, donor liver	C

HCPCS Code	Short Descriptor	SI
47142	Partial removal, donor liver	C
47143	Prep donor liver, whole	C
47144	Prep donor liver, 3-segment	C
47145	Prep donor liver, lobe split	C
47146	Prep donor liver/venous	C
47147	Prep donor liver/arterial	C
47300	Surgery for liver lesion	C
47350	Repair liver wound	C
47360	Repair liver wound	C
47361	Repair liver wound	C
47362	Repair liver wound	C
47380	Open ablate liver tumor rf	C
47381	Open ablate liver tumor cryo	C
47400	Incision of liver duct	C
47420	Incision of bile duct	C
47425	Incision of bile duct	C
47460	Incise bile duct sphincter	C
47480	Incision of gallbladder	C
47550	Bile duct endoscopy add-on	C
47570	Laparo cholecystoenterostomy	C
47600	Removal of gallbladder	C
47605	Removal of gallbladder	C
47610	Removal of gallbladder	C
47612	Removal of gallbladder	C
47620	Removal of gallbladder	C
47700	Exploration of bile ducts	C
47701	Bile duct revision	C
47711	Excision of bile duct tumor	C
47712	Excision of bile duct tumor	C
47715	Excision of bile duct cyst	C
47720	Fuse gallbladder & bowel	C
47721	Fuse upper gi structures	C
47740	Fuse gallbladder & bowel	C
47741	Fuse gallbladder & bowel	C
47760	Fuse bile ducts and bowel	C
47765	Fuse liver ducts & bowel	C
47780	Fuse bile ducts and bowel	C
47785	Fuse bile ducts and bowel	C
47800	Reconstruction of bile ducts	C
47801	Placement, bile duct support	C
47802	Fuse liver duct & intestine	C
47900	Suture bile duct injury	C
48000	Drainage of abdomen	C
48001	Placement of drain, pancreas	C
48020	Removal of pancreatic stone	C
48100	Biopsy of pancreas, open	C

HCPCS Code	Short Descriptor	SI
48105	Resect/debride pancreas	C
48120	Removal of pancreas lesion	C
48140	Partial removal of pancreas	C
48145	Partial removal of pancreas	C
48146	Pancreatectomy	C
48148	Removal of pancreatic duct	C
48150	Partial removal of pancreas	C
48152	Pancreatectomy	C
48153	Pancreatectomy	C
48154	Pancreatectomy	C
48155	Removal of pancreas	C
48400	Injection, intraop add-on	C
48500	Surgery of pancreatic cyst	C
48510	Drain pancreatic pseudocyst	C
48520	Fuse pancreas cyst and bowel	C
48540	Fuse pancreas cyst and bowel	C
48545	Pancreatorrhaphy	C
48547	Duodenal exclusion	C
48548	Fuse pancreas and bowel	C
48551	Prep donor pancreas	C
48552	Prep donor pancreas/venous	C
48554	Transpl allograft pancreas	C
48556	Removal, allograft pancreas	C
49000	Exploration of abdomen	C
49002	Reopening of abdomen	C
49010	Exploration behind abdomen	C
49020	Drain abdominal abscess	C
49040	Drain, open, abdom abscess	C
49060	Drain, open, retrop abscess	C
49062	Drain to peritoneal cavity	C
49203	Exc abd tum 5 cm or less	C
49204	Exc abd tum over 5 cm	C
49205	Exc abd tum over 10 cm	C
49215	Excise sacral spine tumor	C
49220	Multiple surgery, abdomen	C
49255	Removal of omentum	C
49425	Insert abdomen-venous drain	C
49428	Ligation of shunt	C
49605	Repair umbilical lesion	C
49606	Repair umbilical lesion	C
49610	Repair umbilical lesion	C
49611	Repair umbilical lesion	C
49900	Repair of abdominal wall	C
49904	Omental flap, extra-abdom	C
49905	Omental flap, intra-abdom	C
49906	Free omental flap, microvasc	C

HCPCS Code	Short Descriptor	SI
50010	Exploration of kidney	C
50040	Drainage of kidney	C
50045	Exploration of kidney	C
50060	Removal of kidney stone	C
50065	Incision of kidney	C
50070	Incision of kidney	C
50075	Removal of kidney stone	C
50100	Revise kidney blood vessels	C
50120	Exploration of kidney	C
50125	Explore and drain kidney	C
50130	Removal of kidney stone	C
50135	Exploration of kidney	C
50205	Biopsy of kidney	C
50220	Remove kidney, open	C
50225	Removal kidney open, complex	C
50230	Removal kidney open, radical	C
50234	Removal of kidney & ureter	C
50236	Removal of kidney & ureter	C
50240	Partial removal of kidney	C
50250	Cryoablate renal mass open	C
50280	Removal of kidney lesion	C
50290	Removal of kidney lesion	C
50300	Remove cadaver donor kidney	C
50320	Remove kidney, living donor	C
50323	Prep cadaver renal allograft	C
50325	Prep donor renal graft	C
50327	Prep renal graft/venous	C
50328	Prep renal graft/arterial	C
50329	Prep renal graft/ureteral	C
50340	Removal of kidney	C
50360	Transplantation of kidney	C
50365	Transplantation of kidney	C
50370	Remove transplanted kidney	C
50380	Reimplantation of kidney	C
50400	Revision of kidney/ureter	C
50405	Revision of kidney/ureter	C
50500	Repair of kidney wound	C
50520	Close kidney-skin fistula	C
50525	Repair renal-abdomen fistula	C
50526	Repair renal-abdomen fistula	C
50540	Revision of horseshoe kidney	C
50545	Laparo radical nephrectomy	C
50546	Laparoscopic nephrectomy	C
50547	Laparo removal donor kidney	C
50548	Laparo remove w/ureter	C
50600	Exploration of ureter	C

HCPCS Code	Short Descriptor	SI
50605	Insert ureteral support	C
50610	Removal of ureter stone	C
50620	Removal of ureter stone	C
50630	Removal of ureter stone	C
50650	Removal of ureter	C
50660	Removal of ureter	C
50700	Revision of ureter	C
50715	Release of ureter	C
50722	Release of ureter	C
50725	Release/revise ureter	C
50728	Revise ureter	C
50740	Fusion of ureter & kidney	C
50750	Fusion of ureter & kidney	C
50760	Fusion of ureters	C
50770	Splicing of ureters	C
50780	Reimplant ureter in bladder	C
50782	Reimplant ureter in bladder	C
50783	Reimplant ureter in bladder	C
50785	Reimplant ureter in bladder	C
50800	Implant ureter in bowel	C
50810	Fusion of ureter & bowel	C
50815	Urine shunt to intestine	C
50820	Construct bowel bladder	C
50825	Construct bowel bladder	C
50830	Revise urine flow	C
50840	Replace ureter by bowel	C
50845	Appendico-vesicostomy	C
50860	Transplant ureter to skin	C
50900	Repair of ureter	C
50920	Closure ureter/skin fistula	C
50930	Closure ureter/bowel fistula	C
50940	Release of ureter	C
51060	Removal of ureter stone	C
51525	Removal of bladder lesion	C
51530	Removal of bladder lesion	C
51550	Partial removal of bladder	C
51555	Partial removal of bladder	C
51565	Revise bladder & ureter(s)	C
51570	Removal of bladder	C
51575	Removal of bladder & nodes	C
51580	Remove bladder/revise tract	C
51585	Removal of bladder & nodes	C
51590	Remove bladder/revise tract	C
51595	Remove bladder/revise tract	C
51596	Remove bladder/create pouch	C
51597	Removal of pelvic structures	C

HCPCS Code	Short Descriptor	SI
51800	Revision of bladder/urethra	C
51820	Revision of urinary tract	C
51840	Attach bladder/urethra	C
51841	Attach bladder/urethra	C
51845	Repair bladder neck	C
51860	Repair of bladder wound	C
51865	Repair of bladder wound	C
51900	Repair bladder/vagina lesion	C
51920	Close bladder-uterus fistula	C
51925	Hysterectomy/bladder repair	C
51940	Correction of bladder defect	C
51960	Revision of bladder & bowel	C
51980	Construct bladder opening	C
53415	Reconstruction of urethra	C
53448	Remov/replc ur sphinctr comp	C
54125	Removal of penis	C
54130	Remove penis & nodes	C
54135	Remove penis & nodes	C
54336	Revise penis/urethra	C
54390	Repair penis and bladder	C
54411	Remov/replc penis pros, comp	C
54417	Remv/replc penis pros, compl	C
54430	Revision of penis	C
54650	Orchiopexy (Fowler-Stephens)	C
55605	Incise sperm duct pouch	C
55650	Remove sperm duct pouch	C
55801	Removal of prostate	C
55810	Extensive prostate surgery	C
55812	Extensive prostate surgery	C
55815	Extensive prostate surgery	C
55821	Removal of prostate	C
55831	Removal of prostate	C
55840	Extensive prostate surgery	C
55842	Extensive prostate surgery	C
55845	Extensive prostate surgery	C
55862	Extensive prostate surgery	C
55865	Extensive prostate surgery	C
55866	Laparo radical prostatectomy	C
56630	Extensive vulva surgery	C
56631	Extensive vulva surgery	C
56632	Extensive vulva surgery	C
56633	Extensive vulva surgery	C
56634	Extensive vulva surgery	C
56637	Extensive vulva surgery	C
56640	Extensive vulva surgery	C
57110	Remove vagina wall, complete	C

HCPCS Code	Short Descriptor	SI
57111	Remove vagina tissue, compl	C
57112	Vaginectomy w/nodes, compl	C
57270	Repair of bowel pouch	C
57280	Suspension of vagina	C
57296	Revise vag graft, open abd	C
57305	Repair rectum-vagina fistula	C
57307	Fistula repair & colostomy	C
57308	Fistula repair, transperine	C
57311	Repair urethrovaginal lesion	C
57531	Removal of cervix, radical	C
57540	Removal of residual cervix	C
57545	Remove cervix/repair pelvis	C
58140	Myomectomy abdom method	C
58146	Myomectomy abdom complex	C
58150	Total hysterectomy	C
58152	Total hysterectomy	C
58180	Partial hysterectomy	C
58200	Extensive hysterectomy	C
58210	Extensive hysterectomy	C
58240	Removal of pelvis contents	C
58267	Vag hyst w/urinary repair	C
58275	Hysterectomy/revise vagina	C
58280	Hysterectomy/revise vagina	C
58285	Extensive hysterectomy	C
58293	Vag hyst w/uro repair, compl	C
58400	Suspension of uterus	C
58410	Suspension of uterus	C
58520	Repair of ruptured uterus	C
58540	Revision of uterus	C
58548	Lap radical hyst	C
58605	Division of fallopian tube	C
58611	Ligate oviduct(s) add-on	C
58700	Removal of fallopian tube	C
58720	Removal of ovary/tube(s)	C
58740	Revise fallopian tube(s)	C
58750	Repair oviduct	C
58752	Revise ovarian tube(s)	C
58760	Remove tubal obstruction	C
58822	Drain ovary abscess, percut	C
58825	Transposition, ovary(s)	C
58940	Removal of ovary(s)	C
58943	Removal of ovary(s)	C
58950	Resect ovarian malignancy	C
58951	Resect ovarian malignancy	C
58952	Resect ovarian malignancy	C
58953	Tah, rad dissect for debulk	C

HCPCS Code	Short Descriptor	SI
58954	Tah rad debulk/lymph remove	C
58956	Bso, omentectomy w/tah	C
58957	Resect recurrent gyn mal	C
58958	Resect recur gyn mal w/lym	C
58960	Exploration of abdomen	C
59120	Treat ectopic pregnancy	C
59121	Treat ectopic pregnancy	C
59130	Treat ectopic pregnancy	C
59135	Treat ectopic pregnancy	C
59136	Treat ectopic pregnancy	C
59140	Treat ectopic pregnancy	C
59325	Revision of cervix	C
59350	Repair of uterus	C
59514	Cesarean delivery only	C
59525	Remove uterus after cesarean	C
59620	Attempted vbac delivery only	C
59830	Treat uterus infection	C
59850	Abortion	C
59851	Abortion	C
59852	Abortion	C
59855	Abortion	C
59856	Abortion	C
59857	Abortion	C
60254	Extensive thyroid surgery	C
60270	Removal of thyroid	C
60505	Explore parathyroid glands	C
60521	Removal of thymus gland	C
60522	Removal of thymus gland	C
60540	Explore adrenal gland	C
60545	Explore adrenal gland	C
60600	Remove carotid body lesion	C
60605	Remove carotid body lesion	C
60650	Laparoscopy adrenalectomy	C
61105	Twist drill hole	C
61107	Drill skull for implantation	C
61108	Drill skull for drainage	C
61120	Burr hole for puncture	C
61140	Pierce skull for biopsy	C
61150	Pierce skull for drainage	C
61151	Pierce skull for drainage	C
61154	Pierce skull & remove clot	C
61156	Pierce skull for drainage	C
61210	Pierce skull, implant device	C
61250	Pierce skull & explore	C
61253	Pierce skull & explore	C
61304	Open skull for exploration	C

HCPCS Code	Short Descriptor	SI
61305	Open skull for exploration	C
61312	Open skull for drainage	C
61313	Open skull for drainage	C
61314	Open skull for drainage	C
61315	Open skull for drainage	C
61316	Implt cran bone flap to abdo	C
61320	Open skull for drainage	C
61321	Open skull for drainage	C
61322	Decompressive craniotomy	C
61323	Decompressive lobectomy	C
61332	Explore/biopsy eye socket	C
61333	Explore orbit/remove lesion	C
61340	Subtemporal decompression	C
61343	Incise skull (press relief)	C
61345	Relieve cranial pressure	C
61440	Incise skull for surgery	C
61450	Incise skull for surgery	C
61458	Incise skull for brain wound	C
61460	Incise skull for surgery	C
61470	Incise skull for surgery	C
61480	Incise skull for surgery	C
61490	Incise skull for surgery	C
61500	Removal of skull lesion	C
61501	Remove infected skull bone	C
61510	Removal of brain lesion	C
61512	Remove brain lining lesion	C
61514	Removal of brain abscess	C
61516	Removal of brain lesion	C
61517	Implt brain chemotx add-on	C
61518	Removal of brain lesion	C
61519	Remove brain lining lesion	C
61520	Removal of brain lesion	C
61521	Removal of brain lesion	C
61522	Removal of brain abscess	C
61524	Removal of brain lesion	C
61526	Removal of brain lesion	C
61530	Removal of brain lesion	C
61531	Implant brain electrodes	C
61533	Implant brain electrodes	C
61534	Removal of brain lesion	C
61535	Remove brain electrodes	C
61536	Removal of brain lesion	C
61537	Removal of brain tissue	C
61538	Removal of brain tissue	C
61539	Removal of brain tissue	C
61540	Removal of brain tissue	C

HCPCS Code	Short Descriptor	SI
61541	Incision of brain tissue	C
61542	Removal of brain tissue	C
61543	Removal of brain tissue	C
61544	Remove & treat brain lesion	C
61545	Excision of brain tumor	C
61546	Removal of pituitary gland	C
61548	Removal of pituitary gland	C
61550	Release of skull seams	C
61552	Release of skull seams	C
61556	Incise skull/sutures	C
61557	Incise skull/sutures	C
61558	Excision of skull/sutures	C
61559	Excision of skull/sutures	C
61563	Excision of skull tumor	C
61564	Excision of skull tumor	C
61566	Removal of brain tissue	C
61567	Incision of brain tissue	C
61570	Remove foreign body, brain	C
61571	Incise skull for brain wound	C
61575	Skull base/brainstem surgery	C
61576	Skull base/brainstem surgery	C
61580	Craniofacial approach, skull	C
61581	Craniofacial approach, skull	C
61582	Craniofacial approach, skull	C
61583	Craniofacial approach, skull	C
61584	Orbitocranial approach/skull	C
61585	Orbitocranial approach/skull	C
61586	Resect nasopharynx, skull	C
61590	Infratemporal approach/skull	C
61591	Infratemporal approach/skull	C
61592	Orbitocranial approach/skull	C
61595	Transtemporal approach/skull	C
61596	Transcochlear approach/skull	C
61597	Transcondylar approach/skull	C
61598	Transpetrosal approach/skull	C
61600	Resect/excise cranial lesion	C
61601	Resect/excise cranial lesion	C
61605	Resect/excise cranial lesion	C
61606	Resect/excise cranial lesion	C
61607	Resect/excise cranial lesion	C
61608	Resect/excise cranial lesion	C
61609	Transect artery, sinus	C
61610	Transect artery, sinus	C
61611	Transect artery, sinus	C
61612	Transect artery, sinus	C
61613	Remove aneurysm, sinus	C

HCPCS Code	Short Descriptor	SI
61615	Resect/excise lesion, skull	C
61616	Resect/excise lesion, skull	C
61618	Repair dura	C
61619	Repair dura	C
61624	Transcath occlusion, cns	C
61680	Intracranial vessel surgery	C
61682	Intracranial vessel surgery	C
61684	Intracranial vessel surgery	C
61686	Intracranial vessel surgery	C
61690	Intracranial vessel surgery	C
61692	Intracranial vessel surgery	C
61697	Brain aneurysm repr, complx	C
61698	Brain aneurysm repr, complx	C
61700	Brain aneurysm repr, simple	C
61702	Inner skull vessel surgery	C
61703	Clamp neck artery	C
61705	Revise circulation to head	C
61708	Revise circulation to head	C
61710	Revise circulation to head	C
61711	Fusion of skull arteries	C
61735	Incise skull/brain surgery	C
61750	Incise skull/brain biopsy	C
61751	Brain biopsy w/ct/mr guide	C
61760	Implant brain electrodes	C
61860	Implant neuroelectrodes	C
61863	Implant neuroelectrode	C
61864	Implant neuroelectrde, addl	C
61867	Implant neuroelectrode	C
61868	Implant neuroelectrde, add'l	C
61870	Implant neuroelectrodes	C
61875	Implant neuroelectrodes	C
62005	Treat skull fracture	C
62010	Treatment of head injury	C
62100	Repair brain fluid leakage	C
62115	Reduction of skull defect	C
62116	Reduction of skull defect	C
62117	Reduction of skull defect	C
62120	Repair skull cavity lesion	C
62121	Incise skull repair	C
62140	Repair of skull defect	C
62141	Repair of skull defect	C
62142	Remove skull plate/flap	C
62143	Replace skull plate/flap	C
62145	Repair of skull & brain	C
62146	Repair of skull with graft	C
62147	Repair of skull with graft	C

HCPCS Code	Short Descriptor	SI
62148	Retr bone flap to fix skull	C
62161	Dissect brain w/scope	C
62162	Remove colloid cyst w/scope	C
62163	Neuroendoscopy w/fb removal	C
62164	Remove brain tumor w/scope	C
62165	Remove pituit tumor w/scope	C
62180	Establish brain cavity shunt	C
62190	Establish brain cavity shunt	C
62192	Establish brain cavity shunt	C
62200	Establish brain cavity shunt	C
62201	Brain cavity shunt w/scope	C
62220	Establish brain cavity shunt	C
62223	Establish brain cavity shunt	C
62256	Remove brain cavity shunt	C
62258	Replace brain cavity shunt	C
63043	Laminotomy, add'l cervical	C
63044	Laminotomy, add'l lumbar	C
63050	Cervical laminoplasty	C
63051	C-laminoplasty w/graft/plate	C
63076	Neck spine disk surgery	C
63077	Spine disk surgery, thorax	C
63078	Spine disk surgery, thorax	C
63081	Removal of vertebral body	C
63082	Remove vertebral body add-on	C
63085	Removal of vertebral body	C
63086	Remove vertebral body add-on	C
63087	Removal of vertebral body	C
63088	Remove vertebral body add-on	C
63090	Removal of vertebral body	C
63091	Remove vertebral body add-on	C
63101	Removal of vertebral body	C
63102	Removal of vertebral body	C
63103	Remove vertebral body add-on	C
63170	Incise spinal cord tract(s)	C
63172	Drainage of spinal cyst	C
63173	Drainage of spinal cyst	C
63180	Revise spinal cord ligaments	C
63182	Revise spinal cord ligaments	C
63185	Incise spinal column/nerves	C
63190	Incise spinal column/nerves	C
63191	Incise spinal column/nerves	C
63194	Incise spinal column & cord	C
63195	Incise spinal column & cord	C
63196	Incise spinal column & cord	C
63197	Incise spinal column & cord	C
63198	Incise spinal column & cord	C

HCPCS Code	Short Descriptor	SI
63199	Incise spinal column & cord	C
63200	Release of spinal cord	C
63250	Revise spinal cord vessels	C
63251	Revise spinal cord vessels	C
63252	Revise spinal cord vessels	C
63265	Excise intraspinal lesion	C
63266	Excise intraspinal lesion	C
63267	Excise intraspinal lesion	C
63268	Excise intraspinal lesion	C
63270	Excise intraspinal lesion	C
63271	Excise intraspinal lesion	C
63272	Excise intraspinal lesion	C
63273	Excise intraspinal lesion	C
63275	Biopsy/excise spinal tumor	C
63276	Biopsy/excise spinal tumor	C
63277	Biopsy/excise spinal tumor	C
63278	Biopsy/excise spinal tumor	C
63280	Biopsy/excise spinal tumor	C
63281	Biopsy/excise spinal tumor	C
63282	Biopsy/excise spinal tumor	C
63283	Biopsy/excise spinal tumor	C
63285	Biopsy/excise spinal tumor	C
63286	Biopsy/excise spinal tumor	C
63287	Biopsy/excise spinal tumor	C
63290	Biopsy/excise spinal tumor	C
63295	Repair of laminectomy defect	C
63300	Removal of vertebral body	C
63301	Removal of vertebral body	C
63302	Removal of vertebral body	C
63303	Removal of vertebral body	C
63304	Removal of vertebral body	C
63305	Removal of vertebral body	C
63306	Removal of vertebral body	C
63307	Removal of vertebral body	C
63308	Remove vertebral body add-on	C
63700	Repair of spinal herniation	C
63702	Repair of spinal herniation	C
63704	Repair of spinal herniation	C
63706	Repair of spinal herniation	C
63707	Repair spinal fluid leakage	C
63709	Repair spinal fluid leakage	C
63710	Graft repair of spine defect	C
63740	Install spinal shunt	C
64752	Incision of vagus nerve	C
64755	Incision of stomach nerves	C
64760	Incision of vagus nerve	C

HCPCS Code	Short Descriptor	SI
64809	Remove sympathetic nerves	C
64818	Remove sympathetic nerves	C
64866	Fusion of facial/other nerve	C
64868	Fusion of facial/other nerve	C
65273	Repair of eye wound	C
69155	Extensive ear/neck surgery	C
69535	Remove part of temporal bone	C
69554	Remove ear lesion	C
69950	Incise inner ear nerve	C
75900	Intravascular cath exchange	C
75952	Endovasc repair abdom aorta	C
75953	Abdom aneurysm endovas rpr	C
75954	Iliac aneurysm endovas rpr	C
75956	Xray, endovasc thor ao repr	C
75957	Xray, endovasc thor ao repr	C
75958	Xray, place prox ext thor ao	C
75959	Xray, place dist ext thor ao	C
92970	Cardioassist, internal	C
92971	Cardioassist, external	C
92975	Dissolve clot, heart vessel	C
92992	Revision of heart chamber	C
92993	Revision of heart chamber	C
99190	Special pump services	C
99191	Special pump services	C
99192	Special pump services	C
99251	Inpatient consultation	C
99252	Inpatient consultation	C
99253	Inpatient consultation	C
99254	Inpatient consultation	C
99255	Inpatient consultation	C
99293	Ped critical care, initial	C
99294	Ped critical care, subseq	C
99295	Neonate crit care, initial	C
99296	Neonate critical care subseq	C
99298	Ic for lbw infant < 1500 gm	C
99299	Ic, lbw infant 1500-2500 gm	C
99356	Prolonged service, inpatient	C
99357	Prolonged service, inpatient	C
99433	Normal newborn care/hospital	C
99477	Init day hosp neonate care	C
0048T	Implant ventricular device	C
0049T	External circulation assist	C
0050T	Removal circulation assist	C
0051T	Implant total heart system	C
0052T	Replace component heart syst	C
0053T	Replace component heart syst	C

HCPCS Code	Short Descriptor	SI
0075T	Perq stent/chest vert art	C
0076T	S&i stent/chest vert art	C
0077T	Cereb therm perfusion probe	C
0078T	Endovasc aort repr w/device	C
0079T	Endovasc visc extnsn repr	C
0080T	Endovasc aort repr rad s&i	C
0081T	Endovasc visc extnsn s&i	C
0090T	Cervical artific disc	C
0092T	Artific disc addl	C
0093T	Cervical artific diskectomy	C
0095T	Artific diskectomy addl	C
0096T	Rev cervical artific disc	C
0098T	Rev artific disc addl	C
0157T	Open impl gast curve electrd	C
0158T	Open remv gast curve electrd	C
0163T	Lumb artif diskectomy addl	C
0164T	Remove lumb artif disc addl	C
0165T	Revise lumb artif disc addl	C
0166T	Tcath vsd close w/o bypass	C
0167T	Tcath vsd close w bypass	C
0169T	Place stereo cath brain	C
0184T	Exc rectal tumor endoscopic	C
G0341	Percutaneous islet celltrans	C
G0342	Laparoscopy islet cell trans	C
G0343	Laparotomy islet cell transp	C

ADDENDUM L.--PROPOSED OUT-MIGRATION ADJUSTMENT

Provider Number	Reclassified for CY 2009	Out-Migration Adjustment	Qualifying County Name	County Code
010022	*	0.1128	CHEROKEE	01090
010027		0.0015	COFFEE	01150
010029	*	0.0289	LEE	01400
010032		0.0325	RANDOLPH	01550
010035	*	0.0254	CULLMAN	01210
010038		0.0047	CALHOUN	01070
010040		0.0061	ETOWAH	01270
010045		0.0222	FAYETTE	01280
010046		0.0061	ETOWAH	01270
010047		0.0127	BUTLER	01060
010049		0.0015	COFFEE	01150
010052	*	0.0103	TALLAPOOSA	01610
010059	*	0.0069	LAWRENCE	01390
010061	*	0.0542	JACKSON	01350
010065	*	0.0103	TALLAPOOSA	01610
010078		0.0047	CALHOUN	01070
010083	*	0.0134	BALDWIN	01010
010091		0.0046	CLARKE	01120
010100	*	0.0134	BALDWIN	01010
010101	*	0.0211	TALLADEGA	01600
010109		0.0382	PICKENS	01530
010110		0.0215	BULLOCK	01050
010125		0.0476	WINSTON	01660
010128		0.0046	CLARKE	01120
010129		0.0134	BALDWIN	01010
010138		0.0066	SUMTER	01590
010143	*	0.0254	CULLMAN	01210
010146		0.0047	CALHOUN	01070
010150	*	0.0127	BUTLER	01060
010158	*	0.0023	FRANKLIN	01290
010164	*	0.0211	TALLADEGA	01600
013027		0.0134	BALDWIN	01010
013032		0.0061	ETOWAH	01270
014006		0.0061	ETOWAH	01270
030067		0.0298	LAPAZ	03055
040014	*	0.0199	WHITE	04720
040019	*	0.0258	ST. FRANCIS	04610
040039	*	0.0172	GREENE	04270
040047		0.0117	RANDOLPH	04600
040067		0.0007	COLUMBIA	04130
040071	*	0.0149	JEFFERSON	04340
040076	*	0.1000	HOT SPRING	04290

Provider Number	Reclassified for CY 2009	Out-Migration Adjustment	Qualifying County Name	County Code
040081		0.0357	PIKE	04540
042007		0.0149	JEFFERSON	04340
043034		0.0036	CHICOT	04080
050002		0.0010	ALAMEDA	05000
050007		0.0146	SAN MATEO	05510
050009	*	0.0180	NAPA	05380
050013	*	0.0180	NAPA	05380
050014	*	0.0139	AMADOR	05020
050042	*	0.0162	TEHAMA	05620
050043		0.0010	ALAMEDA	05000
050069	*	0.0020	ORANGE	05400
050070		0.0146	SAN MATEO	05510
050073	*	0.0171	SOLANO	05580
050075		0.0010	ALAMEDA	05000
050084		0.0132	SAN JOAQUIN	05490
050089	*	0.0017	SAN BERNARDINO	05460
050090	*	0.0058	SONOMA	05590
050099	*	0.0017	SAN BERNARDINO	05460
050101	*	0.0171	SOLANO	05580
050113		0.0146	SAN MATEO	05510
050118	*	0.0132	SAN JOAQUIN	05490
050122		0.0132	SAN JOAQUIN	05490
050129	*	0.0017	SAN BERNARDINO	05460
050133	*	0.0178	YUBA	05680
050136	*	0.0058	SONOMA	05590
050140	*	0.0017	SAN BERNARDINO	05460
050150	*	0.0342	NEVADA	05390
050167		0.0132	SAN JOAQUIN	05490
050168	*	0.0020	ORANGE	05400
050173	*	0.0020	ORANGE	05400
050174	*	0.0058	SONOMA	05590
050193	*	0.0020	ORANGE	05400
050194	*	0.0052	SANTA CRUZ	05540
050195		0.0010	ALAMEDA	05000
050197	*	0.0146	SAN MATEO	05510
050211		0.0010	ALAMEDA	05000
050224	*	0.0020	ORANGE	05400
050226	*	0.0020	ORANGE	05400
050230	*	0.0020	ORANGE	05400
050242	*	0.0052	SANTA CRUZ	05540
050245	*	0.0017	SAN BERNARDINO	05460
050264		0.0010	ALAMEDA	05000
050272	*	0.0017	SAN BERNARDINO	05460
050279	*	0.0017	SAN BERNARDINO	05460

Provider Number	Reclassified for CY 2009	Out-Migration Adjustment	Qualifying County Name	County Code
050283		0.0010	ALAMEDA	05000
050289		0.0146	SAN MATEO	05510
050291	*	0.0058	SONOMA	05590
050298		0.0017	SAN BERNARDINO	05460
050300	*	0.0017	SAN BERNARDINO	05460
050305		0.0010	ALAMEDA	05000
050313		0.0132	SAN JOAQUIN	05490
050320		0.0010	ALAMEDA	05000
050325		0.0033	TUOLUMNE	05650
050327	*	0.0017	SAN BERNARDINO	05460
050335	*	0.0033	TUOLUMNE	05650
050336		0.0132	SAN JOAQUIN	05490
050348	*	0.0020	ORANGE	05400
050366		0.0015	CALAVERAS	05040
050367	*	0.0171	SOLANO	05580
050385	*	0.0058	SONOMA	05590
050426	*	0.0020	ORANGE	05400
050444		0.0233	MERCED	05340
050476	*	0.0278	LAKE	05160
050488		0.0010	ALAMEDA	05000
050494	*	0.0342	NEVADA	05390
050512		0.0010	ALAMEDA	05000
050517	*	0.0017	SAN BERNARDINO	05460
050526	*	0.0020	ORANGE	05400
050528	*	0.0233	MERCED	05340
050541	*	0.0146	SAN MATEO	05510
050543	*	0.0020	ORANGE	05400
050547	*	0.0058	SONOMA	05590
050548	*	0.0020	ORANGE	05400
050551	*	0.0020	ORANGE	05400
050567	*	0.0020	ORANGE	05400
050570	*	0.0020	ORANGE	05400
050580	*	0.0020	ORANGE	05400
050584		0.0017	SAN BERNARDINO	05460
050586	*	0.0017	SAN BERNARDINO	05460
050589	*	0.0020	ORANGE	05400
050603	*	0.0020	ORANGE	05400
050609	*	0.0020	ORANGE	05400
050618	*	0.0017	SAN BERNARDINO	05460
050667	*	0.0180	NAPA	05380
050678	*	0.0020	ORANGE	05400
050680	*	0.0171	SOLANO	05580
050690	*	0.0058	SONOMA	05590
050693	*	0.0020	ORANGE	05400

Provider Number	Reclassified for CY 2009	Out-Migration Adjustment	Qualifying County Name	County Code
050714		0.0052	SANTA CRUZ	05540
050720	*	0.0020	ORANGE	05400
050744	*	0.0020	ORANGE	05400
050745	*	0.0020	ORANGE	05400
050746	*	0.0020	ORANGE	05400
050747	*	0.0020	ORANGE	05400
050748		0.0132	SAN JOAQUIN	05490
050754		0.0146	SAN MATEO	05510
050758	*	0.0017	SAN BERNARDINO	05460
052034		0.0010	ALAMEDA	05000
052035		0.0020	ORANGE	05400
052037		0.0017	SAN BERNARDINO	05460
052039		0.0020	ORANGE	05400
052040		0.0017	SAN BERNARDINO	05460
053034		0.0020	ORANGE	05400
053037		0.0017	SAN BERNARDINO	05460
053301		0.0010	ALAMEDA	05000
053304		0.0020	ORANGE	05400
053306		0.0020	ORANGE	05400
053308		0.0020	ORANGE	05400
054003		0.0146	SAN MATEO	05510
054074		0.0171	SOLANO	05580
054093		0.0017	SAN BERNARDINO	05460
054110		0.0010	ALAMEDA	05000
054111		0.0017	SAN BERNARDINO	05460
054122		0.0180	NAPA	05380
054123		0.0132	SAN JOAQUIN	05490
054135		0.0020	ORANGE	05400
054141		0.0171	SOLANO	05580
060001		0.0042	WELD	06610
060003	*	0.0069	BOULDER	06060
060010		0.0153	LARIMER	06340
060027	*	0.0069	BOULDER	06060
060030		0.0153	LARIMER	06340
060103	*	0.0069	BOULDER	06060
060116	*	0.0069	BOULDER	06060
060119		0.0153	LARIMER	06340
063033		0.0042	WELD	06610
064007		0.0069	BOULDER	06060
064016		0.0153	LARIMER	06340
070006	*	0.0045	FAIRFIELD	07000
070010	*	0.0045	FAIRFIELD	07000
070018	*	0.0045	FAIRFIELD	07000
070028	*	0.0045	FAIRFIELD	07000

Provider Number	Reclassified for CY 2009	Out-Migration Adjustment	Qualifying County Name	County Code
070033	*	0.0045	FAIRFIELD	07000
070034	*	0.0045	FAIRFIELD	07000
074000		0.0045	FAIRFIELD	07000
074012		0.0045	FAIRFIELD	07000
074014		0.0045	FAIRFIELD	07000
080001	*	0.0043	NEW CASTLE	08010
080003	*	0.0043	NEW CASTLE	08010
082000		0.0043	NEW CASTLE	08010
083300		0.0043	NEW CASTLE	08010
084001		0.0043	NEW CASTLE	08010
084002		0.0043	NEW CASTLE	08010
084003		0.0043	NEW CASTLE	08010
100014	*	0.0047	VOLUSIA	10630
100017	*	0.0047	VOLUSIA	10630
100045	*	0.0047	VOLUSIA	10630
100047	*	0.0028	CHARLOTTE	10070
100068	*	0.0047	VOLUSIA	10630
100072	*	0.0047	VOLUSIA	10630
100077	*	0.0028	CHARLOTTE	10070
100081	*	0.0022	WALTON	10650
100118	*	0.0177	FLAGLER	10170
100232	*	0.0054	PUTNAM	10530
100236	*	0.0028	CHARLOTTE	10070
100252	*	0.0151	OKEECHOBEE	10460
100290		0.0342	SUMTER	10590
100292	*	0.0022	WALTON	10650
110023	*	0.0416	GORDON	11500
110029	*	0.0052	HALL	11550
110040	*	0.1455	JACKSON	11610
110041	*	0.0623	HABERSHAM	11540
110100		0.0790	JEFFERSON	11620
110101		0.0067	COOK	11311
110142		0.0185	EVANS	11441
110146	*	0.0805	CAMDEN	11170
110150	*	0.0227	BALDWIN	11030
110187	*	0.0643	LUMPKIN	11701
110189	*	0.0066	FANNIN	11450
110190		0.0241	MACON	11710
110205		0.0507	GILMER	11471
114018		0.0227	BALDWIN	11030
130003	*	0.0235	NEZ PERCE	13340
130024		0.0675	BONNER	13080
130049	*	0.0319	KOOTENAI	13270
130066		0.0319	KOOTENAI	13270

Provider Number	Reclassified for CY 2009	Out-Migration Adjustment	Qualifying County Name	County Code
130067	*	0.0725	BINGHAM	13050
132001		0.0319	KOOTENAI	13270
134010		0.0725	BINGHAM	13050
140001		0.0369	FULTON	14370
140026		0.0315	LA SALLE	14580
140043	*	0.0056	WHITESIDE	14988
140058	*	0.0126	MORGAN	14770
140110	*	0.0315	LA SALLE	14580
140116		0.0007	MC HENRY	14640
140160	*	0.0332	STEPHENSON	14970
140161		0.0168	LIVINGSTON	14610
140167	*	0.0632	IROQUOIS	14460
140176		0.0007	MC HENRY	14640
140234		0.0315	LA SALLE	14580
150006	*	0.0113	LA PORTE	15450
150015	*	0.0113	LA PORTE	15450
150022		0.0158	MONTGOMERY	15530
150030	*	0.0192	HENRY	15320
150072		0.0105	CASS	15080
150076	*	0.0215	MARSHALL	15490
150088	*	0.0111	MADISON	15470
150091	*	0.0050	HUNTINGTON	15340
150102	*	0.0108	STARKE	15740
150113	*	0.0111	MADISON	15470
150133	*	0.0193	KOSCIUSKO	15420
150146	*	0.0319	NOBLE	15560
153040		0.0215	MARSHALL	15490
154014		0.0193	KOSCIUSKO	15420
154035		0.0105	CASS	15080
154047		0.0215	MARSHALL	15490
160013		0.0179	MUSCATINE	16690
160030		0.0013	STORY	16840
160032		0.0235	JASPER	16490
160080	*	0.0066	CLINTON	16220
170137	*	0.0420	DOUGLAS	17220
170150		0.0166	COWLEY	17170
180012	*	0.0080	HARDIN	18460
180017	*	0.0035	BARREN	18040
180049	*	0.0488	MADISON	18750
180064		0.0314	MONTGOMERY	18860
180066	*	0.0439	LOGAN	18700
180070		0.0240	GRAYSON	18420
180079		0.0259	HARRISON	18480
183028		0.0080	HARDIN	18460

Provider Number	Reclassified for CY 2009	Out-Migration Adjustment	Qualifying County Name	County Code
184012		0.0080	HARDIN	18460
190003	*	0.0085	IBERIA	19220
190015	*	0.0243	TANGIPAHOA	19520
190017	*	0.0187	ST. LANDRY	19480
190034		0.0189	VERMILION	19560
190044		0.0261	ACADIA	19000
190050		0.0044	BEAUREGARD	19050
190053		0.0101	JEFFRSON DAVIS	19260
190054		0.0085	IBERIA	19220
190078		0.0187	ST. LANDRY	19480
190086	*	0.0061	LINCOLN	19300
190088	*	0.0387	WEBSTER	19590
190099		0.0189	AVOYELLES	19040
190106	*	0.0102	ALLEN	19010
190116		0.0085	MOREHOUSE	19330
190133		0.0102	ALLEN	19010
190140		0.0035	FRANKLIN	19200
190144	*	0.0387	WEBSTER	19590
190145		0.0090	LA SALLE	19290
190184	*	0.0075	CALDWELL	19100
190190		0.0075	CALDWELL	19100
190191	*	0.0187	ST. LANDRY	19480
190246		0.0075	CALDWELL	19100
190257	*	0.0061	LINCOLN	19300
190277		0.0387	WEBSTER	19590
192022		0.0061	LINCOLN	19300
192026		0.0387	WEBSTER	19590
192034		0.0187	ST. LANDRY	19480
192036		0.0243	TANGIPAHOA	19520
192040		0.0243	TANGIPAHOA	19520
192050		0.0261	ACADIA	19000
193036		0.0187	ST. LANDRY	19480
193044		0.0243	TANGIPAHOA	19520
193047		0.0189	VERMILION	19560
193049		0.0189	VERMILION	19560
193055		0.0075	CALDWELL	19100
193058		0.0085	MOREHOUSE	19330
193063		0.0243	TANGIPAHOA	19520
193067		0.0101	JEFFRSON DAVIS	19260
193068		0.0243	TANGIPAHOA	19520
193069		0.0085	MOREHOUSE	19330
193073		0.0187	ST. LANDRY	19480
193079		0.0243	TANGIPAHOA	19520
193081		0.0261	ACADIA	19000

Provider Number	Reclassified for CY 2009	Out-Migration Adjustment	Qualifying County Name	County Code
193088		0.0261	ACADIA	19000
193091		0.0085	IBERIA	19220
194047		0.0387	WEBSTER	19590
194065		0.0061	LINCOLN	19300
194075		0.0101	JEFFRSON DAVIS	19260
194077		0.0061	LINCOLN	19300
194081		0.0044	BEAUREGARD	19050
194082		0.0101	JEFFRSON DAVIS	19260
194083		0.0085	MOREHOUSE	19330
194085		0.0261	ACADIA	19000
194087		0.0061	LINCOLN	19300
194091		0.0243	TANGIPAHOA	19520
194092		0.0035	FRANKLIN	19200
200024	*	0.0094	ANDROSCOGGIN	20000
200032		0.0359	OXFORD	20080
200034	*	0.0094	ANDROSCOGGIN	20000
200050	*	0.0227	HANCOCK	20040
210001		0.0187	WASHINGTON	21210
210023		0.0079	ANNE ARUNDEL	21010
210028		0.0379	ST. MARYS	21180
210043		0.0079	ANNE ARUNDEL	21010
210061		0.0188	WORCESTER	21230
212002		0.0187	WASHINGTON	21210
214001		0.0079	ANNE ARUNDEL	21010
214003		0.0187	WASHINGTON	21210
214015		0.0188	WORCESTER	21230
220001	*	0.0067	WORCESTER	22170
220002	*	0.0271	MIDDLESEX	22090
220010	*	0.0355	ESSEX	22040
220011	*	0.0271	MIDDLESEX	22090
220019	*	0.0067	WORCESTER	22170
220025	*	0.0067	WORCESTER	22170
220029	*	0.0355	ESSEX	22040
220033	*	0.0355	ESSEX	22040
220035	*	0.0355	ESSEX	22040
220049	*	0.0271	MIDDLESEX	22090
220058	*	0.0067	WORCESTER	22170
220062	*	0.0067	WORCESTER	22170
220063	*	0.0271	MIDDLESEX	22090
220070	*	0.0271	MIDDLESEX	22090
220080	*	0.0355	ESSEX	22040
220082	*	0.0271	MIDDLESEX	22090
220084	*	0.0271	MIDDLESEX	22090
220090	*	0.0067	WORCESTER	22170

Provider Number	Reclassified for CY 2009	Out-Migration Adjustment	Qualifying County Name	County Code
220095	*	0.0067	WORCESTER	22170
220098	*	0.0271	MIDDLESEX	22090
220101	*	0.0271	MIDDLESEX	22090
220105	*	0.0271	MIDDLESEX	22090
220163	*	0.0067	WORCESTER	22170
220171	*	0.0271	MIDDLESEX	22090
220174	*	0.0355	ESSEX	22040
220176	*	0.0067	WORCESTER	22170
222000		0.0271	MIDDLESEX	22090
222003		0.0271	MIDDLESEX	22090
222024		0.0271	MIDDLESEX	22090
222026		0.0355	ESSEX	22040
222044		0.0355	ESSEX	22040
222047		0.0355	ESSEX	22040
222048		0.0067	WORCESTER	22170
223026		0.0271	MIDDLESEX	22090
223028		0.0355	ESSEX	22040
223029		0.0067	WORCESTER	22170
223033		0.0067	WORCESTER	22170
224007		0.0271	MIDDLESEX	22090
224026		0.0067	WORCESTER	22170
224032		0.0067	WORCESTER	22170
224033		0.0355	ESSEX	22040
224038		0.0271	MIDDLESEX	22090
230003	*	0.0220	OTTAWA	23690
230005		0.0473	LENAWEE	23450
230013	*	0.0025	OAKLAND	23620
230015		0.0295	ST. JOSEPH	23740
230019	*	0.0025	OAKLAND	23620
230021	*	0.0101	BERRIEN	23100
230022	*	0.0212	BRANCH	23110
230029	*	0.0025	OAKLAND	23620
230035	*	0.0095	MONTCALM	23580
230037	*	0.0210	HILLSDALE	23290
230047	*	0.0021	MACOMB	23490
230069	*	0.0210	LIVINGSTON	23460
230071	*	0.0025	OAKLAND	23620
230072	*	0.0220	OTTAWA	23690
230075		0.0047	CALHOUN	23120
230078	*	0.0101	BERRIEN	23100
230092	*	0.0223	JACKSON	23370
230093		0.0058	MECOSTA	23530
230096	*	0.0295	ST. JOSEPH	23740
230099	*	0.0231	MONROE	23570

Provider Number	Reclassified for CY 2009	Out-Migration Adjustment	Qualifying County Name	County Code
230121	*	0.0678	SHIAWASSEE	23770
230130	*	0.0025	OAKLAND	23620
230151	*	0.0025	OAKLAND	23620
230174	*	0.0220	OTTAWA	23690
230195	*	0.0021	MACOMB	23490
230204	*	0.0021	MACOMB	23490
230207	*	0.0025	OAKLAND	23620
230208	*	0.0095	MONTCALM	23580
230217		0.0047	CALHOUN	23120
230222	*	0.0035	MIDLAND	23550
230223	*	0.0025	OAKLAND	23620
230227	*	0.0021	MACOMB	23490
230254	*	0.0025	OAKLAND	23620
230257	*	0.0021	MACOMB	23490
230264	*	0.0021	MACOMB	23490
230269	*	0.0025	OAKLAND	23620
230277	*	0.0025	OAKLAND	23620
230279	*	0.0210	LIVINGSTON	23460
230301	*	0.0025	OAKLAND	23620
232023		0.0021	MACOMB	23490
232025		0.0101	BERRIEN	23100
232028		0.0047	CALHOUN	23120
232030		0.0025	OAKLAND	23620
232034		0.0435	ALLEGAN	23020
232036		0.0223	JACKSON	23370
233025		0.0047	CALHOUN	23120
233028		0.0025	OAKLAND	23620
233031		0.0021	MACOMB	23490
234011		0.0025	OAKLAND	23620
234021		0.0021	MACOMB	23490
234023		0.0025	OAKLAND	23620
234024		0.0021	MACOMB	23490
234025		0.0276	TUSCOLA	23780
234037		0.0047	CALHOUN	23120
234039		0.0021	MACOMB	23490
240018		0.0805	GOODHUE	24240
240044		0.0625	WINONA	24840
240064	*	0.0134	ITASCA	24300
240069	*	0.0267	STEELE	24730
240071	*	0.0385	RICE	24650
240117		0.0527	MOWER	24490
240211		0.0812	PINE	24570
250023	*	0.0541	PEARL RIVER	25540
250040	*	0.0021	JACKSON	25290

Provider Number	Reclassified for CY 2009	Out-Migration Adjustment	Qualifying County Name	County Code
250117	*	0.0541	PEARL RIVER	25540
250128		0.0446	PANOLA	25530
250162		0.0014	HANCOCK	25220
252011		0.0446	PANOLA	25530
260059		0.0077	LACLEDE	26520
260064	*	0.0089	AUDRAIN	26030
260097		0.0300	JOHNSON	26500
260116	*	0.0087	ST. FRANCOIS	26930
260163		0.0087	ST. FRANCOIS	26930
264005		0.0087	ST. FRANCOIS	26930
264027		0.0087	CEDAR	26190
280077		0.0080	DODGE	28260
280123		0.0123	GAGE	28330
290002	*	0.0277	LYON	29090
300011	*	0.0074	HILLSBOROUGH	30050
300012	*	0.0074	HILLSBOROUGH	30050
300017	*	0.0102	ROCKINGHAM	30070
300020	*	0.0074	HILLSBOROUGH	30050
300023	*	0.0102	ROCKINGHAM	30070
300029	*	0.0102	ROCKINGHAM	30070
300034	*	0.0074	HILLSBOROUGH	30050
303026		0.0102	ROCKINGHAM	30070
304001		0.0102	ROCKINGHAM	30070
310002	*	0.0268	ESSEX	31200
310009	*	0.0268	ESSEX	31200
310015	*	0.0203	MORRIS	31300
310017	*	0.0203	MORRIS	31300
310018	*	0.0268	ESSEX	31200
310038	*	0.0209	MIDDLESEX	31270
310039	*	0.0209	MIDDLESEX	31270
310050	*	0.0203	MORRIS	31300
310054	*	0.0268	ESSEX	31200
310070	*	0.0209	MIDDLESEX	31270
310076	*	0.0268	ESSEX	31200
310083	*	0.0268	ESSEX	31200
310093	*	0.0268	ESSEX	31200
310096	*	0.0268	ESSEX	31200
310108	*	0.0209	MIDDLESEX	31270
310119	*	0.0268	ESSEX	31200
312018		0.0209	MIDDLESEX	31270
312020		0.0203	MORRIS	31300
313025		0.0268	ESSEX	31200
313300		0.0209	MIDDLESEX	31270
314010		0.0268	ESSEX	31200

Provider Number	Reclassified for CY 2009	Out-Migration Adjustment	Qualifying County Name	County Code
314011		0.0209	MIDDLESEX	31270
314016		0.0203	MORRIS	31300
314020		0.0268	ESSEX	31200
320003	*	0.0482	SAN MIGUEL	32230
320011		0.0338	RIO ARRIBA	32190
320018		0.0024	DONA ANA	32060
320085		0.0024	DONA ANA	32060
322001		0.0482	SAN MIGUEL	32230
323025		0.0482	SAN MIGUEL	32230
323032		0.0024	DONA ANA	32060
324007		0.0024	DONA ANA	32060
324009		0.0024	DONA ANA	32060
324010		0.0024	DONA ANA	32060
324011		0.0338	RIO ARRIBA	32190
324012		0.0024	DONA ANA	32060
330004	*	0.0633	ULSTER	33740
330008	*	0.0126	WYOMING	33900
330010		0.0067	MONTGOMERY	33380
330027	*	0.0123	NASSAU	33400
330033		0.0223	CHENANGO	33080
330047		0.0067	MONTGOMERY	33380
330073	*	0.0151	GENESEE	33290
330094	*	0.0503	COLUMBIA	33200
330103	*	0.0131	CATTARAUGUS	33040
330106	*	0.0123	NASSAU	33400
330126	*	0.0642	ORANGE	33540
330132		0.0131	CATTARAUGUS	33040
330135		0.0642	ORANGE	33540
330144		0.0054	STEUBEN	33690
330151		0.0054	STEUBEN	33690
330167	*	0.0123	NASSAU	33400
330175		0.0260	CORTLAND	33210
330181	*	0.0123	NASSAU	33400
330182	*	0.0123	NASSAU	33400
330191	*	0.0017	WARREN	33750
330198	*	0.0123	NASSAU	33400
330205		0.0642	ORANGE	33540
330224	*	0.0633	ULSTER	33740
330225	*	0.0123	NASSAU	33400
330235	*	0.0306	CAYUGA	33050
330259	*	0.0123	NASSAU	33400
330264		0.0642	ORANGE	33540
330276		0.0036	FULTON	33280
330277	*	0.0054	STEUBEN	33690

Provider Number	Reclassified for CY 2009	Out-Migration Adjustment	Qualifying County Name	County Code
330331	*	0.0123	NASSAU	33400
330332	*	0.0123	NASSAU	33400
330372	*	0.0123	NASSAU	33400
330386	*	0.0745	SULLIVAN	33710
334017		0.0642	ORANGE	33540
334061		0.0642	ORANGE	33540
340020		0.0156	LEE	34520
340021	*	0.0162	CLEVELAND	34220
340024		0.0177	SAMPSON	34810
340027	*	0.0128	LENOIR	34530
340037		0.0162	CLEVELAND	34220
340038		0.0253	BEAUFORT	34060
340039	*	0.0101	IREDELL	34480
340068	*	0.0087	COLUMBUS	34230
340069	*	0.0015	WAKE	34910
340070	*	0.0395	ALAMANCE	34000
340071	*	0.0226	HARNETT	34420
340073	*	0.0015	WAKE	34910
340085		0.0250	DAVIDSON	34280
340096		0.0250	DAVIDSON	34280
340104		0.0162	CLEVELAND	34220
340114	*	0.0015	WAKE	34910
340126	*	0.0100	WILSON	34970
340129	*	0.0101	IREDELL	34480
340133		0.0260	MARTIN	34580
340138	*	0.0015	WAKE	34910
340144	*	0.0101	IREDELL	34480
340145	*	0.0336	LINCOLN	34540
340151		0.0052	HALIFAX	34410
340173	*	0.0015	WAKE	34910
344001		0.0015	WAKE	34910
344011		0.0015	WAKE	34910
344014		0.0015	WAKE	34910
360002		0.0141	ASHLAND	36020
360010	*	0.0074	TUSCARAWAS	36800
360013	*	0.0135	SHELBY	36760
360025	*	0.0077	ERIE	36220
360036	*	0.0126	WAYNE	36860
360040		0.0387	KNOX	36430
360044		0.0127	DARKE	36190
360065	*	0.0075	HURON	36400
360071		0.0035	VAN WERT	36820
360086	*	0.0186	CLARK	36110
360096	*	0.0071	COLUMBIANA	36140

Provider Number	Reclassified for CY 2009	Out-Migration Adjustment	Qualifying County Name	County Code
360107	*	0.0119	SANDUSKY	36730
360125	*	0.0133	ASHTABULA	36030
360156		0.0119	SANDUSKY	36730
360175	*	0.0183	CLINTON	36130
360185	*	0.0071	COLUMBIANA	36140
360187	*	0.0186	CLARK	36110
360245	*	0.0133	ASHTABULA	36030
362007		0.0119	SANDUSKY	36730
364040		0.0186	CLARK	36110
370014	*	0.0361	BRYAN	37060
370015	*	0.0366	MAYES	37480
370023		0.0090	STEPHENS	37680
370065		0.0096	CRAIG	37170
370072		0.0258	LATIMER	37380
370083		0.0051	PUSHMATAHA	37630
370100		0.0100	CHOCTAW	37110
370149	*	0.0302	POTTAWATOMIE	37620
370156		0.0121	GARVIN	37240
370169		0.0163	MCINTOSH	37450
370172		0.0258	LATIMER	37380
370214		0.0121	GARVIN	37240
372017		0.0100	CHOCTAW	37110
372019		0.0302	POTTAWATOMIE	37620
373032		0.0100	CHOCTAW	37110
380022	*	0.0067	LINN	38210
384011		0.0107	UMATILLA	38290
390008		0.0060	LAWRENCE	39450
390016	*	0.0060	LAWRENCE	39450
390030		0.0284	SCHUYLKILL	39650
390031	*	0.0284	SCHUYLKILL	39650
390044	*	0.0191	BERKS	39110
390052		0.0047	CLEARFIELD	39230
390056		0.0036	HUNTINGDON	39380
390065	*	0.0532	ADAMS	39000
390066	*	0.0372	LEBANON	39460
390079	*	0.0003	BRADFORD	39130
390086	*	0.0047	CLEARFIELD	39230
390096	*	0.0191	BERKS	39110
390110	*	0.0003	CAMBRIA	39160
390113	*	0.0053	CRAWFORD	39260
390117		0.0002	BEDFORD	39100
390122		0.0053	CRAWFORD	39260
390125		0.0022	WAYNE	39760
390130	*	0.0003	CAMBRIA	39160

Provider Number	Reclassified for CY 2009	Out-Migration Adjustment	Qualifying County Name	County Code
390138	*	0.0218	FRANKLIN	39350
390146		0.0022	WARREN	39740
390150	*	0.0031	GREENE	39370
390151	*	0.0218	FRANKLIN	39350
390162	*	0.0205	NORTHAMPTON	39590
390183	*	0.0284	SCHUYLKILL	39650
390201		0.1170	MONROE	39550
390236		0.0003	BRADFORD	39130
390313	*	0.0284	SCHUYLKILL	39650
390316		0.0191	BERKS	39110
392030		0.0532	ADAMS	39000
392031		0.0003	CAMBRIA	39160
392034		0.0205	NORTHAMPTON	39590
393026		0.0191	BERKS	39110
393050		0.0205	NORTHAMPTON	39590
394014		0.0191	BERKS	39110
394016		0.0022	WARREN	39740
394020		0.0372	LEBANON	39460
420002		0.0004	YORK	42450
420007	*	0.0027	SPARTANBURG	42410
420009	*	0.0113	OCONEE	42360
420019		0.0158	CHESTER	42110
420020	*	0.0007	GEORGETOWN	42210
420027	*	0.0108	ANDERSON	42030
420030	*	0.0069	COLLETON	42140
420036	*	0.0064	LANCASTER	42280
420039	*	0.0111	UNION	42430
420043		0.0157	CHEROKEE	42100
420053		0.0035	NEWBERRY	42350
420054		0.0003	MARLBORO	42340
420062	*	0.0109	CHESTERFIELD	42120
420068	*	0.0027	ORANGEBURG	42370
420069	*	0.0052	CLARENDON	42130
420070	*	0.0052	SUMTER	42420
420082		0.0008	AIKEN	42010
420083	*	0.0027	SPARTANBURG	42410
420098	*	0.0007	GEORGETOWN	42210
422004		0.0027	SPARTANBURG	42410
423028		0.0004	YORK	42450
423029		0.0108	ANDERSON	42030
424011		0.0108	ANDERSON	42030
430008		0.0535	BROOKINGS	43050
430048		0.0129	LAWRENCE	43400
430094		0.0129	LAWRENCE	43400

Provider Number	Reclassified for CY 2009	Out-Migration Adjustment	Qualifying County Name	County Code
440007		0.0219	COFFEE	44150
440008	*	0.0449	HENDERSON	44380
440012		0.0007	SULLIVAN	44810
440016		0.0144	CARROLL	44080
440017		0.0007	SULLIVAN	44810
440024	*	0.0230	BRADLEY	44050
440025	*	0.0007	GREENE	44290
440031		0.0019	ROANE	44720
440033		0.0027	CAMPBELL	44060
440035	*	0.0301	MONTGOMERY	44620
440047		0.0338	GIBSON	44260
440050		0.0007	GREENE	44290
440051		0.0082	MC NAIRY	44540
440057		0.0021	CLAIBORNE	44120
440060	*	0.0338	GIBSON	44260
440070		0.0109	DECATUR	44190
440081		0.0052	SEVIER	44770
440084		0.0025	MONROE	44610
440109		0.0070	HARDIN	44350
440115		0.0338	GIBSON	44260
440137		0.0738	BEDFORD	44010
440144	*	0.0219	COFFEE	44150
440148	*	0.0296	DE KALB	44200
440174		0.0312	HAYWOOD	44370
440176		0.0007	SULLIVAN	44810
440180		0.0027	CAMPBELL	44060
440181		0.0365	HARDEMAN	44340
440182		0.0144	CARROLL	44080
440185	*	0.0230	BRADLEY	44050
442016		0.0007	SULLIVAN	44810
443027		0.0007	SULLIVAN	44810
444008		0.0365	HARDEMAN	44340
450032		0.0254	HARRISON	45620
450039	*	0.0024	TARRANT	45910
450052	*	0.0276	BOSQUE	45160
450059		0.0075	COMAL	45320
450064	*	0.0024	TARRANT	45910
450087	*	0.0024	TARRANT	45910
450090		0.0650	COOKE	45340
450099	*	0.0145	GRAY	45563
450135	*	0.0024	TARRANT	45910
450137	*	0.0024	TARRANT	45910
450144		0.0559	ANDREWS	45010
450163		0.0054	KLEBERG	45743

Provider Number	Reclassified for CY 2009	Out-Migration Adjustment	Qualifying County Name	County Code
450192		0.0271	HILL	45651
450194		0.0213	CHEROKEE	45281
450210		0.0151	PANOLA	45842
450224	*	0.0195	WOOD	45974
450236		0.0389	HOPKINS	45654
450270		0.0271	HILL	45651
450283	*	0.0653	VAN ZANDT	45947
450324	*	0.0132	GRAYSON	45564
450347	*	0.0370	WALKER	45949
450348	*	0.0059	FALLS	45500
450370		0.0235	COLORADO	45312
450389	*	0.0618	HENDERSON	45640
450393	*	0.0132	GRAYSON	45564
450395	*	0.0441	POLK	45850
450419	*	0.0024	TARRANT	45910
450438		0.0235	COLORADO	45312
450451		0.0536	SOMERVELL	45893
450460		0.0053	TYLER	45942
450469	*	0.0132	GRAYSON	45564
450497		0.0375	MONTAGUE	45800
450539		0.0067	HALE	45582
450547	*	0.0195	WOOD	45974
450563	*	0.0024	TARRANT	45910
450565	*	0.0510	PALO PINTO	45841
450573		0.0126	JASPER	45690
450596	*	0.0743	HOOD	45653
450615		0.0032	CASS	45260
450639	*	0.0024	TARRANT	45910
450641		0.0375	MONTAGUE	45800
450672	*	0.0024	TARRANT	45910
450675	*	0.0024	TARRANT	45910
450677	*	0.0024	TARRANT	45910
450698		0.0127	LAMB	45751
450747	*	0.0126	ANDERSON	45000
450755		0.0276	HOCKLEY	45652
450770	*	0.0182	MILAM	45795
450779	*	0.0024	TARRANT	45910
450813	*	0.0126	ANDERSON	45000
450838		0.0126	JASPER	45690
450872	*	0.0024	TARRANT	45910
450880	*	0.0024	TARRANT	45910
450884		0.0049	UPSHUR	45943
450886	*	0.0024	TARRANT	45910
450888		0.0024	TARRANT	45910

Provider Number	Reclassified for CY 2009	Out-Migration Adjustment	Qualifying County Name	County Code
452018		0.0024	TARRANT	45910
452019		0.0024	TARRANT	45910
452028		0.0024	TARRANT	45910
452041		0.0132	GRAYSON	45564
452088		0.0024	TARRANT	45910
452099		0.0024	TARRANT	45910
453040		0.0024	TARRANT	45910
453041		0.0024	TARRANT	45910
453042		0.0024	TARRANT	45910
453089		0.0126	ANDERSON	45000
453094		0.0024	TARRANT	45910
453300		0.0024	TARRANT	45910
453303		0.0024	TARRANT	45910
454009		0.0213	CHEROKEE	45281
454012		0.0024	TARRANT	45910
454019		0.0024	TARRANT	45910
454051		0.0024	TARRANT	45910
454052		0.0024	TARRANT	45910
454061		0.0024	TARRANT	45910
454072		0.0024	TARRANT	45910
454086		0.0024	TARRANT	45910
454101		0.0067	HALE	45582
460001		0.0023	UTAH	46240
460013		0.0023	UTAH	46240
460017		0.0383	BOX ELDER	46010
460023		0.0023	UTAH	46240
460039	*	0.0383	BOX ELDER	46010
460043		0.0023	UTAH	46240
460052		0.0023	UTAH	46240
460055		0.0023	UTAH	46240
462005		0.0023	UTAH	46240
490019	*	0.1088	CULPEPER	49230
490084		0.0187	ESSEX	49280
490110		0.0185	MONTGOMERY	49600
500003	*	0.0166	SKAGIT	50280
500007	*	0.0166	SKAGIT	50280
500019		0.0131	LEWIS	50200
500039	*	0.0094	KITSAP	50170
500041	*	0.0020	COWLITZ	50070
510012		0.0124	MASON	51260
510018	*	0.0188	JACKSON	51170
510047	*	0.0269	MARION	51240
520028	*	0.0286	GREEN	52220
520035		0.0076	SHEBOYGAN	52580

Provider Number	Reclassified for CY 2009	Out-Migration Adjustment	Qualifying County Name	County Code
520044		0.0076	SHEBOYGAN	52580
520057		0.0193	SAUK	52550
520059	*	0.0195	RACINE	52500
520071	*	0.0161	JEFFERSON	52270
520076	*	0.0146	DODGE	52130
520095		0.0193	SAUK	52550
520096	*	0.0195	RACINE	52500
520102	*	0.0242	WALWORTH	52630
520116	*	0.0161	JEFFERSON	52270
522005		0.0195	RACINE	52500
523026		0.0195	RACINE	52500
524020		0.0193	SAUK	52550
524021		0.0242	WALWORTH	52630
524022		0.0146	DODGE	52130
670015		0.0024	TARRANT	45910
670023		0.0024	TARRANT	45910
673026		0.0075	COMAL	45320

ADDENDUM M.--PROPOSED HCPCS CODES FOR ASSIGNMENT TO COMPOSITE APCS FOR CY 2009

HCPCS Code	Short Descriptor	CI	SI	Single Code APC Assignment	Composite APC Assignment
90801	Psy dx interview		Q3	0323	0034
90802	Intac psy dx interview		Q3	0323	0034
90804	Psytx, office, 20-30 min		Q3	0322	0034
90805	Psytx, off, 20-30 min w/e&m		Q3	0322	0034
90806	Psytx, off, 45-50 min		Q3	0323	0034
90807	Psytx, off, 45-50 min w/e&m		Q3	0323	0034
90808	Psytx, office, 75-80 min		Q3	0323	0034
90809	Psytx, off, 75-80, w/e&m		Q3	0323	0034
90810	Intac psytx, off, 20-30 min		Q3	0322	0034
90811	Intac psytx, 20-30, w/e&m		Q3	0322	0034
90812	Intac psytx, off, 45-50 min		Q3	0323	0034
90813	Intac psytx, 45-50 min w/e&m		Q3	0323	0034
90814	Intac psytx, off, 75-80 min		Q3	0323	0034
90815	Intac psytx, 75-80 w/e&m		Q3	0323	0034
90845	Psychoanalysis		Q3	0323	0034
90846	Family psytx w/o patient		Q3	0324	0034
90847	Family psytx w/patient		Q3	0324	0034
90849	Multiple family group psytx		Q3	0325	0034
90853	Group psychotherapy		Q3	0325	0034
90857	Intac group psytx		Q3	0325	0034
90862	Medication management		Q3	0606	0034